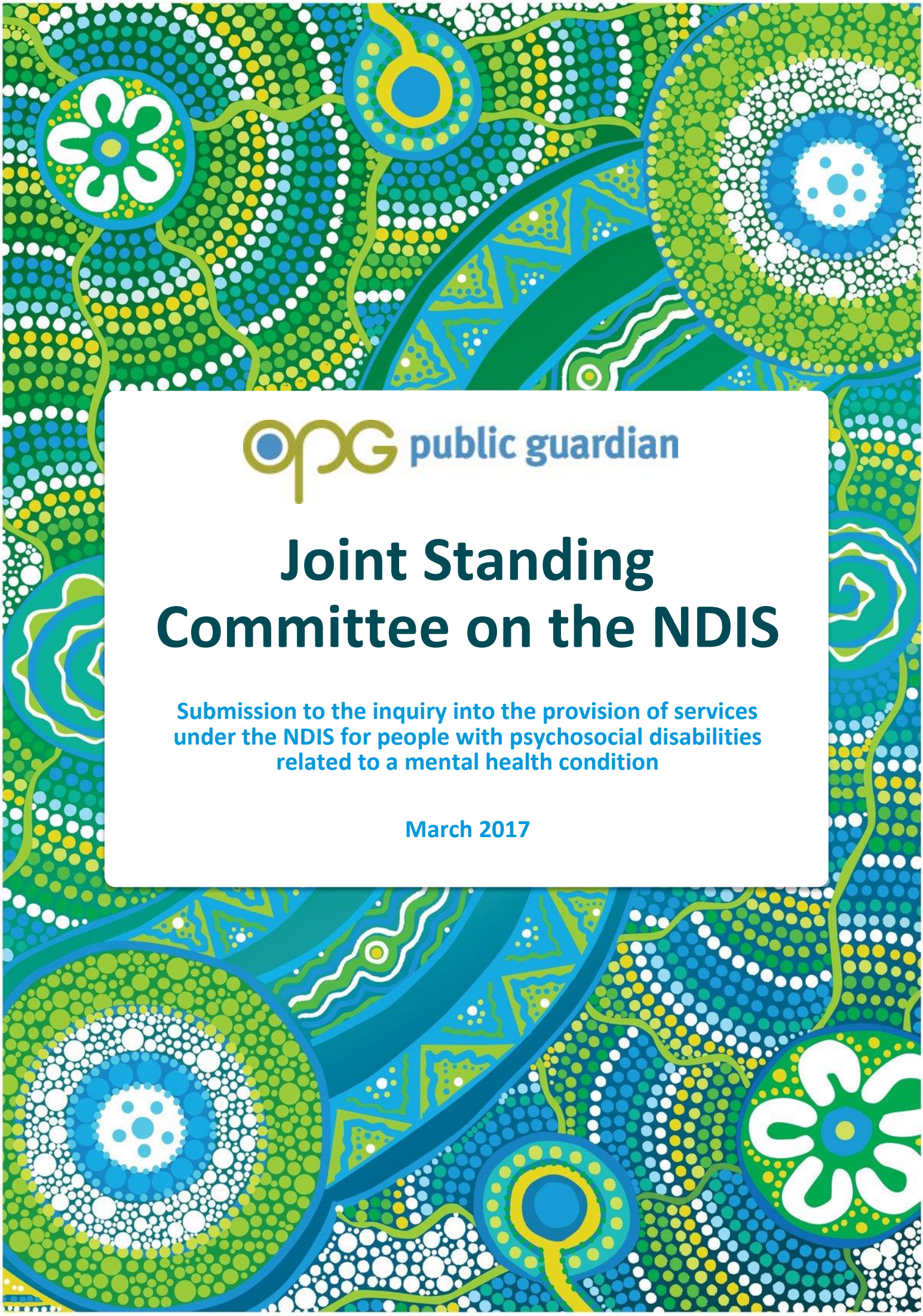

public guardian

Joint Standing Committee on the NDIS

Submission to the inquiry into the provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition

March 2017

About the Office of the Public Guardian

The Office of the Public Guardian (OPG) is an independent statutory office which promotes and protects the rights and interests of adults with impaired decision-making capacity, and children and young people in out-of-home care or staying at a visitable site.

