Submission

Productivity Commission

Disability Care and Support

April 2011

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1 Executive Summary

Mind Australia (Mind) is pleased to be able to present this submission for consideration by the Australian Productivity Commission Inquiry into a 'national long term care and support scheme in Australia'.

Mind is a leading non-government provider of consumer-focussed, recovery-oriented mental health services in Victoria and South Australia. The organisation works primarily with people who experience significant and ongoing problems associated with their mental health issues.

Recovery, in a mental health context, involves a focus on helping people to live well while managing their symptoms.

Mind is supportive of the overall framework proposed for the National Disability Insurance Scheme (NDIS). Mind also believes that appropriate investments in each of the three tiers proposed will be important to the schemes long term impact.

Mind is aware that the Commission has sought feedback on specific issues regarding the inclusion of mental health and the boundaries with the mental health sector.

The key proposals which are detailed in this submission are:

- **Mind supports the inclusion of people with mental health problems within the NDIS because we judge that the scheme will provide significant benefits to recipients not likely be available through alternative service systems.**

  Mind believes that the core framework of the scheme which focuses upon providing eligible people with an entitlement to support and personal control and choice will contribute much to the wellbeing of recipients.

- **Mind would support the use of functional assessment of disability as the primary drive of decisions regarding eligibility and accepts that information about a diagnosis is one aspect of the information base. We would not support a scheme with eligibility based exclusively or primarily on diagnosis.**

  Equity considerations inform our conclusion that eligibility should be determined predominantly on the basis of a functional assessment rather than focussing upon diagnosis as the basis for inclusion in the scheme.

- **Mind believes that the assessment and support provided should be based upon the six criteria outlined rather than focussed solely on communication, mobility and self care.**

  The submission notes the sustained but changing and changeable support needs which are common for people facing complex mental health related challenges and argues that a broadly based assessment process will be required in order to identify the level and character of needs such individuals and families may experience.

- **Mind believes that interface issues with mental health and other sectors can be resolved at the schemes planning and implementation phases.**

  The submission comments on the complexity of current arrangements and the need for investing in long term support services. It also argues that shared systems and collaborative practice arrangements are required now and the NDIS can become part of that landscape and need not introduce new barriers to a seamless client focussed service.

- **Mind believes that the NDIS should:**

    - **provide flexible packages based on the support framework outlined in the draft report in boxes 3.3 and 3.4**

    - **have the capacity to adapt the care and support packages to respond to changing needs over time.**

  The submission notes the range of services currently provided and accepts that this is a sound basis from which individual consumers (with or without care co-ordination) can work with potential providers to shape a service mix and delivery arrangements that best meets their needs.

- **Mind considers that inclusion of a clear definition of disability based on the ABS one (above) will assist the Commission in ensuring that the scope of the scheme is clear to all parties.**

2 Introduction

2.1 Purpose

This document presents the submission by Mind Australia (Mind) for consideration by the Australian Productivity Commission Inquiry established to inquire into and report on "a national long term care and support scheme in Australia"[1].

The Inquiry published in February 2011 a 2 volume draft report along with a number of appendices.

The draft report proposed the establishment of a new National Disability Insurance Scheme (NDIS) to provide insurance cover for all Australians in the event of significant disability. The scheme would provide a comprehensive framework for addressing the information and awareness needs of the nation as well as providing support to those with significant needs.

It estimated that around 360,000 would receive funding for long term high quality care and support through the scheme. These packages would be portable across Australia and enable recipients to choose their own service providers, request a disability support agency to assemble a package on their behalf, or cash out part of their funding allocation.

The NDIS would cover the same range of supports currently provided by specialist providers but would give people more opportunities to access and choose services which meet their individual needs.

The scheme does not replace the role of mainstream services such as health, education and housing and the draft report expresses concern that possible cost shifting should be constrained.

This submission contains Mind's response to the above request along with additional comments.

2.2 Context

Mind is a leading non-government provider of consumer-focused, recovery-oriented mental health services in Victoria and South Australia. It has been delivering services in Victoria for 30 years and in South Australia since 2005. In 2007, following a significant period of change, it changed its name from Richmond Fellowship Victoria to Mind.

Historically, Mind's focus has been on providing psychosocial rehabilitation services to people experiencing serious mental illness. Mind's focus developed further four years ago and moved to more strongly embrace a recovery approach. This focuses on supporting people who experience serious mental illness in their recovery journey, and assisting them to live well in the community, with or without symptoms. It emphasises the role of relationships, enabling environments, relevant skill building and the development of an enhanced sense of identity as fundamental to recovery.

