

Australian Government

**NDIS Review**

September 2023

# Improving access and equity

### About the Royal Australian and New Zealand College of Psychiatrists

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is a membership organisation that prepares doctors to be medical specialists in the field of psychiatry, supports and enhances clinical practice, advocates for people affected by mental illness, and advises governments on mental health care. The RANZCP is the peak body representing psychiatrists in Australia and New Zealand and, as a binational college, has strong ties with associations in the Asia-Pacific region. The RANZCP is responsible for training, educating, and representing psychiatrists in Australia and New Zealand. The RANZCP has more than 8000 members, including over 5800 qualified psychiatrists.

### Introduction

The RANZCP welcomes the opportunity to contribute to the Australian Government's National Disability Insurance Scheme (NDIS) Review. The recommendations contained within this submission expand on the RANZCP's [January 2023 submission](#) to the NDIS Review. The recommendations are based on consultation with RANZCP Committees, which are made up of community members and psychiatrists with direct experience working with NDIS participants and prospective participants. The RANZCP is well-positioned to provide assistance and advice about this issue due to the breadth of academic, clinical, and service delivery expertise it represents.

The RANZCP is committed to supporting the Government to improve the experience of NDIS participants and currently serves as a member of the NDIS National Mental Health Sector Reference Group.

This submission highlights challenges in the current NDIS system and makes recommendations for improvement, illustrated by experiences from RANZCP members.

### Summary of key recommendations

The RANZCP recommends the Government:

- Review NDIS's permanent qualifying disability model to encompass a recovery-centred approach.
- Improve governance and coordination between NDIS and other health and care services.
- Ensure the out-of-pocket cost to see a qualified healthcare professional for the participant or prospective participant does not act as a barrier to gaining access to the NDIS via the creation of a new Medicare Benefits Schedule (MBS) item for access report-writing for psychosocial disability for the NDIS.
- Ensure equitable access to NDIS for participants and prospective participants, including those in regional, rural and remote areas.
- Support prospective NDIS participants who are in prison to develop a NDIS Plan prior to release to ensure they can access support immediately upon their release.
- Better support people with neurodevelopmental disabilities to access NDIS services.
- Consider the Australian ADHD Professionals Association's (AADPA) Australian Evidence-Based Clinical Practice Guideline for Attention Deficit Hyperactivity Disorder (ADHD) recommendations in relation to the NDIS.

### 1. Review NDIS's permanent qualifying disability model to encompass a recovery-centred approach

Around 10% of the NDIS's 1.1 million participants have a primary psychological disability, yet the criteria for accessing NDIS support can be challenging to meet for mental health patients.[1] Individuals with acute mental health conditions may not have a qualifying permanent disability, and many mental health conditions have an episodic course which does not fit with the NDIS's permanent disability model. This can lead to difficulties in accessing the necessary support.

Recovery is an important principle in psychiatry, with transformative potential for all people with mental illness (see the RANZCP [Position Statement 86: Recovery and the psychiatrist](#)). Recovery-oriented mental health practice refers to the application of sets of capabilities that support people to recognise and take responsibility for their own recovery and wellbeing and to define their goals, wishes, and aspirations.[2] The current structure and processes of the NDIS can restrict the delivery of recovery-oriented support.

*"I had a patient with Functional Neurological Disorder [FND] with an episode of paralysis where an adolescent couldn't even get up from bed to use the toilet or attend University. She had recovered from a similar issue prior, and we were confident that we could get her back to recovery, but when NDIS was applied for, as she needed full-time care during the episode of total paralysis, it was rejected saying FND is not 'permanent'. The family was understandably upset that our report was the one that was quoted as the reason for rejection. After that the family appealed with a report from a [different healthcare provider stating] she has a "permanent" condition. This meant the young person disengaged from our service and the recovery focus was completely off the agenda in the treatment goals for her management."*

*"I was seeing a patient who was under a NDIS plan who among other things was experiencing high levels of anxiety. As part of an exposure therapy treatment plan, it had been recommended that the patient try catching public transport with the carer who would otherwise have driven them. However, gaining access to funding for public transport use required considerable time and paperwork and without it being identified as a clear patient goal was difficult to approve, especially on a short-term basis. This is further magnified by patient fears that if NDIS funding is not used it will be taken away."*

The NDIS's permanent disability model should be reviewed to ensure that a recovery-focused approach is supported.

