Australian Psychological Society

Joint Standing Committee on the National Disability Insurance Scheme (NDIS) inquiry into transitional arrangements for the NDIS

APS response

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1 Introduction

The Australian Psychological Society (APS) welcomes the opportunity to provide a submission to the Joint Standing Committee inquiry into transitional arrangements for the National Disability Insurance Scheme (NDIS).

The APS is the largest professional organisation for psychologists in Australia representing over 22,000 members of whom a significant portion deliver evidence-based psychological services to consumers, including consumers in the disability sector and clients of the NDIS. In making this submission, the APS sought feedback from members who are or have provided services to consumers of the NDIS. On the basis of member feedback, this submission will focus on the following components of the terms of reference:

- The boundaries and interface of NDIS service provision, and other non-NDIS service provision, with particular reference to health services
- The consistency of NDIS plans and delivery of NDIS and other services for people with disabilities across Australia
- Other issues (specifically relating to the delivery of behaviour support).

2 The boundaries and interface of NDIS service provision and health services

The *National Disability Insurance Scheme Act 2013 (Clth)* (NDIS Act) section 34(f) indicates that the NDIS will not fund supports that are more appropriately funded or provided by the health system. For example, the NDIS is not responsible for the diagnosis and clinical treatment of chronic health problems or of other health conditions unrelated to a person's ongoing functional impairment. In theory, the separation of disability and health-related needs is a reasonable requirement but *in practice*, determining whether or not an identified consumer need should be met by a health or disability service provider is often not clear cut. Psychologists report that there is considerable inconsistency in the decisions by planners as to what constitutes a 'health' condition requiring intervention by a health service and what constitutes a 'disability/ functional impairment' requiring intervention through the NDIS. These inconsistencies often impact negatively on consumers, especially when it means they are directed to a service that is not appropriate for their needs.

The main area of concerns is in relation to disability and mental health issues. In relation to mental health, it is very clear that the NDIS is responsible for supports that enable a person with a mental illness to undertake activities of daily living and function within the community while the health system is responsible for early intervention, acute and continuing clinical care for people with a mental illness. However, for an individual with a mental illness *related to their disability* that is impacting on their capacity to undertake activities of daily living – what service is responsible for service provision? For example, if an individual has significant anxiety and/or mood and/or behavioural issues as a result of their disability and this is contributing to their ability to function within the community, should services be provided under the NDIS or via the health system? The experience of members is that this

depends on what planner is working with the client, or the location of the consumer. Some consumers are provided psychological services via the NDIS, yet for *the same issue or circumstances*, other consumers are told to obtain a GP Mental Health Plan and see a psychologist under Medicare. This anomaly cannot be explained by consumer choice. Member feedback strongly suggests that planners in some locations are much more likely to send a consumer who mentions they have anxiety, behavioural or mood issues to the health system without even exploring the genesis of the issue.

The APS is particularly concerned about the repeated feedback from members that planners are telling clients to use both the health system and the NDIS to provide psychological services to consumers. The following de-identified case studies illustrate this issue:

a) *The NDIS planner included 4 sessions per year for "disability specific counselling". The plan states: "X needs assistance to adjust and deal with the emotions associated with this. X accesses mainstream support, however, this has been included to cover the gap payment ($10 per session)".*

b) *Consumer X was told by their NDIS planner that psychological services were appropriate to include in the plan but that the consumer must use the 10 "free" psychology sessions under Medicare before the NDIS would fund the psychology services. Once the 10 sessions were exhausted, X would have sufficient NDIS funding to allow for additional fortnightly psychology sessions throughout the year.*

c) *I have a young client who was referred to me for management of anxiety and depression associated with high functioning autism. The client is under the NDIS but the planner refused to include psychological services. We have been working on some CBT, behavioural therapies, and social and interpersonal skills. It has been difficult to achieve good clinical outcomes because the 10 x 50 minute sessions under Medicare are inadequate given the client's disability and the client has insufficient funds to extend the number of sessions. The mental health issues are now impacting on the client's level of functioning and community involvement.*

d) *X is a 36 year old male client who lives in supported accommodation. He has a moderate intellectual disability and ASD and has a substantial NDIS package. X was displaying increasingly aggressive behaviours leading to four admissions to a mental health facility over a short period of time. The mental health facility eventually deemed X to be "unsuitable" for their care due to his intellectual disability. The NDIS planner was contacted to obtain emergency respite but because there was no funding specifically allocated to emergency respite, the request was rejected by the planner. Thus, the mainstream mental health service rejected the client due to his intellectual disability but the NDIS planner was also unable to provide suitable care for the client.*