The OPG provides an important protective role in Queensland by administering a community visitor program, which provides statewide visiting services to:

- adults with impaired decision-making capacity residing in government funded facilities and some private hostels, and
- children and young people in out-of-home care (foster care, kinship care, residential care) or at a visitable site (residential facilities, detention centres, corrective services facilities, authorised mental health services).

The OPG works to protect the rights and interests of adults who have impaired capacity to make their own decisions, recognising that everyone should be treated equally, regardless of their state of mind or health. The OPG has a direct role in implementing obligations and ensuring rights as prescribed by the United Nations *Convention on the Rights of Persons with Disabilities* are upheld.

The OPG's legislative obligations with respect to adults with impaired capacity are to:

- make personal and health decisions if the Public Guardian is their guardian or attorney
- investigate allegations of abuse, neglect or exploitation
- advocate and mediate for adults with impaired capacity, and
- educate the public on the guardianship and attorney systems.

When appointed by the Queensland Civil and Administrative Tribunal as guardian, the Public Guardian routinely makes complex and delicate decisions on health care and accommodation, and guides adults through legal proceedings in the criminal, child protection and family law jurisdictions.

The *Public Guardian Act 2014* and *Guardianship and Administration Act 2000* set out the OPG's legislative functions, obligations and powers. The *Powers of Attorney Act 1998* regulates the authority for adults to appoint substitute decision makers under an Advance Health Directive or an Enduring Power of Attorney.

The OPG also provides individual advocacy for children and young people through its child visiting program, complemented by its child advocacy program. This program gives children and young people engaged with the child protection system an independent voice, ensuring their views are taken into consideration when decisions are made that affect them, thereby implementing a key element of the United Nations *Convention on the Rights of the Child*.

The community visitors and child advocates provide an oversight mechanism to ensure that the Charter of Rights for a child in care under the *Child Protection Act 1999* are upheld. This includes upholding the rights of children and young people to be provided with a safe and stable living environment, and to be placed in care that best meets their needs and is culturally appropriate.

Submission to the inquiry

Position of the Public Guardian

The Office of the Public Guardian (OPG) welcomes the opportunity to provide a submission to the Joint Standing Committee (the Committee) on the National Disability Insurance Scheme (NDIS) inquiry into the provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition. The views contained in this submission are that of the OPG and do not purport to represent the views of the Queensland Government.

The OPG would be pleased to lend any additional support as the inquiry progresses. Should clarification be required regarding any of the issues raised, the OPG would be happy to make representatives available for further discussions.

This submission addresses the inquiry's terms of reference in relation to the experiences of the OPG and our clients and raises additional issues for the Committee's consideration, which the OPG considers significant to the inquiry.

The role of the OPG in relation to the NDIS

The National Disability Insurance Agency (NDIA) commenced full scheme transition to the NDIS in the Townsville service region of Queensland from 1 July 2016. All participants in receipt of state government disability support funding in this region were required to be transitioned to an NDIA funded plan prior to 31 January 2017, when state government funding ceased. During this period of transition, OPG's clients with psychosocial disabilities relating to mental illness have not always had an easy transition to the NDIS. In many cases, they have experienced barriers in accessing and transitioning to the NDIS. Details of some of these issues, including case studies, are provided in this submission.

In the experience of the OPG, while some people with psychosocial disability are able to navigate the NDIS, either independently or through the use of informal supports, some adults have required the formal appointment of a statutory guardian to make critical NDIS-related decisions. In Queensland, the Queensland Civil and Administrative Tribunal (QCAT) may appoint a guardian for an adult if they are satisfied: the adult has impaired capacity for a non-financial matter; there is a need for a decision in relation to the matter; and the adult's needs will not be adequately met, or interests adequately protected, without an appointment.[1] The Public Guardian may only be appointed as a person's guardian for a matter as a last resort; that is, if there is no other appropriate person available for appointment for the matter.[2]

[1] Section 12(1) *Guardianship and Administration Act 2000*.
[2] Section 14(2) *Guardianship and Administration Act 2000*.

The OPG has been working closely with existing OPG clients to provide support in relation to the NDIS. For these clients, the OPG has been involved in all aspects of the NDIS process, including: pre-planning and planning; attending formal planning meetings; making service provision decisions; reviewing plans and seeking formal reviews for inaccurate or inappropriate plans; and signing service agreements. However, in addition to the OPG's existing client base there has been a significant number of adults who have been identified by external agencies as requiring decision-making support under the NDIS. The OPG has worked proactively on behalf of these adults to obtain further information about the person's disability and identify advocacy options as an alternative to guardianship, and has referred matters on the person's behalf back to the NDIA where appropriate. Only as a matter of last resort and where it is absolutely necessary, has the OPG obtained formal guardianship appointments for the specific purpose of enabling a person to participate in the NDIS.