In the context of mental health, recovery does not necessarily involve 'cure'. It focuses upon enhancing people's capacity to live a meaningful life and to come to terms with the implications of their symptoms. People with long term support needs consistent with the focus of the NDIS can still achieve recovery in this definition.

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[1] Productivity Commission: Draft Report Disability Care and Support, volumes 1 and 2 plus appendices, February 2011

Mind's Strategic Plan 2010-2015 outlines Mind's vision as:

> "Mind will work to support people facing serious mental health challenges to live well and be socially included. In short: Mental Illness – Recovery the Norm – Inclusion the Reality "[2].

Mind's purpose is to:

> "… be a resource to recovery for people who are facing serious mental health related challenges to support them to actively participate in social and economic life by provision of and advocacy for evidence based services and policies which achieve positive social outcomes".

Mind's staff support clients to set their own recovery goals, to access mental health, community, housing, employment and training services, and to participate and contribute in the social and economic life of their communities. In 2008-09 Mind supported recovery for over 4,000 clients and indirectly to many of their families and carers, a 23 per cent growth on 2007/2008. It assisted over 500 young people with severe mental illness and employed 530 staff across Victoria and South Australia.

Mind is a provider of all of the services outlined in Box 3.4 – Specialist Supports in the Mental Health Sector of part 1 of the Commission's Draft Report[3].

Mind therefore has significant experience and expertise relating to clients recovering from mental illness and associated issues they face in doing this.

2.3 The relation of following comments to the terms of reference

The comments in the next section represent Mind's views based on our experience in relation to some important issues and the additional information sought by the Commission.

We would welcome the opportunity for staff and clients to add to them at any public hearings the inquiry may hold.

2.4 Mind contact person

For further information about the contents of this submission, please contact:

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General Manager, Research, Development and Advocacy
Mind Australia

[2] Mind Strategic Plan 2010 – 2015 (no date)
[3] Productivity Commission Draft Report, Disability Care and Support Vol 1 P166.

3 Overview

The National Disability Insurance Scheme as outlined in the Commission's draft report represent a fundamental shift in thinking and approach to disability in the Australian community. The three tier framework is particularly attractive because it:

- Recognises the urgent need for the nation to invest in changing the status and acceptance of people with all kinds of disability. This is pertinent for all kinds of disabilities but particularly so for those dealing with mental health problems and their families. The stigma as well as structural barriers remain significant. The impact of the proposed investment in tier 3 will be diminished in the absence of a significant and sustained investment in 'minimising the impacts of disability'.

- Deals with the information and system access issues which many people face. Mental health and other services systems are currently un-necessarily complex and fragmented but even a streamlined and flexible system can be difficult to navigate for new comers or those who need multiple and changing support services.

- Provides a new and adequately resourced mechanism to provide support and services to people with complex, multiple and long term needs.

Mind's support for the NDIS is based upon this comprehensive framework and the presumption that each component will be adequately resourced. It is our view that the final report needs to emphasis the interdependencies in the framework.

That said the rest of this submission focuses on the questions about mental health raised in the draft report and the role of tier 3 in resourcing people with substantial support needs.

3.1 Feedback sought by the Productivity Commission in its draft report

For completeness we have included the text from the draft report regarding the specific issues on which the Commission seeks feedback.

> *The Commission seeks feedback on where the boundaries between the mental health sector and the NDIS might lie. In particular, the Commission would appreciate feedback on which system would be best placed to meet the daily support needs (not clinical needs) of individuals with a disability arising from long lasting mental health conditions (such as schizophrenia), including:*
>
> - *which services would be provided by the NDIS and not the mental health sector and how these could be clearly identified*
> - *the magnitude of the budget that would be required*
> - *how to guard against cost shifting*
> - *how the NDIS would practically integrate any role in ongoing non-acute services with the wider mental health sector, including any shared responsibilities of case managers in the two systems.*

4 The Need

There is overwhelming data which demonstrates that people with serious mental health problems require ongoing support and in its absence face ongoing health, economic and social isolation. In this context we note the results of only one major study into the circumstances of people with a psychiatric disability[4].

