AFDO Productivity Commission Inquiry – Round 2 Submission

ELIGIBILITY CRITERIA

Overall, there has been strong community support for not restricting access to an NDIS. Those who were consulted echoed AFDO's concerns as laid out in our first submission to this inquiry, namely that:

1. To place boundaries around the system would be to violate the human rights of people with disability;
2. There are other universal systems – such as Medicare – in Australia, and disability care and support is important enough to be another area of universal coverage;
3. Functional criteria should be used for deciding who is eligible;
4. Benefits from small amounts of support may be large for people with mild to moderate support needs.

Recommendation: That the NDIS should include mechanisms for offering supportv for people with mild to moderate disability.

Recommendation: People with disability should be eligible for the NDIS regardless of age or residency status.

Recommendation: The NDIS should work from functional definitions of disability.

Should these recommendations fail to be met, the following concerns need to be taken into consideration:

People with a severe or profound core activity limitation in mobility, self care or communication

Recommendation: That guidelines and clear information about eligibility criteria be developed in the early stages of the NDIS transition. Target audiences should include people with disability, their families and assessors working within the NDIS.

People with disability are concerned that their eligibility may be difficult to determine, and will rely heavily on their skill in advocating for their own needs, as well as the skill of the assessor and the appropriateness of the assessment tool.

“Severe and profound… I wouldn’t know what those terms meant.”

In particular, the ways in which different disability types ‘significantly’ impact on a person can vary considerably. The Commission’s draft report acknowledges this to some extent in the discussion about assessment, but it is worth emphasizing that these difficulties will impact upon people getting into the NDIS in the first place.

This is particularly the case for people with sensory disability. A person who is blind or vision impaired may find that, for instance, they do not have trouble showering or dressing themselves, but they do need assistance to learn how to do their hair and to get feedback on whether their clothes match up. Support may also be very context dependent: a person with hearing impairment may need some assistance to communicate over the telephone via a captioned telephone, but may not require support because they can lipread.

People for whom early interventions are necessary

For some people with disability, early interventions for degenerative conditions may be predictable. However, the type of symptoms and their onset vary significantly for many people with degenerative disabilities. This means that what the system classes as an 'early intervention' versus a part of a person's longer term supports, might not be very clear. For example:

"*It takes so long for us to get the things we need that by the time they come we might not need them anymore, or we've been needing them so urgently that we've gone out and paid for them ourselves. When I was first diagnosed with MS we had to pay for my electric wheelchair and chair lift because I wasn't using them daily, even though we knew from the information we had that I soon would. We just didn't know if it would be in six days, six weeks, six months or six years."*

As this example shows, for the NDIS to best meet the needs of people who require early intervention, it will need to:

- Have fluid boundaries between what is an 'early intervention' and what is an 'ongoing support need', with the ability for people to access both as needed even if they fall into the early intervention category;

- Be responsive in re-evaluating people's needs as quickly as possible once a person with disability or their supporters has identified that their needs have increased;

- Provide for emergency loans or purchases of aids and equipment, or emergency packages of support for people across all eligibility types, including those using 'early intervention'.

Furthermore, the early intervention eligibility criteria and support delivery system needs to take into account that interventions which produce positive results are not always therapeutic or medical in nature. For example, a person with a degenerative physical disability might wish to move to a location closer to accessible public transport. This would allow them to continue working and/or participating in the community. Depending on that person's situation they might need:

- advocacy to assist with moving in the public housing system or to break a private rental lease;

- financial assistance through existing mainstream government programs and/or the NDIS in order to pay for bond or removalists;

- advice about public transport accessibility in a number of locations to help with decision making; and/or

- Physical assistance from personal support workers to pack and unpack.

While nearly all of these items - bar financial support to move - are clearly covered under the NDIS, they are not so clearly labeled as 'early interventions'. Only the final need for support would qualify as a ‘tier three’ support; however, addressing this need for support could be crucial to ensuring that a person has the ability to plan for a better ongoing quality of life. To persist with the idea that an early intervention is purely medical in nature would be counter-productive.

People who do not fit into any other category but who can demonstrate great benefit from support

This category poses two difficulties: firstly, it will be difficult for people with disability who have never had support to prove that they can benefit greatly from getting it. As with some of the other categories of support, whether a person is able to gain the support they need will depend heavily on how articulate and pushy they, or their supporters, are.

Secondly, there are potentially many people with disability who could fit into this category; the Commission has already indicated that it is mindful of not ‘opening the floodgates’ in this area. However, many people who fall into the mild or moderate categories of disability can demonstrate great advantages to minimal supports. For example, a person who is hearing impaired may ‘only’ need two hearing aids in order to function in a way which means they are not left out of social interactions and can independently use the telephone, go to the movies and work. Even if a $500 annual co-payment is introduced, it would take ten years for a person who needed hearing aids which sell for $5,000 to reach an equivalent personal cost.

Psychosocial Disability

Recommendation: The NDIS should include people with psychosocial disability who need support. Eligibility for people with psychosocial disability should not be tied to unreliable, and often unwanted, diagnoses, but rather to the functional needs of the person. Consideration should be given to the fact that people with psychosocial disability often need supports which are similar to those used by other disability types, but for different reasons.

There has been a strong sentiment at AFDO consultations that people with psychosocial disability should be included under the NDIS. Many feel that psychosocial disability should not be placed into separate legal and systemic categories for support. In particular, a number of people mentioned that a dual diagnosis of another kind of disability as well as a psychosocial disability often makes it difficult to get support for one or both conditions:

“My son’s got high functioning autism and OCD. He sees someone once a month, a psychiatrist, but when we try to get him into other support programs they say ‘Oh, he’s just a teenager, he’ll grow out of it’ or ‘It might just be something to do with the autism’ or ‘Oh, it’s not life threatening so we can’t help you’.”

For people living with psychosocial disability, the level of support required may vary greatly. In general, it falls into categories of:

- **Need for daily support:** among a number of people with psychosocial disability, there is an ongoing need for daily support. This would include people with severe, persistent disability, but is not restricted to people who experience psychosis; some people with mood related conditions such as anxiety or depression may find themselves unable to leave home for extended periods of time, for example.

  The kinds of supports required by people with psychosocial disability are often similar to those required by other people with disability, though they are needed for vastly different reasons: a person who becomes anxious in large crowds may need access to a taxi voucher scheme because public transport travel is too difficult, for example. Flexibility of supports is especially important to this group, given that relationships can change quickly and supports appear or disappear with little notice.