As part of the implementation of the NDIS, there has been a notable increase in applications to QCAT for the appointment of the Public Guardian as guardian for NDIS-related matters. A significant number of adults in this group have a psychosocial disability, many of whom also have a dual diagnosis of intellectual or cognitive disability.

The critical role advocates play in the transition to the NDIS

People with psychosocial disabilities should have access to support that enables meaningful engagement with the NDIS, and can assist them to overcome barriers navigating the system. Informal support and advocacy are critical mechanisms that a person with disability can use to engage with the NDIS. For this reason, the OPG will refer matters to advocacy organisations where appropriate, rather than seek or support the formal appointment of a guardian. However, one of the challenges the OPG has faced in the rollout of the NDIS is the lack of advocacy organisations available and funded, particularly culturally appropriate organisations to assist Aboriginal and Torres Strait Islander people. For example, there are only two advocacy organisations in Townsville. This has led to significant waiting times on advocacy services, and risks a person being subjected to a more restrictive decision-making regime such as guardianship, in lieu of available advocacy support. The irony is that in order to engage with the NDIS which is centred upon choice and control, adults with psychosocial disability may have a guardian appointed on their behalf specifically for the purpose of being able to enter into the NDIS. It is therefore crucial that advocacy agencies are funded not only for 'participant readiness', but to support the person through the entire NDIS process.

The case studies in this submission highlight the critical role advocates play in the transition and planning process. Without the involvement of a guardian in these cases, very different, less preferable outcomes may have resulted. People with psychosocial disabilities who are not under guardianship are particularly vulnerable in this process if they do not have adequate support to ensure their needs are met. In these circumstances, it is vital that people with psychosocial disabilities are made aware of, and encouraged, to access advocacy agencies who can provide assistance throughout the NDIS planning process.

Eligibility criteria for the NDIS for people with a psychosocial disability

Under the Terms of Reference (a) the Committee has inquired as to the eligibility criteria for the NDIS for people with a psychosocial disability.

From the OPG's experience, there have been gaps in the eligibility documentation transferred from Disability Services Queensland (DSQ) to the NDIA which have affected the ability of clients to transition smoothly to the NDIS. Several OPG clients who received disability support through DSQ have been unable to establish NDIS eligibility due to a lack of information available on their NDIA file. To overcome this issue, the NDIA has requested eligibility information and specialist reports from the OPG. However, this has been problematic as the OPG often does not have disability services eligibility documentation on file. The OPG has been required to go to great lengths to find relevant documentation, or obtain reports. This in itself presents the OPG with additional challenges. Often clients with psychosocial disabilities struggle to attend medical appointments due to a distrust of the medical profession, or other government arranged appointments. Further, many of our clients with psychosocial disabilities will be transient, with no fixed address making it difficult to obtain evidence and documentation.

The OPG also has existing clients who have never been engaged with DSQ but would satisfy eligibility for the NDIS and require support to navigate the NDIS process. Often the most significant reason why these clients have not engaged with DSQ is due to their distrust of government systems. This distrust may in some circumstances be linked with the existence of a psychosocial disability and a reluctance to engage with governments, police, doctors or other authority figures. Clients with psychosocial disabilities may also be engaged in drug and alcohol misuse or abuse. While the link between mental health and substance misuse and abuse is well established, the NDIS does not fund drug or alcohol programs. Consequently, clients may be ineligible for the NDIS due to their substance misuse issues which are secondary to their mental health diagnosis. The unfortunate result is that these clients are caught in the paradox of a 'Catch 22' from which they cannot escape. Support to help these persons engage with 'systems' requires intensive personal and specialist support for this highly marginalised group of individuals, which is usually best carried out by small, specialised non-government support and advocacy services.

