



MHCA submission on the NDIS Rules March 2013

Introduction

The Mental Health Council of Australia (MHCA) is the peak, national organisation representing and promoting the interests of the Australian non-government mental health sector. The membership of the MHCA includes national organisations of mental health services, consumers, carers, special needs groups, clinical service providers, community and private mental health service providers, national research institutions and state/territory peak bodies.

The MHCA is committed to the development of a national disability insurance scheme that will provide much needed support for the human rights of people with a psychosocial disability. These rights are clearly outlined in the United Nations Convention on the Rights of Persons with Disabilities¹.

While the MHCA does not underestimate the scale of the task involved in the implementation of the NDIS Launch, we are disappointed that the implementation process appears to be overlooking important detail and losing the original impetus to protect the rights of the most marginalised groups of people with a disability at this crucial stage in its development. It seems the Draft Rules are at odds with important principles detailed in the NDIS Legislation.

The MHCA is gravely concerned that the NDIS Rules reflect a step backwards from the intent of the Productivity Commission and the original conception of the NDIS scheme to include people with a psychosocial disability related to mental illness and episodic support needs in the NDIS.

The MHCA is also disappointed that the development of the NDIS legislation and rules is being undertaken in such a short timeframe and advises that this has the significant potential to compromise the quality of that legislation and rules and the operation of the Launch Sites. This will in turn impact on the effective engagement of many people with complex support needs in those sites. This includes people with a psychosocial disability whose disability support needs are not currently met. The participation of these consumers in the NDIS launch is essential to shape the way in which the NDIS can effectively meet the support needs of the most marginalised groups of people with a disability.

The following is an outline of the MHCA's concerns.

¹ United Nations. (2006). *Convention on the Rights of Persons with Disabilities*. United Nations, Geneva.

Rules for Becoming a Participant

Section 5.2, *When does a person meet the disability requirements?* and 5.5, *When is an impairment permanent or likely to be permanent?* These provisions appear to exclude people with a psychosocial disability whose impairment related support needs may be intermittent. This new development is contrary to the MHCA understanding to date that people with a significant episodic impairment are included in the NDIS.

It is also disturbing that the first reading of the Bill covers the support needs of people with a psychosocial disability:

the person's support needs in relation to his or her impairment or impairments are likely to continue for the person's lifetime.

However the subsequent Amendment 16 to the Bill appears to have restricted this access to people whose impairments are permanent over a lifetime.² Given the implications of this change and that there has been little time for the community to consider the NDIS Rules or the amendments, it would appear that these provisions have more to do with rationing NDIS supports than they do with meeting the programs stated objectives.

Section 5.7 appears to attempt to qualify this discrepancy:

If an impairment is of a degenerative nature, the impairment is, or likely to be, irreversible if medical or other treatment would not or would be unlikely to improve it.

However, for this provision to be effective it must include not only “medical or other treatment” but also “disability support”. This is because in many cases the illness status and support needs of people with psychosocial disability are highly dependent on the adequacy of current disability supports rather than medical supports. That is, their illness and impairment could easily deteriorate if they do not have access to psychosocial supports that assist them to maintain their permanent accommodation or engagement with the community.

Section 5.8, covering the criteria, that the person “can perform tasks” is ambiguous. It is unclear if this provision will cover the needs of people who may technically have the capacity to perform tasks but *because of their impairment* are not inclined to perform tasks without prompting or negotiation, even in the face of detriment to their own wellbeing. There would be many people with psychosocial disability in this category including people with intellectual disability, acquired brain injury as well as mental health consumers. This section needs to be clarified so that these people are not excluded from disability support.

Supports for Participants

The MHCA is extremely concerned that the rules in Section 7.8 specify that the NDIS will not be responsible for:

² Parliament of the Commonwealth of Australia House of Representatives. (2013) National Disability Insurance Scheme Bill 2012, Supplementary Explanatory Memorandum, Amendments to be moved of behalf of the Government.

Early intervention designed to reduce the progression of a mental health condition (as early interventions in relation to mental health conditions are primarily the responsibility of the health system).

This section must also include:

Early intervention designed to reduce the progression of a psychosocial disability related to a mental health condition would be covered under the NDIS.

Unless this change is made, the MHCA would consider this decision to exclude the support needs of people with a psychosocial disability related to mental health conditions to be arbitrarily made and highly discriminatory. It is simply false to state that “early interventions in relation to mental health conditions are primarily the responsibility of the health system”. Rather this provision appears to be arbitrary discrimination based solely on the nature of someone’s disability. The MHCA and other stakeholders will oppose such provisions vigorously.

The assumption that special rules around disability are required for mental health is very similar to the one first proposed by, and eventually rejected by, the Productivity Commission: that the disability needs of people with psychosocial disability resulting from mental illness should be met by the health system and not the disability system.