- **Need for intermittent support:** People with ongoing but episodic psychosocial disability may need little or no support for longer periods of time, but require intensive non-medical assistance – such as help to pay bills and maintain their house.

- **People who require early access to other supports**: While ongoing and periodic support may be useful for people with certain types of psychosocial disability, simply obtaining the right kinds of support at the right time can prevent people from becoming disabled by a psychological condition. In these cases, people can be referred to other specialist supports.

  Where there are multiple issues occurring, the NDIS should offer advocacy and case management support as necessary. The NDIS should have systemic functions which look at barriers to use of these resources.

At present people with psychosocial disability require a formal diagnosis to access supports. As outlined further in this submission, such a focus on diagnosis can lead to a number of difficulties for people who are unable to be diagnosed or for those who believe they need assistance but do not agree with a medical diagnosis.

“I know so many people who have had more than one diagnosis. I’ve had eight. It took me over twenty years to get the right diagnoses and the right treatments.”

Likewise, people with multiple disability do not need to be left in the same traps where their psychosocial disability is considered to be ‘too mild’ for them to access supports under the NDIS while their other condition/s are covered by the scheme.

People over Aged Pension Age

Recommendation: People over the aged pension age should still be able to have access to the NDIS to ensure that their disability specific support needs are met.

Recommendation: People with disability within the NDIS who reach age pension age should be able to ‘mix and match’ their supports between the NDIS and the aged care system should they so wish.

There are grave concerns about the plans to restrict the NDIS to people under the Aged Pension Age. This means that people who require disability-specific supports will have to find them within an aged care system which does not cater to disability specific supports; nor does it plan to do so from any currently available evidence.

Choice for people over the aged pension age should not be a matter of one or the other; the approach should be mix and match. People with disability over the age of 65 may choose age-appropriate accommodation (such as a retirement village or nursing home) which means they require fewer supports (such as assistance with making meals, cleaning and home modifications like a shower hoist), but will still require disability specific supports (such as a wheelchair, interpreter or support worker to help with budgeting).

People who are not Permanent Residents

Recommendation: Any person on Australian soil should have access to disability supports under the NDIS as a basic human right. Restricting eligibility to permanent residents restricts the rights of people with disability to migrate or to seek asylum in Australia; these are critically protected rights under the UN CRPD.

While other forms of support – such as free healthcare – are not made available to people who are not permanent residents of Australia, this is done on the assumption that a) adequate private models of support exist for those who need services like healthcare and can afford it, and b) generic support services for migrants and refugees will often cater to the needs of those who cannot support themselves.

In the case of disability supports, whether you can access adequate private supports depends, like many other things, on where you live and how adept you are at navigating sometimes confusing systems. Many cultures harbor the belief that a person with disability should be looked after within the family unit, and a lack of ability to choose formal supports can lead to people with disability becoming more vulnerable.

Assessment

0.1 Assessing Eligibility

Diagnosis and Assessing Eligibility

There are a number of strong arguments for not relying on medical diagnosis of disability when deciding whether someone is eligible for supports under the NDIS. A medical diagnosis may be impossible, or may take a long time to achieve. A person who legitimately needs supports should not lose out in the meantime.

For example, a person with multiple sclerosis only receives a diagnosis after two episodes, which may be years apart. There are a range of tests which can confirm that a person's condition 'looks like' multiple sclerosis, but none are considered conclusive without a second episode of symptoms.

Yet a first episode may mean an inability to walk for some amount of time. This is far more relevant to a person's need for support than whether they have an official diagnosis. Once they have a diagnosis their prognosis may be useful for planning their ongoing supports (different types of MS proceed with different speed and severity), but it is obvious that support should begin before planning can be done in such cases.

Furthermore, some diagnoses may not be accurate. For people with psychosocial disability, this is especially likely; many people with psychosocial disability endure one or more incorrect diagnoses followed by incorrect treatment for their condition before they find something that works - assuming that they do.

This is often because psychosocial disabilities have broad diagnostic criteria which tend to overlap from condition to condition. Again, there are no definitive tests, and a diagnosis is often made by a psychiatrist who has seen a person for a very limited amount of time: for example, four fifteen minute sessions. Furthermore, people who dispute their psychiatrist's diagnosis are often labeled negatively, and may receive another diagnosis related to their 'non compliance', such as Borderline Personality Disorder (BPD) or an anxiety disorder.

In the current system for people with psychosocial disability, to reject a medical diagnosis is to reject both medical and non-medical supports. Often, having a diagnosis is the only way to get access to supports such as housing support and help with daily living skills. This is not a unique situation; access to the Disability Support Pension is partially determined by functioning and partially by a diagnostic threshold. A failure to meet one or the other may mean a failure for a person with any kind of disability to receive what is genuinely necessary support.

DIagnosis and Assessment Tools

Formal diagnoses and disability 'types' are not useful in assessment tools. Uncertainties and inaccuracies of diagnosis are problematic, but it is also true that a person may have one or more disabilities. Statistics show that children with disability are increasingly being born with complex needs[1], and the older a person is the more likely they are to have multiple disabilities[2]. Once a person has more than one disability, they are far more likely to develop further disabilities and health conditions.

Whilst different disability types may have very different needs often assessment tools focus on answers to specific questions to determine the needs of people. For instance, the current Treating Doctors Form for Mobility Allowance asks questions about physical, psychiatric and intellectual disability. Within the physical disability category, the person may have difficulty:

- Walking 400 metres
- Standing in a bus, train etc.
- Sitting in public transport
- Crossing streets and negotiating kerbs
- Negotiating steps in or out of a train
- Negotiating large flights of steps

Nowhere does this assessment take into account an ability to read a timetable or signage, to hear announcements and to find and communicate with staff and other commuters. Even within the category of physical

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[1] AIHW 2008. Disability in Australia: trends in prevalence, education, employment and community living. Cat. no. AUS 103. Canberra: AIHW.

[2] AIHW 2009. Disability in Australia: multiple disabilities and need for assistance. Cat. no. DIS 55. Canberra: AIHW.

disability the assessment is not always relevant: a person who has limited use of their arms may not be able to independently use ticketing machines, open doors or press a button to indicate they would like the next stop on a bus or tram. They would, however, be able to complete all of the listed tasks.