Another challenge for both the OPG and our clients with psychosocial disabilities is the lack of clarity regarding what evidence is required to establish their eligibility for the NDIS. Interpretation of what is 'sufficient evidence' can be highly subjective and, in the experience of the OPG, can vary from planner to planner. The OPG has had to invest significant time and effort in obtaining additional documentation and reports, many of which are costly, in order to satisfy these requirements. In the experience of OPG's frontline guardianship staff, the NDIA has in some cases rejected recent medical reports and requested additional evidence of the client's diagnosis or permanency of condition. This has occurred in the context where the client recently had a guardian appointed for an extended period of between 1-5 years, and QCAT has been satisfied the adult had impaired capacity for these decisions. In obtaining further reports for adults with psychosocial disabilities, they are often required to obtain further evidence of their mental illness. In addition to the problem of getting the

client to a further medical appointment, psychiatric assessments and reports are usually prohibitively expensive. The OPG's clients invariably have limited available funds to cover these kinds of expenses.

On occasion a planner may refer the matter internally within the NDIA to the National Access Team (NAT). The experience of OPG staff is that the NAT may struggle to understand the complexity and challenges faced by persons with psychosocial disability in trying to access the NDIS. This gap in understanding may be exacerbated by NAT members not having face-to-face contact with our clients. OPG's experience is that our clients invariably experience far better outcomes when they work directly with planners, than when they have their eligibility assessed by someone who has never met them, such as the NAT.

In engaging with the NDIA and the eligibility and planning process, OPG staff have observed that adults with psychosocial disability fare better through the process if they have an advocate, whether formal or informal. This is clearly the case with adults who have impaired capacity, such as our guardianship clients, to whom the OPG has provided significant support to engage with the NDIA, as well as in assisting them to navigate the administrative processes to satisfy eligibility.

All of these factors can contribute to gaps and barriers in acquiring adequate evidence to meet the eligibility requirements of the NDIS, and therefore access to necessary services and support. Some of these barriers could be addressed through providing more flexible approaches to eligibility assessments for clients with psychosocial disability. This includes having consistent practice across planners in: acceptance of previous assessments (medical or allied health) of psychosocial disability from DSQ, Queensland Health or other mental health services; acceptance of recent medical reports from state or territory guardianship tribunals; and not requiring additional expensive psychiatric or other medical assessments to be made to prove eligibility, where other evidence is available.

The case studies below illustrate some of these difficulties for OPG clients. All names have been changed to protect our client's identities.

Fred and Bertie

This case study relates to the provision of medical evidence to establish functional impairment.

During transition to the NDIS, these two OPG clients were identified as 'defined' (ie. eligible for the NDIS and receiving services from DSQ prior to transition). Both have a diagnosis of schizophrenia. In both cases, the NDIA advised the OPG that upon reviewing the clients' medical documents, there was insufficient evidence to confirm the permanency of their conditions and how their conditions reduced the clients' functional ability. Being unable to infer a connection between these two criteria, the NDIA required further evidence from a medical specialist; such evidence could include a psychiatrist's report to confirm schizophrenia and the functional impact of schizophrenia while a patient is correctly medicated.

The matter was referred to the NAT. The OPG raised concerns regarding the NDIA's understanding of, and clarity around, psychiatric conditions and how to assess the eligibility criteria of the NDIS.

Both Fred and Bertie fluctuated in their capacity and need for supports, due to their mental illness. Their conditions could change daily, regardless of medical compliance, and impacted the likely enduring nature of impaired functionality and support needs.

The OPG highlighted these concerns with the NDIA. The OPG focused on the assessment requirements, relying upon documentation already held by DSQ and additional medical documents provided to the OPG by QCAT which supported the Public Guardian's appointment as guardian for Fred and Bertie. The OPG provided evidence to the NDIA that the requirement to obtain further specialist reports would incur a significant cost to both Fred and Bertie individually, neither of whom had much money. The NDIA eventually agreed that the documentation already supplied to the NDIA was sufficient to establish the clients' eligibility for the NDIS.

While in this instance our clients had advocates who could speak on their behalf, there will be circumstances where a person with psychosocial disability does not have this type of advocacy available to them. Ultimately, this will either require a change in the NDIA assessment process to ensure these adults are not further disadvantaged, or the need to engage advocacy agencies with greater capacity to provide this support (especially for Aboriginal and Torres Strait Islander people).

Thomas

This case study relates to sufficiency of medical evidence for an OPG client diagnosed with complex health and mental health needs, including paranoid schizophrenia, attention deficit/hyperactivity disorder, and drug-induced psychosis.