- Persons with a psychiatric disability reported the lowest incomes and the greatest disadvantage of any group. Some 71 per cent of this group were renting their homes – often from a social landlord;
- Thirty-nine per cent of respondents with a psychiatric disability indicated that their needs for assistance were only met in part and 5.6 per cent believed their needs for assistance were not met at all.
- Forty per cent of persons with a psychiatric disability lived by themselves and this is a very atypical household structure compared with the Australian population as a whole. Critically, 40 per cent of persons living in a household with at least one other person shared their living arrangements with another person with a disability.
- Very few persons with a psychiatric disability had full-time employment (31.1 per cent) with 35 per cent reporting that they were unable to work because of disability pension or WorkCover issues, and 15 per cent working part-time or casually.
- Seventy-seven per cent of respondents received the Disability Support Pension, and a government pension or allowance was the major source of income for 94 per cent of households.
- Incomes for persons with a disability were very low, with 34.5 per cent of respondents with a psychiatric disability reporting a household income of less than $12,999 and 90 per cent less than $26,000.

Attachment 1 provides a visual representation of the economic and housing vulnerability that arises for many people with a mental health condition because of their marginal status and the episodic nature of the condition and its health consequences.

We also note the text on prevalence of mental illness in the population in the National Mental Health Report 2010[5]. Included in its commentary regarding 'low prevalence' conditions which affect 2-3% of the adult population:

> *"Psychotic illnesses are frequently very disabling, extending over long periods of the person's life. For a high proportion of the people covered in the 1998 survey, their psychotic illness had been continuous, without a remission, for an average of 15 years since the first onset of symptoms."*

[4] From Beer A, Faulkner D: AHURI Research Paper *The housing careers of people with a disability and carers of people with a disability*, Australian Housing and Urban Research Institute, July 2008, p vii

[5] National Mental Health Report 2010, Australian Government P 16.

5 Commentary

5.1 Core Proposition

The draft report rightly notes the inadequate performance of the mental health system in providing support to people with a mental illness. The report also notes that '*the first best policy response is an adequately funded and properly governed mental health system of the kind advocated by many in that sector'* (p 3.29).

Mind agrees that an adequately resourced response to the mental health needs of Australians is urgently needed.

The NDIS, as proposed in the draft report, includes two critical design features that are neither widely advocated nor anticipated in mental health services but would be of great value to people with mental health problems. They are:

1. **An entitlement based approach**. Entitlements are subject to assessment and other processes but for those who meet the criteria the insurance approach ensure appropriately resourced support. While mental health resourcing may grow as a result of current policy interest there is no assurance that this will either in the short, medium or long term be adequate to meet the demand.

2. **Choice and control**. The NDIS is predicated on a system by which the beneficiary either directly or through trusted advisers has substantial control over the arrangements, processes and structures through which support is delivered. Mind believes that this is an important principle while also recognising that it represents a significant risk to organisations operating under current funding arrangements.

Mind also believes that there are equity issues which should inform the decision about inclusion of people facing serious mental health problems. People with similar levels of disability should receive similar access to public resources and status.

Mind supports the inclusion of people with mental health problems within the NDIS because we judge that the scheme will provide significant benefits to recipients not likely be available through alternative service systems.

We recognise the potential system risks but regard them as manageable. We address these issues in this submission.

5.2 Inclusion Criteria

As noted in the section on needs above a significant number of people with serious mental health problems deal with the disabling aspects of their condition in the long term. While recognising the need to ensure that tier 3 of the scheme is carefully focussed in order to contain public outlays, Mind understands that a number of people not suffering from a psychotic condition or schizophrenia are also disabled by their condition and its consequences in the long term.

There are equity issues in any broadly based service system such as the NDIS. We have noted earlier our view that equity considerations are an important aspect of the rationale for inclusion of people with mental health problems.

Equity issues also arise in the treatment of people within the scheme and those who only marginally miss out.

Internal equity

Internal equity issues may arise if the scheme does not recognise and adequately deal with the dynamics of differing forms of disability.

Unlike many of the disability conditions included in the ambit of the NDIS some of the disabling issues faced by people with mental health conditions are episodic in nature and changing in character over time. People affected in this way need support in different ways and at different levels over time. This changeability should not be the rationale for excluding people rather it should be an argument for application of flexible and changing service responses.

The infrastructure of the NDIS would need to be designed to recognise and adapt to these circumstances. We recognise that this is a detail for attention in the implementation planning phase but regard it as important to note in the final report as the primary drivers of the infrastructure as currently outlined are the physical and intellectual disability groups which have different process as well as support needs.

