WESTERN AUSTRALIAN ASSOCIATION FOR MENTAL HEALTH

SUBMISSION TO THE PRODUCTIVITY COMMISSION ON THE NATIONAL DISABILITY INSURANCE SCHEME

Background

This submission is presented to the Productivity Commission by the Western Australian Association for Mental Health (WAAMH) in response to the Commissions draft report *Disability Care and Support*. WAAMH is the peak mental health representative body in Western Australia for community based organizations. It is WAAMHs role to support the development of the community based mental health sector, provide systemic advocacy and representation and influence public opinion for the benefit of people living with mental illness and their carers.

In framing its response, WAAMH considers its diverse membership base and the needs of the community mental health sector more broadly and how the establishment of an NDIS that places mental illness firmly 'in scope' can benefit people living with mental illness.

The boundary between the mental health and disability sectors

In the Draft Report, the Commission identifies a series of requests for information

> *The Commission seeks feedback on where the boundaries between the mental health sector and the NDIS might lie. In particular… 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…*

As WAAMH stated in its initial response to the Commission

> *Mental health should be 'in': mental health should be in the scope of the Disability Care and Support reform. People with mental illness have a disability and as such this disability should be recognized along with physical or intellectual disability. Like people who are challenged by other disabilities, people with mental illness can contribute and have right of citizenship. Putting mental health into the Disability Care and Support discussion will potentially allow funding to be allocated to assist people with mental illness on their recovery journey and can promote inclusion into communities and decrease stigma.*

The question remains, how do we determine the boundary between the mental health and the disability support sectors? Broadly, WAAMH supports the statements made by Wesley Mission, Victoria and National Disability Services, respectively (in regards to people with a mental illness) that

> *...Whilst their mental health needs should remain treated within the mental health sector, their support needs in relation to participation in activities for a reasonable quality of life should be met within the disability system.*

And;

> *...eligibility for people with a mental illness should only be considered when a person needed ongoing support to live within their community or to obtain and maintain employment. The treatment provided for the mental health condition, however, should remain the responsibility of the health sector.*

In the Draft Report *the Costs of the Scheme* identifies a way of determining an individual's eligibility for the NDIS as 'people who need assistance with at least one core activity at least weekly'. WAAMH will discuss 'counting eligible citizens', for want of a better phrase, in detail later in its submission however; This expression is one way of considering eligible population. Those individuals whose core activities are affected by their mental illness i.e. their mobility, communication or other personal functioning is affected to such an extent that they are unable to, for example maintain a tenancy or generally live a healthy existence without assistance.

<u>Determining eligibility for the NDIS</u>

The immediate difficulty in determining eligibility for the NDIS is establishing how to count people (eligible population) by their diagnosis, a dubious task when considering the fluctuating and cyclical nature of mental illness. In some ways, determining eligibility requires abandoning these thought processes in favour of thinking about what are the services that people require to live a life of wellbeing. This type of thinking, firmly embedded in the recovery model (which WAAMH will expand on later) opens the door to move away from simply thinking about what is making someone 'sick' to thinking innovatively about processes and systems that can be put in place to lead to wellness.

Moving away from theory, practical considerations for the Commission in determining eligible population could also be made by accessing data from existing successful mental health programs. These programs are those made available already to individuals who require daily supports to undertake 'core activities'.

- The FaHCSIA funded Personal Helpers and Mentors Program (PHaMS) which uses a recovery approach, assisting people over the age of 16 years to manage their daily activities and to live independently in the community and;
- Any supported accommodation programs that are currently providing housing access to people living with a mental illness who would be unable to maintain a private tenancy.

<u>What is the Recovery model and what does it means for the NDIS</u>

As mentioned previously, WAAMH would also like to bring to the attention of the Commission the *recovery model* of working with people living with a mental illness. The approach of WAAMH, and the mental health sector in WA more broadly (to say nothing of other community based services across

Australia) is firmly entrenched in a recovery model. The model has been adopted internationally with success and refers to the act of working in genuine partnership with the individual involved.

> *(Recovery is)…a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life even within the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effect of mental illness.* (Anthony: 1993)

Too much of the prevailing attitudes to approaching and treating mental illness involve something 'being done to' an individual 'in a special facility'. Inclusion of mental illness in the scope of the NDIS opens the door to more innovative solutions that adopt the recovery model.

In considering the recovery model and inclusion of mental illness in the NDIS, it may help to think of the following: Through misadventure, environment or an individual's genetic predisposition to mental illness a person is affected by a mental health issue. Why shouldn't there be a system that supports this individual? Or, given that mental illness creates significant disadvantage for individuals living with it, what supports need to be available to ensure that an individual is able to move from a point of crisis to recovery; recovery being the living of a satisfying, meaningful and hopeful life within the limitations of mental illness?

If the Government is serious about its social inclusion agenda it must consider, in thinking about mental illness, the need to move from a medicalised to a recovery model, within the scope of the NDIS and other programs it develops in the future to improve the quality of life of individuals living with a mental illness.

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