The OPG provided the NAT with a copy of the QCAT guardianship appointment order for Thomas which included an occupational therapist (OT) report as evidence of Thomas's eligibility for the NDIS. This information clearly set out Thomas's medically confirmed diagnosis and the OT assessment of ongoing moderate functional impairment. Evidence was also provided of Thomas' history of psychiatric concerns and non-compliance.

The NAT indicated that this was insufficient evidence. The NAT stated that they needed evidence that Thomas' condition resulted in permanent functional impairment. The NAT also wanted an assessment of Thomas' condition when he was medically compliant. This was required despite the OT report indicating that the client had been discharged, which would suggest the client was medically compliant at that time.

The OPG contacted DSQ and was provided a letter by a consultant psychiatrist and registered nurse which confirmed the client's diagnosis and Thomas' need for ongoing support. This eventually satisfied eligibility requirements, despite the letter being more ambiguous about Thomas's ongoing functional incapacity than evidence provided in the OT report.

In the case above, one of the means by which this matter could have been addressed, is that NAT could have been satisfied with the initial evidence provided, and worked more closely with the OPG to understand the particular circumstances of the client.

Recommendations regarding eligibility:

- More flexible approaches to eligibility assessments for clients with psychosocial disability
- Consistent practice in planning and clear eligibility criteria designed to meet the needs of persons with psychosocial disability
- Acceptance of previous assessments, whether by medical or allied health professionals of evidence of psychosocial disability
- Acceptance of current medical reports and findings from state or territory tribunals of impairment of capacity due to psychosocial disability
- Not requiring additional expensive psychiatric or other medical assessments to prove eligibility where other evidence is provided
- Appropriate advocacy support for adults during the transition process

The planning process for people with a psychosocial disability, and the role of primary health networks in that process

Under the Terms of Reference (e) the Committee has inquired as to the planning process for people with a psychosocial disability, and the role of primary health networks in that process.

The NDIS planning process can work effectively for many persons with disability. Where a person has impaired capacity due to psychosocial disability, the process can work particularly well where the person has a supportive family, friend or advocate working with them through the process. One of the challenges observed by OPG staff is an additional barrier that a client with psychosocial disability has to overcome, by virtue of having an 'invisible' disability which is not immediately apparent to the public. Further, the administrative requirements can seem complex and overwhelming to navigate on their own.

A key aspect of working with our clients with psychosocial disability is understanding that many of our clients have a history of trauma and often negative experiences with government and other authority figures. This may be trauma incurred through experiences in the mental health and disability sectors, including through institutionalisation, or histories of coerced treatment and the use of restrictive practices. Our clients are often from marginalised backgrounds. Our clients with psychosocial disabilities may lack self-awareness, insight, or motivation for self-care, and have a view that they are functioning appropriately without support, even when they are physically and mentally deteriorating. For our itinerant and homeless clients, health care is not necessarily a priority and there may be minimal, if any, health records available to access. All of these factors can lead to our clients being disengaged throughout the whole NDIS process, often to their own detriment. The OPG as guardian cannot force clients to engage with the NDIS. Therefore, a significant risk for our clients is that they do not engage in NDIS processes, and lose the opportunity to improve their situation and circumstances through accessing NDIS supports.

Some of the planning challenges are exacerbated in rural and remote communities. For example, the OPG has a client in a remote community who has a dual diagnosis with primary mental illness and a mild intellectual disability. The client is on the defined client list and is ready for the NDIS; however, a

planning meeting was repeatedly unable to be scheduled because the NDIA was unable to conduct planning meetings in remote regions.

Positive experiences of NDIA planning processes have included:

- consideration of the person's needs in relation to activities (eg. the types of activities and how these are facilitated), and transport to and from these activities
- services required to support the person to live in the community
- funding (eg. accommodation and community access)
- costs (eg. specialist disability equipment and fulltime care)
- service coordination (especially for people with complex needs)
- consultation with the person's doctor, psychiatrist, OT, physiotherapist and/or specialist
- recognition of the person's aspirations, and
- face-to-face planning sessions.

It is vital that case planning meetings for adults with psychosocial disability are held face-to-face with the person and, wherever possible, with a supporter or advocate. In the OPG's experience, this results in better outcomes and ensures that our clients are an actively engaged in the planning process. Where the NDIA has proposed a telephone planning session, it has been the OPG's practice to request that clients are supported to attend a face-to-face meeting instead. While this has presented challenges to OPG's guardians in order to ensure that our clients attend, face-to-face planning meetings have regularly proven to provide far better outcomes for our clients.

