Public Health Association of Australia

submission on the provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition

28 February 2017

Contact for recipient:
Joint Standing Committee on the National Disability Insurance Scheme
A: PO Box 6100, Parliament House, Canberra ACT 2600
E: ndis.sen@aph.gov.au T: (02) 62773083

Contact for PHAA:
Michael Moore – Chief Executive Officer
A: 20 Napier Close, Deakin ACT 2600
E: phaa@phaa.net.au T: (02) 6285 2373
Contents

Introduction .......................................................................................................................... 3

The Public Health Association of Australia ..................................................................... 3

Vision for a healthy population ......................................................................................... 3

Mission for the Public Health Association of Australia .................................................. 3

Priorities for 2017 and beyond ......................................................................................... 3

Preamble ............................................................................................................................. 4

Health Equity ..................................................................................................................... 4

Social Determinants of Health .......................................................................................... 4

PHAA Response to Terms of Reference ......................................................................... 5

1a. The eligibility criteria for the NDIS for people with a psychosocial disability .......... 5

1b. The transition to the NDIS of all current long and short term mental health Commonwealth Government funded services, including the Personal Helpers and Mentors services (PHaMs) and Partners in Recovery (PIR) programs, and in particular; i. whether these services will continue to be provided for people deemed ineligible for the NDIS; .............................................................................. 6

1c. The transition to the NDIS of all current long and short term mental health state and territory government funded services, and in particular; i. whether these services will continue to be provided for people deemed ineligible for the NDIS; .............................................................................. 6

Conclusion ....................................................................................................................... 7

References ......................................................................................................................... 7
PHAA submission on the provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition

Introduction

The Public Health Association of Australia Incorporated (PHAA) is recognised as the principal non-government organisation for public health in Australia and works to promote the health and well-being of all Australians. The Association seeks better population health outcomes based on prevention, the social determinants of health and equity principles. PHAA is a national organisation comprising around 1900 individual members and representing over 40 professional groups.

The PHAA has Branches in every State and Territory and a wide range of Special Interest Groups. The Branches work with the National Office in providing policy advice, in organising seminars and public events and in mentoring public health professionals. This work is based on the agreed policies of the PHAA. Our Special Interest Groups provide specific expertise, peer review and professionalism in assisting the National Organisation to respond to issues and challenges as well as a close involvement in the development of policies. In addition to these groups the Australian and New Zealand Journal of Public Health (ANZJPH) draws on individuals from within PHAA who provide editorial advice, and review and edit the Journal.

In recent years PHAA has further developed its role in advocacy to achieve the best possible health outcomes for the community, both through working with all levels of Government and agencies, and promoting key policies and advocacy goals through the media, public events and other means.

Vision for a healthy population

The PHAA has a vision for a healthy region, a healthy nation, healthy people: living in an equitable society underpinned by a well-functioning ecosystem and healthy environment, improving and promoting health for all.

Mission for the Public Health Association of Australia

As the leading national peak body for public health representation and advocacy, to drive better health outcomes through increased knowledge, better access and equity, evidence informed policy and effective population-based practice in public health.

Priorities for 2017 and beyond

Key roles of the organisation include capacity building, advocacy and the development of policy. Core to our work is an evidence base drawn from a wide range of members working in public health practice, research, administration and related fields who volunteer their time to inform policy, support advocacy and assist in capacity building within the sector. The aims of the PHAA include a commitment to:

- Advancing a caring, generous and equitable Australian society with particular respect for Aboriginal and Torres Strait Islanders as the first peoples of the nation;
- Promote and strengthen public health research, knowledge, training and practice;
- Promote a healthy and ecologically sustaining human society across Australia, including tackling global warming, environmental change and a sustainable population;
- Promote universally accessible people centered and health promoting primary health care and hospital services that are complemented by health and community workforce training and development;
- Promote universal health literacy as part of comprehensive health care;
- Support health promoting settings, including the home, as the norm;
- Assist other countries in our region to protect the health of their populations, and to advocate for trade policies that enable them to do so;
PHAA submission on the provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition

- Promote the PHAA as a vibrant living model of its vision and aims.

Preamble

PHAA welcomes the opportunity to provide input to the Joint Standing Committee on the NDIS. The reduction of social and health inequities should be an over-arching goal of national policy and recognised as a key measure of our progress as a society. The Australian Government, in collaboration with the States/Territories, should outline a comprehensive national cross-government framework on reducing health inequities. All public health activities and related government policy should be directed towards reducing social and health inequity nationally and, where possible, internationally.

Health Equity

As outlined in the Public Health Association of Australia’s objectives:

*Health is a human right, a vital resource for everyday life, and a key factor in sustainability. Health equity and inequity do not exist in isolation from the conditions of society that underpin people’s health. The health status of all people is impacted by the social, political, and environmental and economic determinants of health. Specific focus on these determinants is necessary to reduce the unfair and unjust effects of conditions of living that cause poor health and disease.*

The PHAA notes that:

- Health inequity differs from health inequality. A health inequality arises when two or more groups are compared on some aspect of health and found to differ. Whether this inequality (disparity) is inequitable, however, requires a judgement (based on a concept of social justice) that the inequality is unfair and/or unjust and/or avoidable. Inequity is a political concept while inequality refers to measurable differences between (or among, or within) groups.¹

- Health inequity occurs as a result of unfair, unjust social treatment – by governments, organisations and people,² resulting in macro politico-economic structures and policies that create living and working conditions that are harmful to health, distribute essential health and other public services unequally and unfairly, preventing some communities and people from participating fully in the cultural, social or community life of society.

