

## **Parliament of Australia**

### **Joint Standing Committee on the National Disability Insurance Scheme**

#### ***Inquiry into market readiness for provision of services under the NDIS***

Occupational Therapy Australia (OTA) submission

February 2018

## Introduction

Occupational Therapy Australia (OTA) welcomes this opportunity to provide a submission to the Joint Standing Committee on the National Disability Insurance Scheme's inquiry into market readiness for provision of services under the NDIS.

Occupational Therapy Australia is the professional association and peak representative body for occupational therapists in Australia. As of December 2017 there were more than 19,500 registered occupational therapists working across the government, non-government, private and community sectors in Australia.

Occupational therapists are allied health professionals whose role is to minimise the functional impairment of their clients to enable them to participate in meaningful and productive activities. Occupational therapists particularly work with people with a disability and their families to maximise outcomes in their life domains including daily living, social and community participation, work, learning and relationships. As such, they are a key provider of services to many NDIS participants.

OTA has been a strong supporter of the NDIS since it was introduced in July 2013, although it is fair to say that our members and the participants they serve continue to experience significant frustrations when trying to navigate the scheme. This submission outlines some of the key issues relating to market readiness and proposes solutions for addressing them.

## Response to the Terms of Reference

### ***a. the transition to a market based system for service providers***

The introduction of the NDIS, and with it more market based arrangements, has raised numerous concerns for service providers. The National Disability Insurance Agency's (NDIA) apparent inability to engage meaningfully with providers, and the lack of clarity and consistency around NDIS processes, act as disincentives to registration as an NDIS provider. At a time when there are doubts about whether the disability workforce will be sufficient to meet NDIS driven demand, the NDIA should not be permitting such disincentives to undermine recruitment. OTA acknowledges that since the release of the updated NDIS Provider Toolkit, prospective providers have had increased success in accessing information about the NDIS.

Following OTA's appearance before the Committee as part of its inquiry into transitional arrangements for the NDIS, we conducted a survey to elicit feedback from occupational therapists on their experiences of NDIS registration. Of those not currently registered, fifty per cent indicated that after consideration, they had decided to delay registering or chosen not to register. Reasons provided by these therapists as to why they have not registered included negative feedback from colleagues about the challenges working in the NDIS, and a perceived administrative burden.

A very small number of respondents (five per cent) indicated that they had been a provider in the past, but had decided to cease working in the scheme. Others indicated that they were very close to revoking their registration due to ongoing frustrations. Concerningly, the vast majority of registered NDIS providers rated their level of satisfaction as a provider as low (72.93 per cent). Reasons given included:

- The failure of the NDIA to communicate effectively with service providers;
- Delays in processing home modifications and assistive technology applications;

- Planners' lack of adequate knowledge and experience, including a lack of awareness of the role of occupational therapists;
- A lack of consistency in terms of what supports are funded in a participant's plan;
- The length of time needed to complete plan reviews; and
- Insufficient information and a lack of clarity around NDIS processes.

### **Clinical supervision**

Members have expressed concern about the level of clinical supervision available in some settings. Small private practices may not offer the same level of clinical supervision as larger organisations. There are reports that new graduates have taken up positions in private practice where they have undertaken complex clinical work involving the prescription of assistive technology (AT), with limited experience and supervision available to them. Fortunately, some states are using existing equipment schemes to support them in the processing of AT applications. A number of the equipment schemes use a classification system where providers receive an approval rating that relates to their level of experience in providing particular AT items. States that do not use a scheme that offers this governance around provider prescription levels are relying on providers to make an ethical decision about whether or not they have the appropriate skills to make clinical decisions relevant to AT provision.

### **Supervision and mentoring for new graduates**

Another factor affecting the supply and demand of allied health professionals in the disability sector is the availability of mentoring and clinical supervision, particularly for new graduates. It is critical that clinicians who have recently entered the workforce have access to professional development opportunities to enable them to adapt to a changing market environment, to prevent high turnover rates and to ensure quality service provision.

OTA members are concerned that as the workforce transitions to NDIS provision, which includes a higher percentage of occupational therapists working in private practice and for non-government organisations (NGOs) than under previous arrangements, there is less senior support and supervision available, as private practices and NGOs do not necessarily have an allied health staffing structure in place. Anecdotally, this may be resulting in new graduate practitioners, and practitioners who move to the disability field, working with less supervision than would be considered ideal by the profession generally.

### **Lack/loss of senior therapists**

A number of skilled and experienced occupational therapists have advised they have elected not to work in the NDIS due to the challenges and barriers in the system. They reported that they have chosen to work with clients whose funding bodies have fewer administrative and procedural barriers. These experienced providers leave a significant gap in the specialty disability field. In addition, there is a concern that a number of providers are choosing to work only with participants who they perceive as having adequate funding to achieve their goals. There is a risk that less experienced therapists are left to provide a service to participants with more complex needs but potentially inadequate funding.

### **Delegation of tasks to assistants / Engaging assistants**

The use of Allied Health Assistants (AHAs) requires further examination. The NDIS enables providers to consider engaging AHAs to fulfil roles such as implementing independent living skills programs with participants. While the profession accepts that participants can and do engage non-professional staff to provide supports, OTA has received feedback highlighting that this needs better oversight. OTA has learned, for example, that a provider was employing their mother, who did not have any relevant training, to provide AHA support to a participant.