In the words of the Draft Report, this assessment tool would produce widely consistent results but limited validity in terms of assessing applicant needs. This highlights why self assessment should be the central – if not the only – assessment tool used to determine eligibility for the NDIS.

Different Assessments for Different Purposes

The purpose of the assessment is almost as important as what is being assessed. The 'what' can change drastically with the recognized outcome. For example, if the purpose is to meet the immediate needs of someone in crisis, what is assessed will be very different to a case where long-term needs are being assessed. In longer term assessments, it is important for certain factors to be included and weighted:

- **Age:** The age of a person will mean that different planned transition points will need to be taken into consideration. It may also mean that a person and their family will have different attitudes to disability and different levels of access to other supports (young families may have some respite provided by grandparents, for example, which will not necessarily be appropriate for a teenager with disability).

- **Gender:** some gender-specific issues will need to be assessed when looking at both eligibility and the need for support. For example, single parents are overwhelmingly women, and victims of domestic violence abuse are far more likely to be women. Because of the sensitive nature of some of these issues, it is important that not only are they taken into account as part of the assessment tools, but in the gender and experience of gender based issues among assessors, case managers and advocates.

- **Ethnicity:** Translators will need to be available at every stage of the NDIS for people with disability who do not speak English as their first language, and issues related to ethnicity – such as different cultural understandings of disability, and the tendency for natural supports to be complex – need to be taken into account.

Rural and regional location: Additional supports for travel and to access specialized supports in innovative ways – such as via a broadband internet connection – will need to be considered as part of assessing the supports needed for people from rural and regional areas.

Assessment of decision making

When considering decision making, assessors will need to be especially mindful that people with disability are often conditioned in very subtle ways to be compliant with those around them. A large part of being able to make one's own decisions is the ability to say "I would like to do x, or to have y." People with disability – especially women, those who have been institutionalized and people from some cultural backgrounds – may have difficulty even expressing their needs. This **does not** mean they do not have the capacity, but again their capacity needs to be assessed, supported and developed over time.

Desirable tools

The Productivity Commission has suggested that the World Health Organisation Disability Assessment Schedule (WHODAS) may be used as an assessment tool. While AFDO does not have expertise in psychometry, there are several issues with this tool which would need further consideration, namely:

a) WHODAS has a number of different versions, some of which are based on self assessment while others are based on assessment by an interviewer. AFDO has a strong preference for a self-assessment tool. While some people may need assistance or guidance to complete a self assessment, assessments need not be unreliable or inconsistent because they are completed subjectively.

b) The questions within WHODAS focus on a timeframe of the previous 30 days. This would pose some problems for people with intermittent disabilities which may be dormant for long periods of time. People with disabilities which present this way may find it useful to be able to be assessed while they are well; in the case of some people with psychosocial disability or severely changing

c) Respondents are asked to consider the difficulty they have experienced completing certain tasks while taking into consideration any natural supports and aids they may have. This will create complexities because the assessment will, in part, decide what level of formal supports and aids a person is entitled to.

d) A literature review[3] of studies examining WHODAS II has found that while the WHODAS II is considered psychometrically sound, there has been limited study in this area to determine its detailed shortcomings; this is in part because there is no standardized version of WHODAS II across countries. The results of some studies indicate that there may be issues when using WHODAS II to assess people with psychosocial disability who do not report having “mental or emotional problems”, and assessing the ability of people with hearing impairment to interact with others.

e) Likewise, the majority of studies related to WHODAS II which were examined in the literature review have had a medical/diagnostic focus, and have not solidly examined the use of WHODAS II to assess the need for, and provision of, supports.

Regardless of the assessment tool or toolkit used, development should be focused on ensuring that it:

- measures need for support accurately
- responds to a person’s context
- allows for flexibility so that assessors can take time to get to know a person better if they feel the need to do so

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[3] Federici, Stefano ; Meloni, Fabio ; Lo Presti, Alessandra, 2009, *International Literature Review on WHODAS II (World Health Organization Disability Assessment Schedule II)*, pp 83 – 110, *Life Span and Disability*

- is developed and reviewed with input from people with disability and other relevant stakeholders

Assessing for the $500 annual payment

Recommendation: The proposed $500 annual premium should not be part of the NDIS.

AFDO strongly believes that there should not be an annual payment attached to using the NDIS. The Australian Bureau of Statistics 2006 Census identified that people with disability are twice as likely to live alone than the general population, so there is a significant population base which would be unable to meet this criteria.

A $500 annual fee is currently equal to 74.6% of fortnightly income for a single person on the base rate of Disability Support Pension. This assumes that a person with a disability who is eligible for income support is also eligible for DSP; at present a large number of people with disability who can work more than 14 hours a week are on NewStart Allowance. These payments are $127 a week lower than DSP.

Social exclusion research affirms the difficulty in making this level of payment: people with disability tend to be more excluded on measures of deprivation[4] which include the ability to get and keep $500 in savings for emergencies. While some have suggested that a payment scheme of $10 a week would be viable for people on government pensions, there is also a human rights argument to consider: supports under similar schemes such as Medicare and the Pharmaceutical Benefits Scheme are free or very low cost to people on DSP. Where costs are imposed people on low incomes and pensions can receive government assistance to meet the burden.

In addition, some people have concerns that a $500 fee will create an inherent conflict of interest at the assessment. It is to the advantage of a person with disability and their family to ‘talk up’ natural supports in order to avoid the $500 payment when they apply to the NDIS. Once it is time to assess what supports a person has versus what they want, the person with

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[4] Saunders, Peter and Wong, Melissa, 2009, *Still Doing it Tough: An Update on Social Exclusion and Deprivation Among Welfare Service Clients*, University of New South Wales

disability and their supporters may need to admit that they would like to rely less on informal supports.

Assessor Qualifications and Conditions of Assessment

Recommendation: AFDO strongly recommends self assessment as the key form of assessment. If this option is not taken up, people with disability should be trained as assessors.

Recommendation: Assessors should be trained to be sensitive to the need for different assessment environments and types of support required by people with disability during the assessment process.

Recommendation: Decision making should be viewed as a non-static, changeable skill among people with disability and assessment and support systems should be supportive of whatever capacity for decision making a person has.

While AFDO firmly believes that self assessment is the best form of assessment, we understand that this is not the Commission's preference. Although we strongly urge the Commission to reconsider self-assessment, AFDO also wishes to make some points about the training, skills and working environments which should be part of an independent assessor's working life.