The Productivity Commission soon realised that this was not a principle that they could endorse based on evidence. As people with disability have fought so long to establish, disability is not a medical issue but an artefact of the diversity of community experience and the capacity of communities to embrace and support the needs of each member. This is outlined in the preamble to the UN Convention on Rights of Person’s with a Disability.³

Undoubtedly, the interface between the health and disability sectors in the area of mental health is complex, as it can be with other conditions. It is clear that much more thought needs to be undertaken in relation to the challenges posed in designing a funding system for people with psychosocial disability resulting from mental illness. This issue has not been addressed to date, despite years of neglect of the needs of people with psychosocial disability. However the inability of government to resolve these challenges in the extremely short timeframe available should not be the reason that the needs of people with a psychosocial disability become a casualty of the implementation of the NDIS.

The MHCA maintain that there is no a valid reason for the NDIS to avoid the provision of appropriate community based disability supports for this group of people who are entitled to them under the United Nations Convention for Rights of Persons with a Disability.

As the Productivity Commission’s report acknowledged:

people with intellectual disability, acquired brain injury and mental illness are over-represented among the homeless, imprisoned and among drug and

³ United Nations Convention on the Rights of Persons with a Disability 2006.

alcohol service users. There is significant scope to reduce the numbers in this position through the community support funded by the NDIS.⁴

If some people with a significant psychosocial disability related to mental illness are to be in any way ineligible for supports or otherwise constrained under the NDIS, then the reasons for this must be articulated and they must apply to all forms of disability. Discrimination on the basis of disability type is not an appropriate foundation for Australia's landmark disability support system.

The MHCA is also concerned about the ramifications of these issues on Section 7.9 which describes supports most appropriately funded through the NDIS. This section appears to foreshadow the possibility that some services currently funded by the health system, such as the *Support for Day to Day Living in the Community Program*, may be funded through the NDIS in the future. If this is the case then the rules which currently appear to restrict access by people with episodic conditions or to early intervention to the NDIS must be made consistent with the intent of these services, which is to support people with a psychosocial disability no matter what their eligibility for the NDIS.

Rules for Nominees

The MHCA is pleased to note that carer input is acknowledged as key element of nominee arrangements in Section 5.7. This provision ensures that the nominee has the duty to consult any person who assists the participant to manage their day to day activities and make decisions.

However it is a serious omission that the Rules for Nominees do not contain any requirement or information about the need for nominees to practice effective supported decision making, including actively building the capacity of participants. The principle of supported decision making must be an integral part of the operation of the NDIS.

For example 4.8b(ii)C states that the CEO must ensure that nominees have regard to the degree to which the nominee is willing to:

Involve the participant in decision-making processes.

This should be replaced with:

Use the principles and strategies consistent with a best practice supported decision making including actively building the participants decision making capacity.

Similarly, Section 5.9 should be strengthened:

A nominee has the duty to apply their best endeavours to developing the capacity of the participant...

The provision that nominees must apply their best endeavours should be replaced by a robust process to determine if nominees are in fact exercising their duty to undertake this capacity building effectively.

⁴ Australian Government Productivity Commission. (2011). *Disability Care and Support, Productivity Commission Draft Report*. Australian Government Productivity Commission, Canberra.

There must also be a provision covering the use of advance directives for people whose impairment may intermittently affect their ability to make decisions. This includes provision for ensuring adequate review processes for nominee arrangements, particularly where the participant expresses preferences that differ from those of the nominee, including while advance directives are in effect.

Supported decision making approaches and review mechanisms must also be cross referenced to Section 5.4 around the nominee duty to ascertain wishes to ensure the rights of the participant. It is not adequate, as proposed in section 5.4a and b, that a nominee reasonably believes that they have ascertained the wishes of the participant and is acting in the personal and social well-being of the participant if the participant's preferences contradict these beliefs. Again, robust review processes must be in place to ensure the rights of participants are reasonably met with respect to nominee arrangements and these should not be optional or only used at the discretion of the CEO.

Further, sections 5.10 and 5.11 related to management of conflict of interest, set up a situation where the nominee effectively self regulates their duty of care in this regard. While it is appropriate that nominees monitor their actions around conflict of interest, this must be backed up by monitoring from an independent party to ensure that the rights of participants are not eroded.

This is particularly the case where nominees are also service fund holders. While it is not ideal for this sort of conflict of interest to occur, the MHCA acknowledges that in some circumstances there may be no alternatives to this arrangement. Therefore these situations in particular must be subject to stringent monitoring arrangements to ensure that the interests of participants are met.

Plan Management

Part 1(d) should be changed to include the following italicised text:

That people with a disability should be involved in decision making processes that affect them, *supported to participate in these decisions to the maximum extent possible* and where possible make decisions for themselves.

Conclusion

It is disappointing that despite the person centred aims of the NDIS, challenges that that appear to relate more to the allocation of services by government funding silos than the evidence are blocking access to effective disability support to people with a psychosocial disability. The drafting of the rules should address these barriers to whole of government approaches. Otherwise it will continue to be impossible to ensure that the most marginalised people with a psychosocial disability do not fall through the gaps in disability service provision.