### 2. Improve governance and coordination between NDIS and other health and care services

The NDIS has created a separation between health services and NDIS services. Acknowledging the intersections between health and disability, however, is imperative in improving the experience of people with disabilities. NDIS services have many interfaces with non-NDIS services provided by states, territories, and the Commonwealth, such as aged and health care, housing, income support, education, and justice services.

As highlighted by the Productivity Commission, clearer governance is needed between these services, as well as more seamless connections and care pathways.[3] A more cohesive model of care needs to ensure NDIS participants receive the full range of supports they need, with providers having a shared understanding of what services are being provided to the participant. This would help ensure an appropriate range and level of supports for the participant.

*"I was treating a patient with paranoid schizophrenia reasonably well controlled on clozapine and was referred to the NDIS via his mother and GP. Despite being his treating psychiatrist for over 20 years the NDIS did not seek any information from me. He subsequently received a significant support package which I believe is well above his requirements and has the potential to de-skill him."*

### 3. Ensure the out-of-pocket cost to see a qualified healthcare professional for the participant or prospective participant does not act as a barrier to gaining access to the NDIS via the creation of a new MBS item for access report-writing for psychosocial disability for the NDIS

The application process for accessing NDIS support can be overwhelming and time-consuming for patients and medical professionals. Proving the severity and impact of mental health conditions through documentation can be complex. Unlike physical disabilities, mental health conditions may not have easily quantifiable symptoms, making it difficult to demonstrate the level of need for and appropriateness of permanent support.

Those with complex mental health conditions are especially vulnerable when they may not be able to cooperate with a structured assessment, complicated by long wait times and needing to attend multiple appointments for the treating doctors to write sufficient reports. People with disabilities from culturally and linguistically diverse (CALD) populations can experience additional challenges in accessing the appropriate support.

*"I had a patient who had tried three times to receive NDIS support for his severely disabled daughter, but his severely limited written English skills struggled to fill out the appropriate forms. Like many migrants, his conversational spoken English was suitable to get through an appointment and he did not require an interpreter in all circumstances, but the standard of English required for NDIS documentation is much higher."*

RANZCP members expressed significant concern about patients whose applications had been declined and who had only received a standard response that didn't clearly state the reason for rejection. Participant concerns are exacerbated by the regular reviews and fears of support packages being cut off.

The amount of support a participant receives can be highly variable depending on individual assessors and locations. While psychiatrists are highly trained and have the expertise to develop treatment plans and clear recommendations as part of a NDIS plan, some RANZCP members tell of having reports rejected without explanation, leading to time-consuming rounds of appeals.

Currently, the MBS does not cover report writing undertaken by medical professionals on behalf of people looking to access the NDIS including reports or evidence for appeals.

*"In my practice I see two children with the same disability getting totally different packages based on the strength of the reports that the family can access. Previously when the Ageing Disability and Home Care department used to look after vulnerable families they used to get good case management, transport, and support to attend appointments, aftercare and respite care organised and so on which provided ongoing support and navigation, but now individuals/families are given funds in the name of 'choice and control' but these families have no choice (they can't navigate the system or have no choice as services don't exist where they live or there are socioeconomic linguistic and geographic barriers) and they can't source or pay upfront to get the reports that are needed to take to the planner."*

The introduction of a bulk-billed MBS item could address equity issues and allow prospective participants to afford the required medical reports. Additional investment and attention are needed, however, to decrease existing wait times across all levels of mental health assessment, and to ensure appropriate services are in place to provide extra assistance to CALD populations.

A template for medical professionals to write reports would also improve consistency and reduce the likelihood of application rejections for administrative details, rather than an assessed lack of need.

#### 4. Ensure equitable access to NDIS for participants and prospective participants, including those in regional, rural, and remote areas

Health inequity is a significant issue in regional, rural, and remote Australia with people in these areas experiencing poorer health and welfare outcomes than people living in metropolitan areas.[4] People living with disability in rural, regional and remote areas face further struggles due to health inequity than the general rural population. Often this is due to limited health services in these areas, however, lack of broader services such as public transport can also significantly impact of health care access, as people with disability may rely on others for transport. RANZCP members report that clients are often paying hidden travel costs to receive NDIS support.