First and foremost, assessors should have lived experience of disability. This has several advantages: firstly, it can take away some of the barriers to discussing sensitive issues such as the need for toileting assistance. It may also mean that the subtleties of working out exactly what a person needs runs more smoothly: a person with disability may be more likely to identify someone who is 'underselling' or exaggerating their level of disability, and to respond accordingly with the right training. As the Draft Report – and the experience of consultation participants – highlights, people with disability need to be approached with the 'right' attitude.

That is, of course, not to say that all people with disability will have the 'right' attitude and all those without do not possess it. However, a system which caters to direct, lived understanding of disability is more likely to be nuanced and responsive. For example, some people who are Deaf or hard of hearing do not want to use hearing aids or cochlea implants, and the assessment process should not assume that these aids are the ideal solution for everyone. Assessors should also not be able to pressure someone to pick the ‘right’ supports.

Assessors may find it useful to visit the person’s home, but in some instances this may not be possible or desirable. Some people are simply more private than others; in some cases a person with disability may feel uncomfortable speaking about abuse which happens in their home while at home:

“I’ve been in this nursing home for a while now even though I’m 49. They take 85% of my pension, plus some money from my savings each week. I have to pay for my clothes, and for any food that I want to have which isn’t bland. I’m always the last to get help, and there’s only one person on staff who knows what to do if I have an emergency. There’s no-one checking what they do with my money – the guy who runs this place also does the books. I want to move out, but I have to keep it secret from the people here. They wouldn’t want to see my money go.”

Because of some of the complexities outlined above, assessors should always offer people with disability the opportunity to use an independent supporter as part of the assessment process. Assessors should be trained to understand the differences between support from a DSO and an informal supporter, and the points at which an advocate rather than supporter should be brought into an assessment situation. A supporter from a DSO may, for example, be best placed to help a person understand what they do and do not have to reveal about their life during an assessment process, how to respond if the assessor makes them feel uncomfortable and what to do if there is conflict between them and their natural supporters as part of the assessment. An independent advocate would be able to assist a person to make complaints about the process of assessment.

Some people have suggested that an assessment carried out by the very agency which has to rationalize funding may pose a conflict of interest. To the greatest extent possible, assessors should be kept separate from the financial and political pressures imposed upon an NDIS. Furthermore, the NDIA needs to be clearly able to identify not just trends in ‘hard’ and ‘soft’ assessments, but also trends which will lead to the need for more funds, such as an increased skill in diagnosing a certain condition leading to more applications for support from people who might not otherwise have considered themselves disabled.

Assessing Natural Supports

Recommendation: The assessment tools and practices for considering natural supports should be developed in consultation with people with disability as well as their supporters.

As noted elsewhere, assessing natural supports will be complex. For some people with disability their natural supports may be limited or unstable; for instance, some people with psychosocial disability talk about the experience of losing friends very suddenly. Even when a person has natural supports willing to assist them, they are not necessarily willing to seek that support:

“My husband and I love each other, and we try to do things to please each other. Sometimes at night I’ll be lying in bed and I need to go to the toilet or even just scratch my leg, but he’s asleep and I don’t want to wake him up to get his help. So I just lie there. The next day he’ll find out about and he’ll be upset that I didn’t ask.”

At other times, natural supports exist because there are no alternatives, but they may not be the most satisfactory solution for anybody concerned:

“My mother is my interpreter at TAFE because we don’t have any trained interpreters here. She’s pretty good, but sometimes she forgets the signs.”

Assessments need to take into account not only what is financially efficient, but what will work best in the context of a person’s life. Assessment of natural supports needs to be based on:

- Whether or not all parties concerned want the natural support to continue;
- How stable the natural supports in a person’s life have tended to be;
- Risks for social exclusion if the support does – or does not – continue to come from an informal source;
- Whether there are intangible benefits to the informal support (like knowing a person intimately) which cannot be easily replaced.

Assessing these kinds of issues will require specific skills and assessment tools. Mediation and conflict resolution skills will need to be a key part of assessor training, and the tools developed to assess natural supports will need to allow for descriptive, qualitative data about lived experience from all concerned.

Information Sharing Across the System

Recommendation: Any information shared by the NDIA based on an assessment should be distributed only with the permission of the person with disability or their nominated representative.

Recommendation: Rules for recording and distributing sensitive information will need to be developed in conjunction with people with disability.

While there was general consensus that sharing information across the NDIS between assessors, disability support organizations and service providers was a good idea, there was strong concern that this should be a matter of personal choice. In particular, people are concerned that negative labels will persist across the system if consent is not given:

“I had a client once years ago who was listed in his file as being dangerous because he was a hair puller. Everyone was cautious around him, but he didn’t seem to cause any problems. It wasn’t until I’d been working with him for a couple of years that he got off balance one day and reached over and grabbed onto my hair to steady himself. He’d been labeled that way by someone who just didn’t understand.”

This is particularly concerning where people with disability may be labeled as ‘challenging’ or ‘non-compliant’ simply because they are not happy in their lives or with the supports they are receiving.

While there are, of course, instances where supporters and staff will need to track issues which are sensitive there need to be clear guidelines developed in consultation with people with disability to ensure that there is a balance between maintaining privacy and passing along relevant information.

Reassessment

Recommendation: That people with disability have access to tailored, responsive reassessments which allow them to choose, respond to crises and offer opportunities for problems to be discussed.

Again, responses have been positive to the suggestion that reassessment occurs at major life transition points. However, it is worth noting some exceptions:

1. Sometimes major life transitions are not predictable or readily planned for – the death of a family member or a divorce – and the reassessment system needs to be able to ‘jump into gear’ for these situations.

2. Once assessed, people may change their mind about the kind of supports they want to use, or how they spend their money. For example, a person may try one recreational activity in their local area only to find that someone further away offers better supports and a more tailored program, but they do not have money in their budget for extra travel. The system will need to work out some level of flexibility to accommodate genuine choice, and to allow people to learn and grow.

3. Some people are less likely to raise concerns about their level of support or to suggest a reassessment, regardless of whether or not they are happy. The system needs to be proactive in ‘checking in’ with people on a regular basis (as opposed to formally reassessing them).

Supports

Disability Support Organisations

Recommendation: DSO staff should be encouraged to act as coordinators and facilitators, but not at the expense of a person's right to be free from pressure or to simply choose who supports them.