Social Determinants of Health

The social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities – the unfair and avoidable differences in health status seen within and between countries. This is particularly pertinent when considering issues such as the NDIS policy.

The determinants of health inequities are largely outside the health system and relate to the inequitable distribution of social, economic and cultural resources and opportunities. Health inequities are the result of the interaction of a range of factors including: macro politico-economic structures and policy; living and working conditions; cultural, social and community influences; and individual lifestyle factors.
PHAA submission on the provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition

PHAA Response to Terms of Reference

1a. The eligibility criteria for the NDIS for people with a psychosocial disability

The NDIS is a significant change in the landscape on mental health care in Australia. This will see the transition of federally funded services being moved to NDIS funding. Important considerations during this transition include that no individual is disadvantaged throughout the process of transitioning services to NDIS. The eligibility criteria and service provision for those deemed ineligible will be central to this.

There should be clarity of the definition of psychosocial disability that is enduring and lifelong. The process of defining eligibility should be transparent in its criteria and how eligibility will be determined. The process should be in consultation with national and state mental health commissions, professional bodies, mental health advocacy agencies and carer organisations. People with lived experience should also be consulted on the process. Assessment tools for disability support services must involve carers/other support workers and be specifically tailored towards people with psychiatric disability.

Clear and defined standards of care provision should be established so that service providers are able to provide optimum support for people living with a psychological disability. It is essential that these targets and standards address areas such as physical health care and mental health, work provision and support for meaningful activity, safety of accommodation and engaging isolated populations such as the homeless, people living with a psychological disability who are incarcerated and any other populations who have difficulty engaging with support services. This will also need to include people with cognitive issues that affect personality, behaviour and decision making.

In the area of psychiatric disability in particular, there needs to be a very close relationship between clinical mental health services, disability support services and other important services such as housing, in order to achieve stable mental health and stability in other life areas.

Assessment of the NDIS services should thus consider ‘social inclusion’ outcomes for people with psychiatric disability (housing, employment, social support).
1b. The transition to the NDIS of all current long and short term mental health Commonwealth Government funded services, including the Personal Helpers and Mentors services (PHaMs) and Partners in Recovery (PIR) programs, and in particular; i. whether these services will continue to be provided for people deemed ineligible for the NDIS;

1c. The transition to the NDIS of all current long and short term mental health state and territory government funded services, and in particular; i. whether these services will continue to be provided for people deemed ineligible for the NDIS;

Mental health disability has a devastating effect on individuals and it should be a priority that there are no gaps in service provision during this process. People living with a mental disability are currently dependent on services and any gap in services may have adverse impacts. This will present a challenge for the implementation and transfer of services from the current models to the new funding models. Service providers will need to prepare for provision of care under the NDIS and this may challenge resources if they are redirected towards funding models rather than care delivery.

Services will face the challenge of structuring and delivering care. Current service delivery has worked under a recovery based approach. This has been supported by the National Mental Health Commission and state mental health commissions, and will need to be clarified with the provision of services under NDIS.

The NDIS is funding people with a permanent psychological disability. Clarity will be needed to determine if the recovery based approach will be a part of this new NDIS service delivery and if, not where these types of services will be available if they are not available through the NDIS.

Funding for alternative mental health services will need to remain for people living with a mental disability who are not eligible for NDIS. This population will require ongoing access to mental health services and provision must be made to ensure that targeted and appropriate services remain available. NDIS funding should be independent of services that are provided for vulnerable populations such as Aboriginal and Torres Strait Islanders, Culturally and Linguistically Diverse, former defence personal, GBLTIQ, farmers, women affected by DV and people living in rural areas, fly in fly out workers and youth and adolescent services. Funding should also be independent from services providing alcohol and other drug support.

There should be national, state and local strategies implemented towards promotion and prevention of mental health to stem the increasing rates of mental health issues within Australia. These should be coordinated and be targeted at all populations across Australia.

The capacity of people with psychiatric disabilities to manage their own care options should be considered. It is recognised that some people with a psychiatric disability may lack insight into their condition or may lack the skills to negotiate their own care packages. Due to the nature of mental health conditions, they may also lack family members or friends who would be willing to act as substitute decision makers. Due to the episodic nature of mental illness, substitute decision makers may also need to be short term. These issues should be taken into account when considering access to psychiatric disability support services.
PHAA submission on the provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition

Conclusion

PHAA supports the broad directions of the provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition. However, we are keen to ensure clarity of eligibility and continuity of service provision in line with this submission. We are particularly keen that the following points are highlighted:

- Eligibility - eligibility criteria need to be clearly defined and be determined in consultation
- Continuity of service provision – for those who are deemed ineligible, funding for services must remain.

The PHAA appreciates the opportunity to make this submission. Please do not hesitate to contact me should you require additional information or have any queries.

Michael Moore
BA, Dip Ed, MPH
Chief Executive Officer
Public Health Association of Australia

28 February 2017

References