Marginal Equity

From Mind's perspective the equity considerations at the margins of the scheme could become a very significant issue if a relatively small group are eligible for NDIS tier 3 and the grossly inadequate provision of mental health services outside the scheme continues. The risks of people with only minor differences in need or circumstances being treated dramatically differently is a critical social issue. This is not an argument against inclusion on equity grounds. Rather it is a request that the final report note the potential for extremely inequitable treatment to arise because of failure to develop social and economic policy in a coherent and consistent manner.

These considerations make the question of access criteria and assessment protocols vitally important.

Mind anticipates that choices about access to the scheme could be informed by:

- **A determination of a relevant diagnosis**. The draft report uses the conditions of psychosis and schizophrenia for the purpose of estimating the potential target population. Mind accepts that these are reasonable proxies for the total pool. There are however a significant number of people with other conditions who experience long term and disabling consequences from their mental health condition.

- **Functional assessment**. A functional assessment based approach would only be informed by information and data which demonstrates the limitations on daily living and economic opportunity arising from a person's situation.

Mind would support the use of functional assessment of disability as the primary drive of decisions regarding eligibility and accepts that information about a diagnosis is one aspect of the information base. We would not support a scheme with eligibility based exclusively or primarily on diagnosis.

Mind understands that this will be challenging and notes that it would be undesirable that too little support was available to meet peak needs or that too much support was provided, inadvertently, risking development of too much dependence.

5.3 Assessment

As noted above assessment is a particularly important issue both as a general design feature of the proposed scheme and for ensuring that people with mental health challenges who are eligible are appropriately assessed.

Mind supports the proposed use of the Australian Bureau of Statistics (ABS) approach by the Commission to define people belonging to Tier 3 to whom funded packages are proposed to be available. These are people who experience significant limitations, **or** have an intellectual disability **or** belong to an early intervention group **or** would gain large identifiable benefits from support not otherwise available (page 13).

However Mind contends that a more accurate assessment of which people experience significant limitations would be gained by consideration of the broader range of restrictions and limitations experienced by people with a disability. The three domains proposed by the Commission to be used to determine eligibility are personal limitations in:

- ***Understanding and communicating***
- ***Getting around***
- ***Self care***

Mind considers that, it would be consistent to also consider the significance of other impairments and restrictions in the following areas when assessing which people are included in Tier 3.

- ***Getting along with others***
- ***Life activities: household, school and work***
- ***Participation in society***

The latter three are relevant for all people who have disabilities, but particularly so for those whose disability arises from their mental illness. There are a number of arguments which support this position. They include:

- Mental illness can have damaging impacts upon family, friends and other important relationships. Sustained support is required to rebuild and then maintain these relationships.

- Some people with mental health challenges need support to gain and sustain access to these mainstream activities as well as other opportunities to participate. Support in all these domains is likely to optimise the wellbeing of the person involved and in so doing diminish their call on the scheme over the long term.

This is not to argue that the scheme should have any responsibility for mainstream activities such as housing, education or employment.

Mind believes that the assessment and support provided should be based upon the six criteria outlined rather than focussed solely on communication, mobility and self care.

5.4 Interfaces with mental health and other services

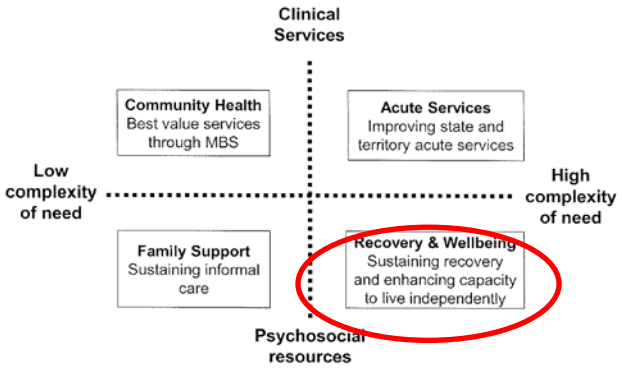
As the draft report indicates, inclusion of people with mental health issues in the ambit of the scheme will raise important issues about the interface with the mental health system.

People with ongoing and serious mental health problems typically require a range of support services clinical mental health services, informal and mainstream services. This means that interface questions are vital now and in the future with or without an NDIS. The structure and arrangements for the NDIS

need to accommodate connections and collaborations with a wide range of partners and or service providers if it is to be effective in supporting people with serious mental health problems.