Recommendation: Support from DSOs should be separate to independent advocacy. Independent advocacy should be funded separately to packages of support, and should be administered and provided by a structure separate to DSOs and assessors.

While there is general support for the idea of Disability Support Organisations, two key concerns remain. Firstly, people with disability and their families are keen to lower the number of contact people in their lives because they have to navigate the NDIS. Some are concerned that a DSO will be just another barrier, or will simply add in too many people to the mix. There are several things which could be done to overcome this:

1. People should have clear information letting them know that they are able to bypass DSOs if they choose.

2. If a person has been working with a supporter during the assessment stages, that person should be allowed to 'link in' a person with the DSO of their choice, and to remain a part of their assessment and service provision process for as long as a person with disability would like. This will allow some people with disability consistency of support, and the added value of someone who knows them to help with the process. It may also alleviate concerns that where there is only one specialist service provider, a person with disability will be pressured to assess for greater needs, or to use their services rather than mainstream or other supports. Key to this, of course, is consent from the person with disability. This support should not be paid from a person's package, but should be provided as part of the infrastructure of the NDIS.

3. Case managers in DSOs should also be able to have a strong ‘linkage’ focus. In particular, a person with disability may still need to go through assessments specific to service providers, or suited to assessing the need for a particular type of aid or equipment once they have been assessed for the scheme as a whole. Case managers should be able to coordinate, and in some instances, administer, further assessments so that they have the least possible impact on a person’s life.

The other major concern has been that DSO’s will include service providers having an advocacy role. Overwhelming sentiment has been that people with disability want independent advocates who will be able to speak for them in any part of the system. Advocates should be available independent of a person’s package, and if they are administered under the NDIA, they should come from a section of the system completely divorced from service provision DSOs and assessors.

This is not only about preventing clear conflicts of interest; advocacy matters are notoriously difficult to quantify. A person may simply need advocacy to resolve an issue of accessing materials in Braille, which as a rule does not take very long, though this does depend on the cooperation of the company or government department concerned. However, it is more common for advocacy relating to accommodation, abuse and neglect and legal entanglements to be complex and difficult to resolve. Some matters take months or years, and could not easily be ‘slotted into’ an individualized package, even if it could be anticipated when and how a person chose to speak up about an issue in their lives. Many people with disability report that they are faced with a number of discriminatory events in any given day or week; the decision to follow up is made in part based on energy and time, and in part on how big the impact of an issue is on their lives. There is no easy way to plan for the ‘triggers’ which send a person to an advocacy organization.

Furthermore, there are some types of advocacy which do not fit easily into individualized models. Systemic advocacy and support for self advocates, family advocates and citizens advocates require ongoing support.

Preserving Local Knowledge and Community Development

Recommendation: Local coordination and feedback mechanisms should be central to the NDIS.

Recommendation: The trial of the NDIS should be conducted in each State and Territory, with particular emphasis on exploring the needs of key groups such as retirees, young families, rural, regional and remote communities, people from Non-English Speaking Backgrounds, women and Aboriginal and Torres Strait Islanders.

For many people – especially those in rural, regional and remote areas – the NDIS will need to capture local knowledge in both future planning and current execution of the scheme. This could include measures such as:

1. Local level input from people with disability and other relevant stakeholders, such as families, service providers and the broader community. Feedback should be provided regarding priority areas for infrastructure investment, disability support staff training needs in the local area, the quality of local service providers and any need for coordination with local and/or state government. Such mechanisms are especially important in rural, regional and remote areas where market forces may not be effective:

   "We've got a number of vision impaired people here in the local area. I'd like to see a regional office for our service agency and there's a group of us [people with vision impairment] *who have been talking to them about it. They won't come here for some reason. They've got offices in several other regional cities, but this is the biggest regional centre in the State and they're refusing to come."*

   This feedback may need to be gathered in a variety of ways, some of which have already been canvassed by the Draft Report, such as consumer satisfaction surveys. However, models of local support and input need to go further, and should be developed through 'on the ground' coordination by NDIA staff.

2. Locally based coordination staff will be critical for the system's ability to plan appropriately and to provide support to those in crisis. Additionally, some support structures should be designed with redundancy and flexibility in mind:

> *"They should have a call centre over East and one here in WA as well. That way we'd be able to make calls during local business hours as well as earlier in the morning and the people over East would get some time to call after hours too."*

3. The trial of the NDIS will need to take into account local conditions. For this reason, it should not be restricted to one state or region, and trial should be carried out in each State and Territory. This would take into account differences in current funding and infrastructure levels in the disability support systems across Australia, but could also consider:
    a. Growth corridors (of retirees and young families);
    b. Areas with high numbers of people from Non-English Speaking Backgrounds and/or people of Aboriginal and Torres Strait Islander heritage;
    c. Areas with distinct economic challenges, such as mining towns where the prices for goods and services can fluctuate dramatically;
    d. Rural, regional and remote areas where travel costs are high and service provision is often restricted.

Need to creatively use funding for therapies

Recommendation: The NDIS should develop a culture and processes to support flexible early interventions, recognizing that some may not be registered therapies, or carried out by registered therapists.

While there is broad agreement that some supports will require a stipulation that people use qualified workers who provide evidence based supports, there are some instances where there will need to be flexibility in the system. For example, a family living in a rural or remote area may not have access to a physiotherapist, but may find a community nurse who can be trained in the techniques required.

In other instances, sidestepping a therapeutic intervention may work well: paying for a broadband connection to allow access to a free online counseling service or for travel costs to access a peer support group may be just as effective as paying for a registered psychologist.

It is important to remember that some disability types have evidence based early interventions which are not therapeutic. This is especially true for sensory disabilities, where Auslan language skills in a child who is Deaf or orientation and mobility skills in a child who is blind are just as valuable as therapeutic skill sets. Both require some element of professional support, but do not need to be as tightly regulated as occupational therapy, physical therapy or speech therapy.

Including Education and Employment

Recommendation: The NDIS should include non-infrastructure related education and employment supports.

People with disability and their families have expressed concerns that mainstream education and employment will be left completely outside the NDIS. The distinction between infrastructure based obligations – which should be left in the hands of employers and Education Departments – and support based obligations should be where the line is drawn, not ‘what is considered reasonable’ to provide under Disability Discrimination Act obligations. For example:

“My daughter was working for a while. She had so much trouble getting support staff to come early in the morning to get her out of bed, and then to get support at work was difficult too. She’s no longer working… sometimes she gets very low about that.”