The following is a story of a positive outcome for an OPG client which was achieved through the NDIA working closely with the OPG.

Prue

Prue is a 62-year-old transgender person who identifies as female, with a diagnosis of Bipolar Affective Disorder. Prior to transitioning to the NDIS, Prue had been assessed by DSQ and was receiving 1-5 hours per week of in-home accommodation support, and 6-11 hours per week of community access. This funding was maintained upon transitioning to NDIS.

After transitioning to the NDIS, the OPG was advised of allegations that Prue's service manager was fraudulently using the client's NDIS portal by drawing down of funds without a service agreement in place. OPG raised a complaint with the NDIA who began to investigate the matter. As a result of the investigation, Prue's service manager issued her with an eviction notice which forced Prue to seek alternative accommodation and support.

Subsequently, OPG contacted the NDIA and requested a face-to-face 'change in circumstances' review. Following a successful review meeting with the NDIA planner, Prue received a significant increase in her community access and core supports, support coordination, and is now funded to reside in a two person co-tenancy with another person with a mental illness.

It is the OPG's opinion that this successful outcome was achieved not only due to the ongoing advocacy provided by the guardian, but also due to the collaboration between the NDIA and OPG in regard to this matter.

In the OPG's experience, where a client with psychosocial disability is assisted and supported by a third party at planning meetings, they end up with better outcomes. If alone and unsupported at the meeting, clients may not feel confident to speak up or clarify information with their planner. The OPG staff who have attended planning meetings have noted how often a planner may accept a client's word at face value when they say they do not want support or accommodation, without delving deeper into the person's circumstances or history. In these circumstances, following prompting by the OPG officer for the client to explain a little of their history, the planner has then obtained greater insight into the client's needs, which has been reflected in their provision of support. Without this additional information, there may be insufficient evidence for the planner to see the need for certain supports. Another example of where advocacy support has been critical, involved an OPG client attending a planning meeting with their guardian where the planner was hearing impaired. The client said that he used to visit the local shopping centre before his health issues escalated, and that he needed support to be able to do this. The planner misheard and repeated back that it was easy for the client to visit the shopping centre, and therefore supports were not needed in this area. The client went silent, and did not speak up and correct the planner. If the guardian had not been there, the client may have lost approximately $50,000 on his plan, which was essential to the client being able to access the community, and was vital for sustaining the wellbeing and community engagement of the client.

In another matter, an OPG client with psychosocial disabilities decided to attend a planning meeting on his own. The client was homeless and lived on the street. At the time, the client said that he did not want support or accommodation, and that in his opinion nothing was wrong and he was fine. The client received very little in his plan as a result. Circumstances could have been different had he had advocacy support present to provide full information regarding his circumstances and support needs.

These two examples demonstrate the critical role that a person's advocate can play in the planning meeting, by assisting both the client and the planner to understand the client's needs and negotiate necessary support outcomes. Adults without this type of support may be seriously disadvantaged in the NDIS planning process, especially if they do not feel confident or comfortable speaking up or correcting the planner.

Recommendation:

There needs to be recognition of the critical role advocates play in the NDIS planning process for people with psychosocial disabilities, and adequate funding of advocacy agencies to build their capacity to perform this role.

In the OPG's experience, there have also been greater inconsistencies in plan outcomes for our clients who have psychosocial disabilities, particularly in relation to support coordination. Some of the factors that the OPG has observed can contribute to these inconsistencies include: the knowledge and skill of the individual NDIA planner who conducts the planning meeting; and the

location of the client at the time of the meeting (eg. mental health facility or supported accommodation). In the OPG's experience, the difference between individual NDIA planners can be the greatest influence in planning outcomes for clients. Anecdotally, planners who appear more engaged in the planning process and take the time to understand our clients' circumstances are more likely to recommend higher levels of funding for our clients. The following examples illustrate the variations between plans and outcomes for our clients*. It is important to note that these OPG clients have similar psychosocial disabilities and support needs*:

- a client in a mental health voluntary rehabilitation unit received 104 hours of support coordination, in addition to $100,000 support
- a client staying in an inpatient secure care unit only received approximately $1,000 for transport
- a client staying at an acute unit under an involuntary treatment order received a $200,000 package
- a client who was released from prison on strict parole and also under an involuntary treatment order, due to go into the community, received 104 hours of community support, but only $3,000 core support
- a client aged in his 50s received only $1,000 for transport—because he had previously been ACAT assessed, the NDIA determined that the NDIS was not appropriate and that the client should go into aged care—the client was a robust man who exhibited behaviours which would be a significant challenge to an aged care facility.