The following diagram illustrates four key segments within the mental health sector. The diagram simplifies a complex service system intended to meet the needs of a diverse range of conditions and people. As such it should be used for high level analysis rather than detailed planning.

Figure 1



The key problem with the diagram is that it places a notional line between acute and recovery services. This is analytically helpful but operationally problematic. There is increasing evidence that these services need to be provided in a 'seamless' manner. People in need of sustained support as a consequence of their mental health challenges are likely to need ongoing access to acute services.

The interface between acute services and recovery services is already important and there are significant efforts underway in some jurisdictions to ensure the interface is not a barrier. These efforts involve:

- Policies which focus upon 'no wrong door' logics. A potential consumer can approach any organisation and can expect effective service or informed referral rather than being turned away
- Shared assessment tools and processes across organisations and sectors
- Shared practitioner involvement

A key question is whether the NDIS would be a barrier to seamless service delivery as an affirmative answer would contradict the core proposition outlined earlier.

In Mind's view the health sector must remain responsible for acute services but does not inherently need to be responsible for the suite of services provided under the recovery and wellbeing construct as outlined. Arrangements differ across jurisdictions but in many recovery and wellbeing services are delivered by a range of specialist and generalist non-government organisations and community health providers. It is anticipated that the NDIS is likely to fund services which could be purchased from a similar range of organisations as well as an expanded number for profit organisations likely to be attracted to the sector.

In order to be able to offer people an understandable and navigable service system which operates seamlessly the key factors are:

- Broadly based service planning processes largely at an area level
- Consistent and interlocking assessment processes which inform service choice and access to service provision

- Provision of care co-ordination support for those who need it in order to manage access to a range of services, clinical, recovery and mainstream

- Collaborative referral processes between services

- Partnership based work on evaluation and research.

There are also important interfaces with the Medicare funded systems and informal systems which would need to be defined if mental health is to be included in the NDIS. The Australian Government has recently announced expansion of the Access to Allied Psychological Services component of the Better Outcomes in Mental Health Care Program. The changes will increase the resources available to people with complex mental health problems to funding for care co-ordination and support in the medium term. As yet there has not been an opportunity to assess how this program will operate or what interface issues may arise. Given the limits imposed on the duration of funding it is likely that this program and NDIS can operate in parallel and without duplication. It may also be appropriate to roll the funds allocated into the NDIS.

As noted earlier in this submission family support is fundamental to people living with ongoing mental health problems. As with other aspects of the NDIS it is important that the scheme reinforce rather than displace informal support. Existing strategies manage this partly by design and partly as a consequence of demand pressures. Work will be required in the implementation planning process to ensure that the existing interfaces are amended and reinforced.

Mind believes that interface issues with mental health and other sectors can be resolved at the schemes planning and implementation phases.

5.5 Support framework

In Mind's view the focus of the NDIS should be upon provision of all the ongoing non-acute rehabilitation and extended care support needs of people experiencing significant disadvantage as a result of their mental illness. This position is consistent with the construct of recovery and wellbeing in the diagram above and the references to Non-acute services discussed in Box 3.3 and the Specialist Supports in box 3.4 of the draft report.

As noted above Mind provides the full range of services identified in the draft report which by implication would provide the core options for those funded by the scheme. That said we anticipate that individual beneficiaries will adapt and customise their support needs.

Mind is currently a substantial provider of care co-ordination and individual packages funded by State Governments and other providers including employment services and health services as well has having some private case management services. This experience demonstrates that individuals can and do adapt their services when supported by an informed and flexible adviser and service provider.

We would note the importance of a family focussed approach as the evidence from our practice indicates that provision of support to families whether living with or independently from the service recipient is an investment which generates significant returns in terms of family relationships and ability to sustain or resume a caring responsibility.

Care co-ordination and service delivery, whether separately delivered or as a package must have clear structure in order to provide focussed and relevant support. For people with complex and long term support needs care co-ordination is often important.

The draft report uses constructs regarding the extent of daily support requirements as the basis for analysis and costing of people's care and support needs – a 'severity' index. Mind accepts that this is an

appropriate tool by which to make macro costing estimates. It is also a reasonable proxy for modelling the support needs of people whose disability is relatively stable and consistent. As outlined earlier and graphically demonstrated in the diagram in Attachment 1, some people facing serious mental health challenges have changing needs. This means that their care and support needs – the severity group in which they fit will change both upwards and downwards and that their support needs will come in clusters rather than being consistent over time.