In many instances, the current reality is that these systems do not provide the supports required. Students with disability routinely find themselves without qualified aides, support workers, interpreters and Braille teachers, let alone adaptive technology and other supports. Clearly there is a need for increased funding for these supports; this either needs to occur through some careful negotiation of what remains state based funding and what goes to the NDIS, or through shifting all supports bar infrastructure to a national funding scheme.

Education supports begin when a child starts pre-school or school, and tend to end at the time a child leaves the state based school education system, creating what are sometimes artificial barriers. Aids and equipment provisions highlight some of the barriers in this area: often students are asked to return their laptops, wheelchairs and other disability related equipment to the system which has provided them, even though they may need them for transition programs or further education. The fact that some higher education institutions (such as TAFEs) and transition programs are stated based, while others (universities and private colleges) are federally funded and reviewed also has the potential to create gaps in support.

A further argument for integration of non-infrastructure educational needs is that disability related educational supports are not always part of formal education systems. This is perhaps most murky in the current outline of the NDIS when it comes to 'early intervention', which may or may not be undertaken as part of a child's pre-school or school education program. For example, a child with an intellectual disability may go to speech therapy outside school hours, but then still require specialized support to be involved at school. But the lines are also unclear at the other end of the education system:

"I had so many arguments with the [disability services] *Department about what was disability related in terms of my son's needs. Finally we agreed that he could have driving lessons so he could work towards getting his licence. Disability Services only approved four lessons, during which time we couldn't even get him into the car because he was so afraid. It was only when the driving instructor said he got funding for ten lessons for foster children that they gave us more money from his package to get him up to ten lessons. Even then it wasn't enough. They wouldn't pay for more, although there was still money left in our budget."*

Likewise, the shift from education to employment may not be a clear divide:

"Our special unit runs a transition program so that the kids can get some work experience in the local community. Transport is a huge problem. We don't have access to a bus, so the kids are often reliant on their parents for support to get to and from their work experience. That means some kids just miss out."

Government already provides some supports for people with disability entering mainstream employment agencies and mainstream jobs. This is done through both generic programs – such as the Employment Assistance Fund – and Disability Employment Services, which can provide information, education and 'job in jeopardy' functions for people with disability who do not access employment support services on an ongoing basis.

However, when it comes to employment agencies, people with disability are rarely given a choice between a specialist who understands their disability support needs – which is rare for some, even in the Disability Employment Services system – and a specialist who might understand the field of work they are qualified to work in, such as an IT recruitment agency. If funding in this area were individualized and self directed across employment support systems it could:

- Give Disability Employment Services incentive not to ‘park’ people who appear more difficult to place in jobs;
- Provide incentives for generic employment and recruitment agencies to become more disability friendly; and
- Allow people with disability the option to ‘pick and choose’, so that they might request recruitment support from a mainstream agency, but ask for on-the-job support from a Disability Employment Service.

It is also important to remember that Disability Employment Services are able to provide employment-specific support to a wider range of people than would be eligible for support under the NDIS. As ABS data proves, not everyone who has a schooling or employment restriction has a significant need for other supports; it is concerning that some people with disability who only need specialist employment support may not be able to access it under the new system.

Interaction with the Health System

Recommendation: That the NDIS actively monitors and negotiates for adequate health related supports, and for appropriate interaction between Health Departments and the NDIA.

As with many other areas of life, the divides between ‘medical supports’ and ‘disability supports’ is not always clear cut. The Draft Report has especially identified the need for support workers to be able to meet a person’s disability related needs in hospital, and the need for therapeutic early interventions. Both are intrinsically health related. There are instances where health related supports are closely tied to having a good quality of life with a disability.

HEALTH RELATED EARLY INTERVENTIONS

While rehabilitation and ongoing therapies are often funded by health departments, the rationales for providing support are often about ‘getting better’, not ‘maintaining the status quo’.

“The biggest thing I’d really need is some rehabilitation. After I had my accident I spent some time in Adelaide [four hours away] *re-learning how to walk and do other things. Once I was at a certain point they let me come home, and I’ve slowly deteriorated again. I could probably still be walking now if I’d had ongoing therapy, instead of being in this chair. But that would mean getting travel to and from the city, paying for accommodation or having someone come out here. Even then I wouldn’t be able to get a therapist who knows rehabilitation and understands acquired brain injury. There’s no-one in our state like that.”*

AFDO does not have a particular view about who pays for these supports, but does strongly feel that they should be made available consistently across the country on an as-needs basis.

ONGOING HEALTH RELATED SUPPORTS

There are times when health-related supports are required on an ongoing basis to improve a person’s quality of life and/or level of function related to their disability.

HEALTH DEPARTMENTS PAYING FOR DISABILITY RELATED SUPPORTS

Although there is a clear divide in many areas between what is paid for by Health Departments and what is paid for by the disability support system, there are some anomalies. Not only is the health system prone to cost transfers because it holds patients in beds because they cannot get access to disability supports, it also sometimes pays directly for more pure ‘supports’. Key examples include housing for people with HIV/AIDS, which is sometimes paid for by Health portfolios, and non-medical supports for people with psychosocial disability, which seem to be universally paid for from Health budgets. In such instances, the risk remains that disability related ‘life supports’ will lose out in competition with directly medical supports because they are the natural priority of the health system.

While AFDO is not in a position to identify all of the anomalies in this area, we believe that it should be a first-order priority for the NDIA to do so, and to negotiate the transfer of costs from state and federal health budgets to the NDIS as appropriate.

Self Directed Supports

AFDO is particularly pleased that the Productivity Commission has called for supports to be self directed in many instances. As with much of the Draft Report, overall comment from people with disability has been positive, but there is a need to be careful about the detail.

Payment Options

Although many people with disability would be happy with monthly payments for their supports, flexibility is critical. Many people with disability are on pensions or fortnightly pay packets, and may find it easier to ‘streamline’ their personal budgets on a fortnightly basis. Others will want the option to have ups and downs in their support use over the course of month; this would make planning to use less support over a short period of time in order to have enough support for a weekend away or attending a work conference much easier.

INITIAL NDIS FUNDING

When a person first elects to get self directed supports, they may need some additional funding to support them through the early stages of setting up their support.

LUMP SUM FUNDING

Many people with episodic disabilities may go for weeks or months without requiring supports. These people should either have:

a) a support ‘bank’ where funding is kept until needed; or
b) access to crisis support funding which can also be self directed, but operates in lump sum amounts over shorter periods of time.