The following is a story of a positive outcome for an OPG client which was achieved through the NDIA planner working closely with the OPG.

David

This case study relates to an OPG guardianship client who received an increase in funding upon transitioning to the NDIS. David is also subject to a Forensic Order.

David was residing in shared 24/7 accommodation with another male in a duplex setting, however David did not interact much with his co-tenant. David received 1:1 support from 9am-1pm, and was subject to a number of restrictive practices including containment and seclusion, the latter of which occurred during the night when support staff slept in the staff room in the other duplex.

During the NDIS planning meeting, David's guardian discussed with the NDIA planner that David's funding should not be contingent upon the circumstances of the co-tenancy arrangement. The guardian explained the impact of the current arrangement and demonstrated how David was being disadvantaged because of this (i.e. unnecessary seclusion).

The NDIA planner worked closely with the OPG and the information provided. The NDIA planner recommended that David should receive 1:1 24/7 NDIS funding.

As a result, this has enabled David's support staff to focus on skill development and improving his quality of life. David is currently looking for a job with the assistance of his support, he is accessing the community in the afternoons, the night-time seclusion has ceased, and he is engaging in meaningful activities that he was unable to access previously.

Where a client has fluctuating mental health issues requiring regular inpatient treatment, there is no consistent support available for when the person returns to live in the community, and on each occasion, the client's plan has to be reviewed. In the OPG's experience, if a person's mental health is stable, the NDIA will engage and be supportive of the person attending planning meetings. However, the NDIA generally will not meet with mental health clients who are in a mental health facility, as the clients are deemed not well enough to participate in the planning meeting. Any planning that occurs when a client is in a mental health facility, is based on the person's current situation as an inpatient, rather than also addressing their support needs upon discharge.

During the rollout of the NDIS in Townsville, the OPG requested planning sessions for all clients in mental health facilities to ensure that there was continuity of services for those in receipt of DSQ funding, which ceased on 31 January 2017. However, as the NDIA planning was based on the current circumstances of the client being a temporary resident of a mental health facility (and not on previous DSQ provision), clients often received significantly less support. There was also no flexibility available within the planning session to plan for their future needs for when the client would be discharged and move back to live in the community. The result of this inflexibility in planning processes means that each time a client transitions back to live in the community, the OPG has to request a review of the client's plan, which is only applicable for inpatient support. If a client later returns for a period of time to an inpatient mental health facility, the whole process has to be undertaken again. This constantly duplicates the planning work for both the NDIA and OPG, and creates additional administrative barriers for clients with fluctuating mental health issues.

People with psychosocial disabilities often have complex needs that do not necessarily fit neatly with the NDIS model. Effective planning requires skilled planners that do not have a rigid 'black-and-white' approach, but can give consideration to the particular circumstances of individuals. It is the OPG's experience that these sessions would benefit from adopting a more flexible and forward thinking approach when creating plans for people with psychosocial disabilities.

It is therefore recommended that the NDIA allow for more flexible planning for persons with psychosocial disability. The risk is that the current process, if ongoing, will burden Commonwealth and States agencies with additional and unnecessary administrative costs, and lead to inadequate outcomes for clients needing to access disability related supports. Rather than relying on a review for a change in circumstances (upon a person's discharge), contingencies should be built into the plan. This would allow for a much more streamlined and efficient transition between the NDIS and mental health service when required, and would put the individual at less of a disadvantage.

Recommendation:

NDIS planning should allow for continuity of services and forward planning based on foreseeable changes of circumstances.

Some service providers may also be unwilling to engage with mental health clients because they do not receive sufficient or consistent funds to support the client. In the case of mental illness, it can be hard for the service provider to plan ahead and operate a business where a person's disability support funding is not easily predictable. It is the OPG's experience that some service providers will not take on mental health clients where they are unsure whether the client will be consistently funded by the NDIS or not.