Mind believes that the NDIS should:

- **provide flexible packages based on the support framework outlined in the draft report in boxes 3.3 and 3.4**

- **have the capacity to adapt the care and support packages to respond to changing needs over time.**

5.6 Magnitude of budget required

> *"It is not known how much spending on mental health services is required to meet the priority needs of the Australian population. However, surveys conducted of the extent of mental illness in the population have found a high level of need."*[6]

There is widespread recognition that clinical, non-clinical and mainstream support services for people recovering from a mental illness are inadequate. While some additional resourcing has been foreshadowed in Commonwealth and State budgets over coming months, this is by no means certain and is unlikely to completely redress the major deficits that Governments acknowledge existing in mental health services and mainstream capacity to provide support.

What can be said is that there will be increased demand and there is need for priority setting and planning the best use of resources available: both those provided through the NDIS and those provided through direct and targeted government funding.

The great majority of mental health resources are in the clinical services area above the horizontal axis in the diagram presented earlier.

Over the 5 year period 2006 to 2011, governments committed a little over $4 billion to mental health under the National Mental Health Action Plan. This was allocated to four identified action areas in the following way:

65%	Integrating and improving the care system;
11%	Promotion, prevention and early intervention; and
5%	Increasing workforce capacity
19%	Participation in the community (including employment and accommodation);

These funds sit alongside other outlays including the Medical Benefits Scheme and the Pharmaceutical Benefits Schemes which accounted for some 25% of total mental health related outlays by all Governments in 2007/08.

Detailed data regarding the current investment in the recovery and wellbeing domain are not available. From an analysis of the data in the National Mental Health Report 2010 released by the Australian Government it is possible to conclude that the investment is relatively small. At a national level:

[6] National Mental Health Report 2010, Australian Government, P 12

- 4.2% of resources are invested in non-government service provision. This sector is the primary provider of recovery services and therefore much but not all of this investment would be associated with recovery service provision

- 3.6% of resources are invested in state and territory residential services. Not all of these services are recovery focuses some are clinical services.

- 23.8% of resources are in state and territory ambulatory services. Most of these are clinical services but a percentage (small) would have a recovery orientation[7].

It should also be noted that these outlays provide services to a range of people some of whom would not meet the criteria for inclusion in the NDIS.

The implication of this commentary is that there would be relatively limited funds available for transfer into the NDIS or to support tax reductions to offset the new costs associated with the introduction of the scheme.

5.7 How to guard against cost shifting

Mind believes that the opportunities for cost shifting in the formal sense are relatively small. Mind understands cost shifting to involve artificial arrangements designed to arrange service provision in order to access resources which would, in the normal course of events, not be available or appropriate.

The opportunities for redistribution of effort are however significant. The mental health service system is relatively locked in by existing allocations to health and other service providers. Service recipients can only access the available services even when they may be sub-optimal. The existence of the NDIS with entitlements and choice as key features would open new options for people and it is likely that this will lead to changes in practice. From a consumer perspective Mind regards this as a good thing. Mind also understands that this has the effect of transferring costs from states and territories onto the nationally funded NDIS and, on balance, believes this is in the national good.

It should however be noted that demand for clinical services considerably exceeds capacity and any redistribution is likely to have the effect of enabling additional people to access clinical services and this is also a public good.

Mind anticipates that the NDIS is likely to require both national agreements and potentially legislative change at state and territory level. In this context agreements regarding maintenance of effort and collaborative agreements regarding the management of mental health should be included.

There are also issues with regard to the funding of family services and specifically the range of nationally and jurisdictionally funded respite programs. The risks seem more of NDIS displacing informal effort rather than cost shifting.

These programs some of which are outside the range of programs used in the draft report to identify offsets (table 14.20 on page 211 of Volume 2) should also be considered for partial inclusion.

5.8 How the NDIS would integrate with on-going non-acute services and the wider mental health sector

Mind believes that NDIS funded support, services and interventions can integrate with both other non-acute and mental health services. Navigation of the mental health, primary health and other

[7] Ibid, P 34.

mainstream service systems such as social housing and employment services is currently a major issue for people with multiple and complex needs.

