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Dear NDIS Consultations team

Australian Psychological Society Response to the Consultation on the Draft Lists of NDIS Supports

The Australian Psychological Society (APS) welcomes the opportunity to provide a submission to the Department of Social Services Consultation on the Draft Lists of NDIS Supports (*the Draft Lists*). As the peak body for psychology in Australia, we are dedicated to advancing the scientific discipline and ethical practice of psychology in the communities we serve to promote good psychological health and wellbeing for the benefit of all Australians.

Psychologists provide a broad array of NDIS supports from a diverse range of practice settings. This includes but extends well beyond providing individual and group-based therapeutic supports, specialist behavioural intervention support and early childhood interventions. Psychologists also work within family systems and together with other providers and organisations as part of an integrated, enabling and participant-centred approach across support categories. It is therefore important the Draft Lists accurately reflect and encourage the full contribution of psychologists and other professionals to the NDIS.

1. Therapeutic Supports

The description of Therapeutic Supports in the Draft Lists should be reformulated to reflect the scope and value of services provided by providers, particularly psychologists and other allied health professionals, whose work makes a significant contribution to capacity building for participants.

Consistency with evidence-based practice

This category is the only place in the Draft Lists where the term “evidence-based” appears. However, the usage of the term appears to be based on an incomplete and potentially misleading understanding of the relationship between evidence and practice.

In psychology, medicine and other clinical disciplines, *evidence-based practice* (EBP) refers to an integrative process in which an intervention or support is provided based on an alignment of the best available research evidence, the clinical expertise of the provider, and the values and preferences of the participant or patient.[1] All three components must be present and well-integrated for practice to be evidence-based.

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A type of therapeutic support in the abstract, therefore, cannot be "evidence-based" without a consideration of how it is provided, by whom, and whether it is in accordance with the participant's wishes and preferences.[2] The description of Therapeutic Support should not be constructed in a way that gives the impression that a type of support can be determined from a distance as being "evidence-based" without considering the context in which it is provided to the participant.

We therefore recommend that the description of therapeutic supports be amended to reflect the proper understanding of evidence-based practice. This would help to address common concerns experienced by psychologists and their clients in relation to planning and funding decisions for therapeutic supports. In particular, the changes would help to make it clear that:

- To be "evidence-based", therapeutic supports must be funded to allow for the sufficient frequency and duration of the support (e.g., the number of sessions allowed by the funding), as well as for the way in which the support needs to be provided (e.g., in naturalistic settings such as at home or at school, where appropriate) in line with the evidence base. This principle would recognise that insufficient or arbitrarily-limited funding leads to in inadequate amount or application of supports in a way which is, at best, wasteful of resources, and at worst, harmful to participants and their goals.
- Therapeutic supports must be provided by a competent provider as it relates to a specific support and a specific participant. This should be a provider for whom the provision of support forms a core part of their individual scope of practice, rather than a provider selected purely because of cost. The Draft Lists should not encourage further professional substitution or deprofessionalisation in the provision of NDIS services. These practices have been detrimental not only to participants but also to the sustainability of the provider workforce and the Scheme itself.
- Therapeutic supports are provided based on a match between the type of support, the provider of the support, and the participant's preferences and values. Encouraging this kind of evidence-based practice is fully consistent with the Scheme's primary value of promoting participants' choice and control.

Expanding scope of domains of therapeutic support

Secondly, the APS recommends that the description be revised to expand the example of domains in which therapeutic supports can provide improvement. As it currently stands, the description does not adequately represent the benefit of therapeutic supports for participants with psychosocial disability. It also does not recognise the role of therapeutic supports in improving the psychosocial functioning of people with disability (whether or not the primarily disability is a psychosocial disability).

We recommend a revised description which is more inclusive of psychosocial disability, including through language used by the NDIA itself,[3] and by aligning the description with the language of other support categories in the Draft Lists. Wording which constrains the range of possible supports or which introduces interpretative ambiguity should be avoided in favour of wording which recognises that therapeutic supports can have a positive impact across a participant's life (e.g., referring to "personal, social or community activities", a term used in other places in the Draft Lists, instead of "daily, practical activities", a term which does not appear elsewhere).

Recommended description: Therapeutic Supports

Therapy supports, funded and provided in accordance with evidence-based practice, to assist a participant to apply their functional skills and/or improve their functional capacity to increase participation and independence in personal, social or community activities in areas such as language and communication, personal care, mobility and movement, interpersonal interactions, psychosocial functioning and community living. This includes funding further assessment by health professionals for support planning and review as required.

2. Exclusion of mainstream mental health supports

The development of the Draft Lists provides a rare opportunity to correct long-standing misperceptions about the distinction between mental health supports and disability supports. A clear statement on this matter is needed to provide certainty for planners, providers and participants alike. In its current form, however, the way in which mainstream mental health supports are excluded is likely to have the opposite effect. The exclusion of mainstream mental health supports does not reflect the reality of participants' experience, the impact of mental health conditions on functional capacity, or the nuanced nature of mental health as a disability or experienced as a consequence of a disability.

Attempts to separate the mental health of participants from their disability are in conflict with the Scheme's purpose and aims. Recent data from the Australian Bureau of Statistics showed that Australians living with disability frequently experience significant barriers in their daily life, relationships and community participation. Importantly, these barriers are often caused by fear and anxiety or the need for additional support to engage with cognitive or emotional tasks.[4] Supports provided by psychologists which address these barriers will necessarily have a positive impact on a participant's mental health, broadly defined,[5] but they are primarily addressing aspects of mental health which are inseparable from the person's experience of disability. As such, such supports must firmly remain within the scope of the NDIS.