Any ‘crisis’ or ‘lump sum’ payments may need to factor in some higher costs because ongoing supports may not have been put in place. For example, a person who needs additional support during a psychotic episode will not necessarily have hired support staff beforehand to assist with household chores.

CRISIS FUNDING

Crisis funding needs to take into account both sudden personal crises – such as death in the family, divorce or serious deterioration in a disability – but larger scale crises as well.

"We had a township near Kununurra get evacuated with flooding a while ago. The whole place was destroyed – not just wheelchairs and continence aids, not just accessible houses, but all the houses of support staff too. What would the NDIS do for them?"

Just as other areas of government must put aside funding for disaster management, so too should the NDIS.

BANKING SUPPORT PAYMENTS

Generally speaking, people with disability have said that the ability to bank 10% of support over 2 years would be reasonable. However, as is the catch-cry with all things disability, choice is the key. People who want to be able to take hgolidays with support should be able to plan to do so, for example. The NDIS should have in-built systems for allowing longer-term or higher percentage 'banking' proposals to be taken into account.

DECISION MAKING AND SELF DIRECTED SUPPORTS

Under Article 12 of the UN CRPD, people with disability are entitled to equal recognition under the law. This means that people with disability should be presumed to have the right – and the capacity – to make decisions that affect their lives, with adequate supports provided for them to do so.

Current systems in Australia, such as guardianship laws, rely on substituted decision making. A person with disability is presumed or perceived to be unable to make any decisions in their life, and thus has some or all decision making capacity placed with another person.

In addition to being in contravention of Article 12, the consistent features of guardianship laws and trustee bodies seem to be mostly negative:

- They do not allow for the privacy and dignity of people with disability, by making guardianship hearings public and/or allowing registers of people on guardianship orders to be made public;

- Often, there is limited external oversight of guardianship orders to ensure that the needs of a person with disability are being met; and

- Trustees often receive a commissioned percentage of the total amount in a trust, so there is incentive to minimize spending on a person with disability's needs as much as possible.

"I have an advocacy client who is currently living in a shed. He has no access to heating or proper shelter, and limited food. The person he lives with, who is supposed to care for him, gets $200 a week from this man's trust fund to compensate for 'caring' duties. We've been to the trustees, this man has $25,000 in his trust account. It's more than enough to get him out of that situation until he can find somewhere else to live… it's enough to put him in a hotel for a while so he can at least be safe. But they won't do that, because apparently it's not economically viable. I don't know what's going to happen to him come winter."

Another example of laws restricting decision making include Community Treatment Orders which oblige people with psychosocial disability to remain on medication in order to freely move in the community; this obviously restricts a person's right to decide whether or not medication is working for them, and to make changes.

While Australian jurisdictions are just beginning to explore supported decision making[5], countries[6] and organisations around the world have looked at supported decision making from both a systemic level (Inclusion

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[5] http://www.publicadvocate.vic.gov.au/file/file/Research/Forums/2010/OPA%20Supported%20Decision-Making%20Forum%202010%20Summary.pdf

[6] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074773

Europe[7]), and a ‘hands on’ level (Paradigm UK[8]). Features of supported decision making systems include:

- Redacting or seriously revising guardianship laws;
- Promoting and building support networks, both formal and informal;
- Promoting self advocacy;
- Developing options for safeguarding the rights of people with disability and clarifying the responsibility of supporters.

Supports for Aboriginal and Torres Strait Islanders

Individualised funding is already being used in a number of indigenous regional communities. It offers more flexibility than block funding approaches as it is able to draw much more easily on the natural resources that are in these communities. There is a demand for more packages. In addition infrastructure costs such as case management, community capacity building etc need to be funded. Equipment such as wheelchairs is an issue in communities as it is often inappropriate for the environment. Local indigenous people should be employed as support workers.

Indigenous Case Studies

Kununurra

Individual support packages enable many people to live independently or with their families. One package allows someone to have 24/7 support through an innovative live in arrangement. Another time a young baby who was born with disability was able to spend the only two years of his life with his family. The packages are complemented by Local Area Coordination where community building is seen as one of the most important functions. The LAC works with families/community to build confidence and capacity to support family members.

Elcho Island

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[7] http://www.inclusion-europe.org/documents/Position%20Supported%20Decision%20Making%20EN.pdf

[8] http://www.paradigm-uk.org/Resources/9/2/9/Supported%20Decision%20Making%20%28Final%20Online%20Version%29.pdf

Aged and Disability Services obtains individual packages for people with disabilities. These packages assist with personal care, lifestyle activities, home care etc. Local indigenous people are employed to provide this support. Supports are tailored to the needs of the recipients and cultural needs are met of both the support workers and people with disabilities. Training is an essential part of this process and needs to be done in culturally appropriate ways which can take more time than average. Training indigenous support works ensures a greater and more consistent supply of workers. One man was able to return to live in his community after spending 18 months at Darwin Hospital.

Complaints and Disputes

The Role of Advocacy in the NDIS

Advocacy support within the new scheme will be critical.

With a shift from a crisis driven system to one which meets some of the disability community's needs, advocacy can, and should, become more proactive. For some people with disability having an advocate or trusted support person can make the difference between getting an accurate assessment of their needs and not; simply having an independent person to explain the process and assist if a person needs to speak up during the process could prevent many ongoing issues. In particular, many people with disability will not follow up on a lack of supports if the NDIA environment does not support this:

"I feel guilty about the amount of support I get. It makes me want to put more back for other people."

Individual advocates currently spend a large portion of their workload on accommodation and service provision cases. They are a vital resource for people with disability when things go wrong, and will be crucial to help with 'frontline' resolution of problems within the NDIS, especially for people who might not otherwise complain:

"Yeah, I'm pretty happy with what I get. The lady comes and cleans my house once a week. If she goes on holidays or she's sick then I just wait an extra week or however long until she comes back. I've had other cleaners come in and they'll be on their mobile phones for fifteen minutes or more while they're supposed to be working. It's just easier to do it this way."

Because of the need for advocacy agencies to be able to speak up against service providers both within the NDIS and in mainstream environments, advocacy needs to remain completely independent of Disability Support Organisations and service providers in particular.