NDIS support will, for those who are eligible, consolidate the resourcing and change the nature of their relationship with the service system. They will no longer be totally dependent upon the effectiveness of referral systems; they will have power through purchasing.

Key points about integration include:

- The NDIS will depend upon a robust and independent assessment process for its operation. While complex in its own right the existence of such an assessment capacity along-side a clinical assessment process will be a good thing. The task will be to ensure that there are protocols in existence which define the roles and interfaces between the two assessments. The assessment of long term disability support needs should be informed by the clinical assessment but is also focussed upon factors beyond that encompassed by a clinical focus.

- Individuals receiving NDIS resources will continue to need clinical services and should have access to such services on the basis of need. Many people will be able to navigate these different services independently while others will benefit from the support of a care co-ordinator.

- For people with serious mental health problems housing, education and employment are critical issues and existing mainstream systems are inadequately responsive. The NDIS may impact upon this situation through increasing provision of care co-ordination capability but the core problems must be tackled through changing policy rather than improving interfaces.

6 Other Matters

6.1 Defining key terms such as "disability"

Mind believes that the final report would benefit from:

- **Clearer definitions of terms**. The draft report includes necessary and appropriate discussions regarding the various definitions of disability which exist.

  Mind supports the Commission's thinking that the social model of disability which considers both the personal limitations and the social limitations experienced by a person should be the basis for this.

  While the COAG National Disability Strategy 2010-2020 uses definitions based on the *Disability Discrimination Act 1992* (Cwlth), its definition of disability is clearly limited by its broad medical definition of disability. This incorporates all forms of medically diagnosable disease or dysfunction, real or imputed, temporary or permanent, and past or present (see Attachment 1 for the CDDA definition).

  This attaches the disability to an individual person, but according to the social model of disability, it ignores the systemic barriers, negative attitudes and social exclusion which it argues that these social aspects contribute significantly to the dis-ability experienced by a person.

  For this reason, the ABS[8] makes a strong distinction between the impairment a person has and the restrictions on activity or participation that result from it. Disability for the ABS results from an impairment, a limitation or a restriction experienced by a person which lasts more than 6 months and restricts their daily life. (See Attachment 1 for the ABS definition). The core element of the ABS definition is:

  > "A person has a disability if they report they have a limitation, restriction or impairment, which has lasted, or is likely to last, for at least six months and restricts everyday activities".

  The ABS specifically includes as a disability any significant and persistent limitation, restriction or impairment that arises from the following which could appropriately apply to people with a significant mental illness:

  - nervous or emotional condition causing restriction
  - mental illness or condition requiring help or supervision
  - receiving treatment or medication for any other long-term conditions or ailments and still being restricted
  - any other long-term conditions resulting in a restriction.

  Mind understands that the Commission needed to test the scope of disability to be included within the NDIS and therefore did not formalise this as a definition. We believe that the final report needs to specify the general definition and the specific criteria which should guide the implementation of the NDIS.

- **Inclusion of a glossary**. Mind wishes to draw the Commission's attention to the apparent lack in the draft report of a glossary containing clear definitions of key terms. For example, while the

[8] Australian Bureau of Statistics (ABS) Disability, Ageing and Carers Australia Summary of Findings 4330.0, 2009, p 27

report discusses within the text the meaning of terms such as “disability”, “severe or profound disability”, “health”, “health services”, “mental health”, ”supports”, “services”, and also refers within the report to how some of these are used, they are not clearly defined in one space such as a glossary.

7 Conclusion

The key messages from this submission are:

- **Mind supports the inclusion of people with mental health problems within the NDIS because we judge that the scheme will provide significant benefits to recipients not likely be available through alternative service systems.**

- **Mind would support the use of functional assessment of disability as the primary drive of decisions regarding eligibility and accepts that information about a diagnosis is one aspect of the information base. We would not support a scheme with eligibility based exclusively or primarily on diagnosis.**

- **Mind believes that the assessment and support provided should be based upon the six criteria outlined rather than focussed solely on communication, mobility and self care.**

- **Mind believes that interface issues with mental health and other sectors can be resolved at the schemes planning and implementation phases.**

- **Mind believes that the NDIS should:**

    - **provide flexible packages based on the support framework outlined in the draft report in boxes 3.3 and 3.4**

    - **have the capacity to adapt the care and support packages to respond to changing needs over time.**