People with disabilities in rural and remote Australia may also face stigma and discrimination over their mental health-related disability which may negatively impact health care.[5] In disadvantaged and underrepresented areas, there can be a lack of skilled personnel with gaps in attitudes, awareness, and training of medical, nursing, and allied health staff. This can pose particular challenges for those navigating the complex health system.

*“The stigma in rural communities is different to metropolitan cities that have had decades of ‘Mental Health Awareness’ campaigns. Rural towns often have smaller populations and closer-knit social networks. This can lead to increased visibility and potential stigma associated with disabilities, making individuals less likely to seek out support.”*

It is the role of the NDIS to intervene and mitigate the impact of thin markets – where there is a gap between participant needs and their use of funded supports.[6] The success of the NDIS is dependent on a robust and diverse market, allowing participants to self-determine goals and supports.[7] The NDIA is aware of thin markets, in relation to NDIS services, an issue which has been raised by the Joint Standing Committee into NDIS Markets, the Productivity Commission, and the NDIA.[6] There continues to be an ongoing divergence between what is funded by the NDIS and what the market can provide. While this has been a prevalent issue for some time, little incentive is provided by the NDIA for services to move into service gaps, and the market response to the need is stalled at best, leaving people without access to the support they need. NDIS service providers have raised the low NDIS pricing or price caps to deliver NDIS support in rural and remote areas.[6]

The RANZCP highlights dire shortages in the disability workforce with challenges meeting demand being worse in regional, rural, and remote areas.[6] In 2018 the Joint Standing Committee on the NDIS conducted the [Inquiry into the market readiness for provision of services under the NDIS](#). [6] The final report found significant disability workforce shortages which were compounded in some regional, rural, and remote areas.[6] Both the Productivity Commission and the NDIA anticipated higher demand in regional and remote areas.[6] The [State of the Disability Sector 2022 report](#) confirms that the issue of disability workforce shortages and skillset are ongoing and impacting sector performance.[8]

#### 5. Support prospective NDIS participants who are in prison to develop a NDIS Plan prior to release to ensure they can access support immediately upon their release

The RANZCP highlights the specific challenges of people with disability who are in prison developing a NDIS Plan prior to their release. Many individuals exiting the prison system face complex challenges, including physical and mental health conditions that may have been exacerbated during their incarceration. While transition services are permitted via policy frameworks, the implementation of this in practice is inconsistent, and supporting practitioners face significant barriers in supporting transition services.[9]

This is a significant issue, given that people with intellectual disability are overrepresented (as both alleged perpetrators and victims) and disadvantaged in justice systems (including police interactions, courts, and prisons.[10 - 14] Evidence also indicates that this overrepresentation is exacerbated for Aboriginal and Torres Strait Islander peoples with intellectual disability.[15,16]

*“The NDIS is not fit for purpose in the forensic field. Forensic patients discharged with carefully made discharge plans that have been approved by the courts are quickly reviewed [by NDIS coordinators] and have their support reduced even if it places the patient in breach of court-ordered license conditions. These decisions are made without consultation with the services involved or by ignoring the representations of the services involved because of the divide made between disability and forensic needs by the NDIA.”*

There is also evidence that those with intellectual disability are at a higher risk of recidivism than those without intellectual disability, and that provision of adequate disability support lowers this risk.[14] Providing transitional supports and planning release prior to exiting prisons is required to prevent homelessness and reduce the likelihood of recidivism. The NDIS needs to work with other government services and agencies to support the best possible outcomes for all people with disability.

## **6. Better support people with neurodevelopmental disabilities to access NDIS services**

There are notable barriers to access to NDIS services for individuals with neurodevelopmental disabilities other than autism spectrum disorder (ASD). People with a marked disability relating to language disorders (e.g. Developmental Language Disorder, Verbal; apraxia or dyspraxia) can have significant difficulties in accessing NDIS.

People with non-traditional presentations of ASD, and people with both ASD and ADHD, can also face difficulties in accessing and determining the appropriate level of support. RANZCP members report instances where NDIS applications have been rejected on the grounds that the disability permanency requirements were not met as “any impairment was secondary to ADHD and depression”.