Furthermore, funded advocacy agencies may assist people with disability who do not access other formal supports within the NDIS. It is critical that 'Tier 2' access to the scheme should include access to advocacy as well as information and referral to mainstream supports. For mainstream supports to be an effective option, people with disability need to be able to complain when they are not accessible or appropriate.

Continued, sustainable funding for systemic advocacy is also necessary to ensure that changes across both the NDIS and broader society continue to serve the best interests of people with disability. Systemic advocacy from disabled person's organizations, representing the genuine voice and lived experience of people with disability, is especially important, and required to be supported under the UN CRPD.

It would be extremely difficult to make advocacy a part of individual packages: systemic and citizen advocacy would not be covered, and while individual advocacy cases can be 'averaged out' in terms of time and costs, they vary greatly in unpredictable ways depending on the individual's needs and the barriers they face. Dedicated funding should be a percentage of total funding so that the real dollar amount increases over time; currently most advocacy agencies do not receive indexed funding so funds are actually going down in real terms.

Recommendation: Advocacy should be funded by dedicated money from the NDIS, but available to all people with disability who need it, not just those in Tier 3 of the system. Advocacy should be increased to allow for supporting people with disability to navigate the NDIS, and to ensure meaningful systemic advocacy from disabled person's organizations.

Internal and External Complaints Mechanisms

There was a great deal of concern expressed that people with disability would only be able to complain about matters of merit to either a body internal to the NDIS or to an overly formal procedural body, such as a court or tribunal.

The idea of a body within the NDIA lacks at the very least the appearance of independence, and at most the potential for complaints handling to be dictated by budgetary constraints; what can and can't be complained about and granted in terms of supports should not be solely beholden to the financial position of the NDIA. Maintaining community standards of support for people with disability is an equally valid goal, and one that can only be achieved if the complaints system operates externally to the NDIA.

An internal complaints mechanism may also create problems when determining a matter of ‘merit’ versus a matter of ‘law’. In the context of the UN CRPD, and even the proposed NDIS legislation which would mandate a reasonable level of supports for people who are eligible for the scheme, matters of law and merit may prove to be one and the same.

Furthermore, a complaint mechanism solely placed within the NDIA would lead people to believe that it would only respond to complaints regarding NDIA provided supports. In a system where self directed, mainstreamed supports will form part of disability supports, there needs to be one or more complaints mechanisms which will have disability specific expertise to resolve any issues with mainstream supports.

AFDO believes that the NDIA needs to provide two things to effectively address complaints:

1. Resources and support to make mainstream complaints processes accessible. This should include tribunals, courts, consumer affairs bureaus and existing Ombudsmen schemes.

2. An independent, easy to access Ombudsman specific to disability supports. Many participants felt that this was a better path than a legalistic process because it would allow better access for people with disability. Ombudsmen also provide a system where complainants are encouraged to resolve their issues with a service provider first, and then given the tools to do so if necessary.

   An Ombudsman for disability supports could be given the mandate to respond to complaints about mainstream support providers for people with disability (where no other scheme existed to do so, or significant access barriers were present to accessing another complaint process) as well as complaints against dedicated disability service providers and the NDIA itself.

Reform and Transition

Infrastructure

While it is clear from the Draft Report that the ‘back end’ costs of providing ongoing support within the system will mostly be met through the individual packages of people with disability, it is important to remember that the levels of support across different states and territories vary markedly, and some initial infrastructure investments will be required. For example, Tasmania currently places people who require more than 34 hours of support per week into group homes, nursing homes or institutions; a significant amount of funding will need to go towards making different housing options both available and accessible.

Overall, recruitment and training, education and awareness raising will need to be key features of the NDIS in its first few years – more so than once the scheme is established nationwide.

Recommendation: That the trial phase of the NDIS includes work to establish a ‘startup’ budget based on the needs of various States and Territories, as well as the general costs of establishment associated with a new scheme.

Education and Awareness Raising

During AFDO’s consultations for its response to this Draft Report, it was noted that only a small number of people with disability appear to be fully engaged in the process of developing and supporting an NDIS, relatively speaking. In general, there was a limited understanding of what the NDIS might mean in the everyday lives of people with disability.

If the NDIS is introduced, people with disability will need a concerted education campaign to inform them of the changes, their choices, their rights and responsibilities. This work should be carried out by the organizations which have the most expertise in communicating with people with disability – disabled person’s organizations. Groups of, and for, people with disability should be adequately funded to be on the frontline of information provision and education in the lead up to both the trial and the full implementation of the NDIS.

Governance

AFDO is generally supportive of the idea that fiscal and legal expertise should exist at the Board level within the NDIA, and that expertise in the lived experience of disability and response to the system should be able to exert influence through a separate, advisory body structure. However, AFDO makes the point that there are many lawyers, financial experts and businesspeople who also happen to be people with disability. The Board of the NDIA can, and should, seek to proactively approach, mentor and appoint people with disability who have the relevant qualifications for a governance role in the scheme. Similarly, the advisory body should be chaired by a person with disability and should include representatives from all peak disabled person’s organizations.

In addition, the Board should be compelled to hear the opinions of those with lived experience of disability and others using the NDIS through the advisory body. Too often the voice of people with disability is lost in the mire of expertise in other areas or the dominant priorities of saving money rather than obtaining equal rights. Reporting mechanisms between the two bodies should be formally established, and the Board should be legally required to respond to all recommendations from the advisory committee with an explanation of any rejected policy directions provided.

Law and Policy Reform

There are several key areas where reform to replace state and territory laws and policies – or to create consistency across states and territories – will need to take place.

DISABILITY SERVICE STANDARDS

While the law creating the NDIS and NDIA will include an allowance for ‘reasonable support’, there needs to be further legal and policy articulation about what this looks like.

Disability Service or Support Standards currently exist in either law or policy across the country. A nationalized version of these standards would need to ensure that people with disability would get the highest level of support available at the moment in the country – that is, that no person is worse off under the NDIS and many are in a better position.

Service standards should require clear reporting outcomes. They should also require service providers to tell their clients - in simple, accessible ways - about complaints processes available through the NDIA, the National Disability Abuse and Neglect Hotline and the state and federal disability discrimination bodies.

PSYCHOSOCIAL SUPPORTS

Because supports for people with psychosocial disability are ‘sectioned off’ into a different budget area to disability supports, they have different requirements and standards. If – as AFDO recommends – psychosocial supports become part of the NDIS, there will need to be an examination of what, if any, considerations need to be made in adapting disability support standards to suit people with psychosocial disability.