Another example of the impact of unpredictable funding occurs where clients residing in an accommodation arrangement funded through their NDIS plan are admitted to a mental health facility for a period of several weeks, and the service provider is unable to hold their accommodation due to the need to maintain their own financial viability. This is because the service provider is unable to draw down funds from the NDIS portal for accommodation while the person is not physically a resident at the time. The inability to retain supported accommodation while admitted to an inpatient facility then means these clients have to find another suitable supported accommodation position that matches their needs when they are discharged. It is particularly difficult to find vacancies at short notice. This can result in the client becoming homeless or being forced to stay on at the mental health facility while waiting for a review of their plan to enable additional funding. In all of these circumstances, this makes it extremely difficult to ensure continuity of care for our clients. The case study below provides an example of this issue.

Melanie

This case study relates to an OPG client's risk of housing loss due to multiple admissions to a mental health facility. Melanie is also under a forensic order.

Melanie has a significant mental illness. She has supported accommodation with a local service provider. However, her mental illness has been fluctuating, and she has required multiple admissions to the local mental health inpatient facility. The service provider has raised concerns with the OPG as Melanie's guardian regarding their financial capacity to hold the client's bed while she is accommodated at a mental health facility.

While accommodated at a mental health facility, her service provider is unable to draw funding from the NDIS portal to hold the bed.

The service provider and the OPG identified that if the client were to lose her accommodation with the provider, it would put Melanie at a heightened risk of escalating her mental health conditions, in part because she had been a long-term resident of the accommodation, and she had an established network at the house.

Melanie was seeking to transition to the NDIS. The NDIA planner requested a copy of the forensic order from the OPG, indicating the client's plan could not be finalised until it was received. There was no clear explanation as to why the forensic order was relevant to the planning process, and risked delaying her plan.

Melanie needed the NDIA to provide her support to maintain her existing housing arrangements while she was in the mental health facility. Following negotiations with the NDIA, the client's supports were able to be replicated and her housing arrangement maintained, and are not currently at risk.

The case study below further demonstrates the challenges when there is a lack of forward planning while a person is in a mental health facility, and the over-reliance on plan review after the person's discharge.

Bobbie

This case study relates to the provision of support coordination in an NDIS plan for an OPG client staying at a mental health facility.

In discussions held between Queensland Health, the OPG and the NDIA, concerns were raised by Queensland Health regarding barriers that the NDIS may pose to Bobbie's discharge from the mental health facility. The NDIA had offered to provide clients who were admitted to a mental health facility with increased support coordination funding, with the view that this funding could be utilised to assist with discharge planning. Once discharged, the plan would go back to the NDIA for an immediate change of circumstances review (with an estimated two-day turnaround), with the intention of then implementing reasonable and necessary supports that complemented the client's release to the community.

The OPG requested a review on the basis that the plan did not meet Bobbie's needs and risked severely disadvantaging him, in part because Bobbie would not be able to connect and coordinate informal or mainstream complex services on his own as his diagnosis would not improve. The NDIA responded that Bobbie's current provider—the Secure Mental Health Rehabilitation Unit—could provide the appropriate supports to cover the lack of support coordination. This was in contradiction with previous discussions. Bobbie needed greater mobility and transport allowance to support community access. However, this was left to Queensland Health to meet the gap given the lack of support coordination provided in the plan. Concerns were raised over Queensland Health's capacity to undertake this function, and the plan was returned for a second review. This matter is ongoing.

One of the challenges appears to be planning for what is 'reasonable and necessary' based solely on a client's current circumstances. The ability to 'forward plan' and take into account a person's future 'reasonable and necessary' supports when they are ready to be discharged into the community would potentially prevent a client from remaining in a mental health facility for longer than necessary. It is therefore recommended that the NDIA allow for more flexible planning for persons with psychosocial disability. This will also alleviate the risk of additional burdens being placed on Commonwealth and States agencies for additional and unnecessary administrative costs, and inadequate outcomes for clients.

Recommendation:

The OPG recommends that the NDIA should allow for more flexible planning for persons with psychosocial disability by:

- supporting these people to attend planning meetings face to face with adequate support
- accommodating individual differences and recognising the fluid nature of psychosocial disability
- providing consistent funding as these people transition in and out of mental health facilities
- ensuring these people have adequate support coordination (funding) to assist with discharge planning, and
- supporting planners to take a more holistic view during the planning process by engaging more closely and developing a deeper understanding of each person.