The necessity of codesign

Our primary recommendation is that an in-depth co-design process is required to develop a participant-focused, sustainable and workable approach to delineating mental health and disability supports, while affirming that there is necessarily an intersection between the two which cannot be eliminated. This co-design process must involve participation from both disability and mental health stakeholders and be represented by providers – such as psychologists – who work across both settings.

We call on the Department to state that the Draft Lists will operate only as an interim measure as it relates to the intersection of mental health and disability, and to commit to an open, transparent and inclusive process of collaborative design for a longer-term and whole-of-NDIS solution.

Interim measures

In relation to an interim list of supports pending a full co-design process, the APS recommends the following amendments to the Draft Lists:

- **Create a new category of "Disability-Related Mental Health Supports".** We recommend the introduction of a limited new support category which recognises the importance of addressing disability-related mental health support needs in order to improve functional capacity. The inclusion of this new category is consistent with the Disability-Related Health Supports category

already included in the Draft Lists. The creation of this new category would remove any doubt that *disability-related* mental health supports are NDIS supports, but that these are distinct from *mainstream* mental health supports, which are not NDIS supports. The definition should specify that this support category is available where:

  - there is a close nexus between the disability and the mental health support need, or
  - no mainstream mental health provider is available or suitable because of the participant's disability, or
  - disability-focused mental health support is required due to the intersection of the participant's multiple needs or impairments.

- **Limit the proposed mainstream mental health supports exclusions.** The description of the Mainstream – Mental Health exclusion category should be amended such that it does not apply to supports which meet the criteria of the new Disability-Related Mental Health Supports category. This would remedy significant problems which exist with the current exclusion, including that:
  - The overly-wide exclusion of treatment for drug and alcohol dependency is inconsistent with the ways in which drug and alcohol dependency can be inextricably connected with a person's disability.[6–8] Drug and alcohol use can be a maladaptive way of coping with a primary disability, and as such, is directly linked to the disability. It is also not uncommon to see drug and alcohol dependency, or other addictions, become the subject of Behaviour Support. Given the complexity of the connection to behaviours, environment and supports, and the need for disability-informed practice and expertise, it is more appropriate for these supports to be funded by the NDIS than in mainstream health services.
  - Similarly, the exclusion of eating disorders is also inconsistent with the clinical evidence about the occurrence of such disorders as a consequence of a person's disability. Avoidant/restrictive food intake disorder (ARFID), for example, is very common in autistic participants.[9,10] Mainstream health services often do not accept referrals for ARFID in eating disorder services, and the provision of specialised treatment in the context of other disability-related supports is essential as part of realising the participant's goals and improving functional capacity.
  - The exclusion of supports relating to "rehabilitation" is highly problematic, given that the term has a wide and well-accepted meaning within the disability context. Any attempt to exclude rehabilitation services and to redirect supports to mainstream health services would be fundamentally flawed and contrary to the intention of the Scheme.

3. Early Intervention Supports across the lifespan

The only category of early intervention supports included in the Draft Lists is Early Intervention Supports for Early Childhood (i.e., for children 0-9 years). Early intervention supports for older children, adolescents and adults has been omitted. This is inconsistent with NDIS guidelines which state that "early intervention can be for both children and adults",[11] reflecting the operation of section 25 of the *NDIS Act 2013*.

Prospective adult NDIS participants who have neurodegenerative diseases (see current NDIS List B) such as Huntington's disease, Parkinson's disease, or Motor Neuron disease, rely on NDIS early intervention to mitigate the functional impact of their progressive impairments. The omission of this support from the Draft Lists would be highly detrimental to such participants, in addition to being in conflict with the intended operation of the Scheme. In addition, the importance of early intervention for all people with psychosocial disability, regardless of age, has been recently affirmed by the NDIS Review.[12]

Given that the Discussion Paper states that "[t]he purpose of the lists is to provide clarity for participants, nominees, providers and the disability community when selecting their supports but it *does not change the types of supports that have always been appropriate to purchase with NDIS funding*" (p. 4, emphasis added), the APS strongly recommends that the Draft Lists be amended to include early intervention supports for all children and adults.

4. Support for Decision Making

NDIS participants who have cognitive impairment often require support for decision making (SfDM). SfDM is not routinely provided in the health system. Participants with moderate to severe psychosocial disability or cognitive impairment stemming from neurodegenerative disorders often require SfDM by trained clinicians. The level of need and degree of functional impairment for many participants often cannot be adequately managed by untrained support staff or informal sources of support.

The *NDIS Supported Decision Making Policy* states that, in relation to decision support needs, "We will fund decision making supports where the support is a reasonable and necessary support" (p. 14).[13] To be consistent with this policy, the APS recommends that Support for Decision Making be recognised as a category of NDIS support in the Draft Lists.

5. Parenting and family therapy

The Mainstream – Child Protection and Family Support category in the Draft Lists excludes parenting programs and family therapy. However, family-centred practice in Early Childhood Intervention is international best practice and can involve supporting parents adjusting to parenting a child with a disability and supporting family functioning to attain best outcomes for children with a developmental delay or disability.[14] The APS therefore recommends that the scope of this category of excluded support be revised to ensure consistency with best practice, including by removing parenting programs and family therapy from the Mainstream – Child Protection and Family Support exclusion category.

Thank you again for the opportunity to provide a submission into the Draft Lists of NDIS Supports. If any further information is required from the APS, I would be happy to be contacted through our National Office on (03) 8662 3300 or by email at: z.burgess@psychology.org.au

Yours sincerely

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