*“Failure to acknowledge the expertise of experienced clinicians with appropriate credentials making a diagnosis and comment about the treatment required. Not all young people or children with ASD can cooperate with a Speech and Language assessment. An appropriately qualified clinician such as a Child and Adolescent psychiatrist can make a diagnosis of ASD in the absence of structured assessments where these cannot be completed due to patient-related factors.”*

For children with an ASD diagnosis, for whom arguably the NDIS is working the best, there are nevertheless significant gaps in practice. The funding process for children with ASD is designed to use a strengths-based approach to build that person's functional capacity.[17] The assessment tools used by the NDIS are inherently deficit focused, where people with ASD and carers are repeatedly required to justify why their support needs should be met by the NDIS. The underlying rights-based principle of the NDIS should lead to an optimum experience for every participant resulting from their engagement with the NDIS. [18] To achieve this, it is crucial that NDIS funding frameworks and best practice interventions for children on the autism spectrum are improved.

The NDIS can support families and carers to make decisions in their child's and family's best interests by providing them with all the information necessary to support their child with ASD. The Australian Autism Alliance Amaze survey of community attitudes found that while 85% of Australians have a personal connection with a person with ASD, only 29% feel they understand how to support them and only 4% of people with autism and their families agree that the community understands how to support them.[19] Information on how the community can better support people with ASD must be nationally delivered, widespread, and evidence-based to relieve children with autism and their families of the burden of education and distribute among government and the community.[9]

### 7. Consider the Australian ADHD Professionals Association's (AADPA) Australian Evidence-Based Clinical Practice Guideline for Attention Deficit Hyperactivity Disorder (ADHD) recommendations in relation to the NDIS

The Australian ADHD Professionals Association's Australian Evidence-Based Clinical Practice Guideline for Attention Deficit Hyperactivity Disorder, which is endorsed by the RANZCP, makes several recommendations related to ADHD in the NDIS, including:

- “Recommendation 7.1.3: People with ADHD should have the same rights of access to the NDIS as those with a disability who do not have ADHD. To ensure optimisation of necessary and reasonable NDIS interventions and supports for people with ADHD, a shared understanding of the following is needed:
  - appropriate accommodations
  - value of suitably qualified ADHD coaches
  - the importance of a specialist in ADHD as a lead member of the care team.”
- “Recommendation 7.1.4: Eligibility and access to support from the NDIS should be decided based on the functional needs of the person with ADHD, and not based solely on diagnosis.

See also the RANZCP's [Position Statement 55: ADHD across the lifespan](#).

### What is working well?

The RANZCP supports the NDIS's aim to provide better support, empowerment, and inclusion for people with disabilities. The NDIS's person-centred approach aims to place participants at the centre of decision-making and planning, ensuring that their individual needs and preferences are respected. For many people, the current NDIS system works well, such as those who have a disability from childhood and can live with a family member or carer in a well-served urban or suburban area. The NDIS has been life-changing for some, providing autonomy and support to allow them to achieve their goals.

The NDIS system also works well for many parents who are carers of children with severe developmental disorders and who, through the NDIS, can receive care that works best for their whole family. The NDIS emphasises early intervention, which means providing support and services at an early stage to prevent the worsening of a disability or to help a child reach their developmental milestones.

The NDIS can provide personalised support to individuals with disabilities tailored to their specific needs, goals, and circumstances. NDIS participants have greater control over the services and supports they receive. They can choose their service providers, determine the type of support they need, and make decisions about how their funding is used. This increases independence and autonomy by providing them with the necessary supports and services to actively participate in their communities and daily activities and has an overall benefit to participants mental health.

The NDIS has also contributed to raising awareness about the needs of people with disabilities and advocating for more inclusive communities.

#### Feedback on the vision of a thriving NDIS

*"I went to the Ekka (Royal Queensland Show) on the weekend, and it was marvellous. Here, I witnessed individuals with a spectrum of disabilities exploring, participating, and enjoying themselves to the fullest. There were laughs as we watched the magicians, gasps when we saw inspiring fashion parades and giggles when we held chickens. Everyone remained safe and relaxed, with support workers redirecting, calming, and guiding clients while protecting them from over-stimulation or exploitation. Side by side, we*

*learned and shared. The disabled individuals were able to participate fully in the social, educational, emotional, and economic activity of the show alongside me. Australia has a chequered and controversial history and often it can be difficult to be "proud" of our past and our actions as a nation. However, that day, I felt proud. Should I have a child or family member with a disability, I am proud that our Australian community will enable them to live full and meaningful lives, as equals."*



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