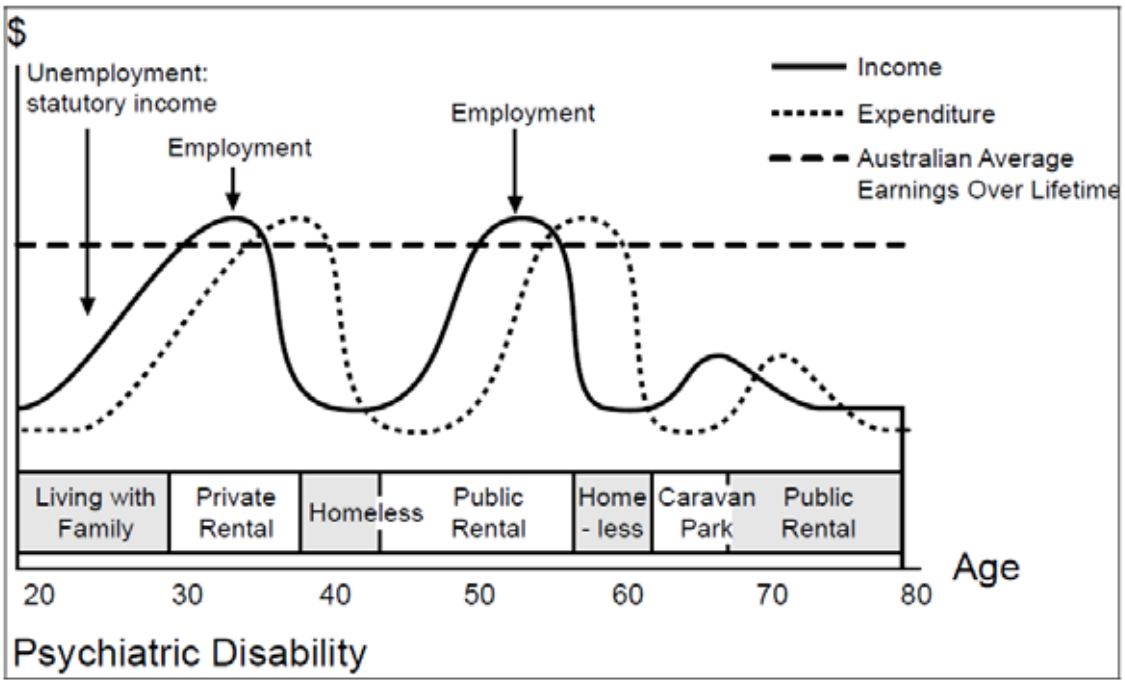
- **Mind considers that inclusion of a clear definition of disability based on the ABS one (above) will assist the Commission in ensuring that the scope of the scheme is clear to all parties.**

Attachment 1

The impact significant mental illness can have on a person's ability over an extended period of time to maintain adequate income, to retain employment and to gain affordable housing is illustrated in the following diagram[9].

This idealised diagram illustrates the impact over time of the impact that episodic mental illness can have on a person who loses his or her job with a resultant significant impact on income and the short and longer term housing that is normally available to him or her. For most people in this situation, gaining rental social or public housing is often the best option they can aspire to because its income-based rent is affordable and is able to vary in times of higher or lower income.

Figure 2.6: Indicative housing career for a person with a psychiatric disability



[9] From Beer A, Faulkner D: AHURI Research Paper *The housing careers of people with a disability and carers of people with a disability*, Australian Housing and Urban Research Institute, July 2008, p 9

Attachment 2 – Mind's Approach to Recovery

Aspects of recovery

Consistent with the organisation's stated purpose Mind seeks to assist clients, carers and families to access whatever resources will support their recovery and promote meaning and purpose in their life. A diversity of areas have been identified as having a significant impact on people's recovery and wellbeing, from both consumer and other sources. Based on this information Mind thinks about recovery in the following ways.

1. The Self

The focus of this domain is the building of one's sense of self that underpins the ability and confidence to make decisions and act purposefully. They key elements of our work are:

- Hope and Trust
- Sense of self

2. Wellness and Capacity

The focus of this domain is upon building capacity to address issues which effect individual wellbeing. The key elements of our work are:

- Mental health
- Physical health
- Living Skills
- Substance use

3. Participation and Engagement

The focus of this domain is upon building capacity to lead a productive and rewarding life as a valued member of the community. The key elements of our work are:

- Relationships
- Social Networks
- Work and education
- Housing