It is important to note that the dual usage of the mainstream health and NDIS systems appears to be at odds with the NDIS Act and an example of cost shifting. However, what is of greatest concern is that consumers are not getting access to the psychological and mental health services appropriate to their

needs. In some cases, psychologists report that the 10 x 50 minute sessions available under Medicare are highly inappropriate for clients with certain disabilities because of communication or other barriers. If an individual's disability means they cannot access treatment for their mental health condition from the mainstream health system, where can they access treatment from? If the condition continues to go untreated and further impacts on activities of daily living and community functioning, at what point can it be considered an issue to be treated under the NDIS? Moreover, the Medicare Better Access psychology items specifically *exclude* people with "mental retardation" (intellectual disability). Given issues such as depression and anxiety are often exquisitely intertwined with the intellectual disability, is it meaningful to treat the mental health issues as totally separate from the disability?

It is apparent that despite the distinction in the NDIS Act, it is often *very difficult to untangle a (mental) health issue from a disability issue*. As a final example, the APS is aware that there are multiple former clients of the state disability service in NSW who previously received psychological services as part of their care. These clients have not been offered equivalent services under the NDIS but have been directed to obtain these services from mainstream health services. It is not clear how these services could be considered part of disability care under one government-funded service, but not under another. Moreover, the clients are now obtaining considerably less psychological support than was previously available to them under the state-funded service.

The APS recommends that:

- The NDIA consider adopting more sensitive psychometric assessment tools to assist planners to determine if consumers with a disability (particularly an intellectual disability) and a mental health issue meet eligibility criteria
- The NDIA, in consultation with the Department of Health, provide planners with information on the criteria for eligibility for a referral to a psychologist under Medicare
- The NDIA invest in on-going training for planners to ensure the consistency of plans across Australia, particularly in relation to the management of access to psychological services.

3 The consistency of NDIS plans and the delivery of NDIS services in relation to behaviour support

An important aspect of behaviour support is the development of evidence-based behaviour support plans (BSPs). The APS frequently receives feedback from members on the considerable variation between NDIS plans in terms of what services, skills and degree of intervention is required, particularly when a client presents with very complex behaviour issues. The most frequently cited concern is that the NDIS plans do not include sufficient time to conduct a functional behaviour assessment and devise, implement and monitor a BSP. The IABA model estimates that it can take up to 80+ hours to adequately complete a behavioural analysis (for information on the IABA model see www.iaba.com).

The following de-identified case study from an APS member is illustrative of the lack of understanding of how to provide complex behaviour support evident in NDIS plans:

X is a 58 year old male with an acquired brain injury who exhibits high level of physical and verbal aggression. He is an amputee with high medical support needs and requires support for all activities of daily living. He also exhibits inappropriate sexualised behaviour towards other clients and staff on a regular basis. He is in supported accommodation in a community setting where he can leave the property. He frequently returns to the facility in an intoxicated state.

Despite the complexity of the behaviour management needs of this client, his NDIS plan included approximately 6 hours of behaviour support. To provide best practice to this client, the psychologist needed to undertake, as a minimum, a functional behaviour analysis and baseline cognitive and adaptive measures; then develop a BSP and instruct the staff of the residential facility in the implementation of the BSP. The psychologist also needed to be available for monitoring and review of the BSP over 12 months.

Inadequate plans such as this fail to meet the needs of the client and have the potential to cause harm, for example, leading to involvement in the criminal justice system and directly placing other vulnerable clients, support staff, and the community at risk. The APS has received multiple examples of similarly inadequate plans from members.

Also of concern is the quality of behaviour support services being provided under the NDIS. Currently, behaviour support can be delivered by psychologists who have a minimum of 6 years training (and other qualified health practitioners) or by a Behaviour Support Clinician or anyone who has done a 4 day course in Applied Behavioural Analysis and has been employed in the disability field for 2 years. There is no distinction made between providers, even when a client presents with extremely challenging and complex behaviours. Moreover, clients and their families/carers are not aware of the significant variability in the skill base of respective providers.

The APS recommends that:

- The NDIA develop guidelines on behaviour support that reflect current best practice that planners should use to assist them to develop appropriate plans. The implementation of the guidelines should be supported by a national training program
- The NDIA review their approach to the behaviour support workforce to ensure that consumers have access to providers with the necessary skills and expertise to meet consumer needs. As a minimum, this workforce should be able to provide evidence of on-going professional development and supervision relevant to behavioural support
- The NDIA provide training to planners to enhance their understanding of the existing mechanisms to ensure consumers with complex needs have access to practitioners with higher level skills and expertise in behaviour support (i.e., Psychologists). Consumers with complex needs should have plans that include funding for the top rate for *Specialist Behaviour Intervention and Support.*