Providers agree that further guidance and clarity is required from the NDIA to ensure quality and safe practice standards protect participants, inclusive of minimum standards of training for AHAs, and adequate oversight of practice by relevant allied health practitioners if undertaking elements of a plan which have been assessed by an allied health practitioner such as an occupational therapist. The roll out of the new NDIS Quality and Safeguarding Framework may assist to some degree.

The NDIA has reportedly advised participants that they can employ occupational therapy students to provide core supports such as assistance with self-care activities. Whilst it is accepted that this is a great opportunity for students to receive work experience in the disability field, there are concerns around the potential for the student to undertake activities without adequate supervision that are rightfully considered the responsibility of a qualified therapist. Clarity regarding effective models of supervision has been sought from the NDIA.

### **Funding to support workforce readiness**

OTA believes that funding should continue to be provided for workforce readiness initiatives in the form of workshops and training programs that promote evidence based interventions for people with disability. This should include training for allied health professionals to assist them to transition to the NDIS. OTA is supportive of initiatives such as the Sector Development Fund (SDF) and Innovative Workforce Fund (IWF), which allow individuals and organisations to apply for grants to support the development of the disability workforce.

### **Changes in business models**

The NDIS funding model has resulted in significant changes to many aspects of service provision. There has been a reduction in the number of occupational therapists employed in large government funded organisations, resulting in an increased number electing to work in sole or small private practices. In addition, the NDIS provides participants with increased choice and control over their supports, resulting in a more market driven system. These changes have resulted in an increasing number of practice governance and practice leadership challenges. One such challenge, reported by numerous allied health professions, are the difficulties sole providers can experience when competing for clients with larger multidisciplinary practices.

In OTA's provider survey mentioned above, we asked if private practitioners would consider increasing the size of their business to cope with the growing demand for allied health services. More than fifty-seven per cent of respondents indicated that they would consider doing this. Some of the factors that may influence these providers to increase the size of their business would include a reduced administrative burden, the availability of suitably qualified staff, consistent referrals, improvements to NDIS processes, and quicker processing of AT applications.

Many of those who said they would not consider increasing the size of their business felt that it was not worth doing so because of the systemic problems currently plaguing the scheme.

A copy of feedback received from members on this subject is included with this submission for the Committee's reference.

### **Transition of staff from the government sector**

State and territory governments are progressively withdrawing from their roles as service providers, which has created challenges for staff who are currently employed by government departments. OTA was recently advised that in Tasmania, only a small percentage of staff from the state disability service will transition to the NDIS. NGOs are reportedly not offering allied health staff a reasonable wage, while many staff are reluctant to enter private practice. The situation is similar in South

Australia, where disability staff are seeking alternative employment in the state-run health department.

### **Shift from generalist to specialist approach**

Providers have reported a perceived shift from a generalist to a specialist approach. Prior to the NDIS, funding models tended to facilitate one occupational therapist providing support for all of a client's OT related needs. The individualised approach that the NDIS has adopted means that participants can, and are more likely to, seek support from a number of providers who have specialist skills. For example, a participant could reasonably have three individual occupational therapy providers for vehicle modifications, home modifications and daily living skills development. Providers have noted increased time spent liaising and coordinating service provision between all engaged providers.

### **Third party verification**

The Committee would be aware that there are currently varying arrangements in place across the country with regards to third party verification requirements. During the transition period, allied health professionals in New South Wales and South Australia have faced numerous challenges with regards to the costs and administrative work associated with undergoing third party verification, while there are emerging problems in Victoria.

In our provider survey mentioned above, we asked respondents to provide details of the costs involved in undergoing third party verification for their business. While this question was not applicable to the majority of respondents, some indicated that the cost involved was substantial and, as a result, they had made a decision to forgo providing supports that required third party verification.

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### ***b. participant readiness to navigate new markets***

OTA is fully supportive of consumers exercising choice and control over the delivery of their supports, although concerns have been raised about some participants' readiness to navigate new markets. Constant references to 'client empowerment' imply that participants are best placed to identify what is most suitable for their needs. The reality is that some participants may not possess the requisite knowledge and skills to choose supports that adequately meet their (often complex) needs. Occupational therapists are experts in working with clients with a diverse range of abilities and supporting them at an individual level that reflects their current capacity.

### **New participant and provider relationships**

One occupational therapist reported that as a result of this shift, they have had negative interactions with clients for the first time in their long career as an OT. They have been told by clients that they only need a therapist to 'sign off' on applications, as they already know what they need/want. It is the role of the therapist to assist the participant in their understanding of their potential options and ultimately to recommend the solution that meets the reasonable and necessary criteria of the NDIS Act.

This therapist also reported that they have been asked by participants to submit applications for AT that the therapist believes are not appropriate or that they consider will not meet the reasonable and necessary criteria. Where they have had a difference of opinion with clients in the past, they have informed these clients that they will not support their request but are happy to help with other solutions.

### **Computer literacy**

Concerns have been raised that the NDIA's perception of a participant being ready to navigate new markets is very much focused on one's computer literacy. This view demonstrates a very limited understanding of the disability field; in particular the skills and knowledge of occupational therapists. It is likely, and in fact many participants have reported that they find it difficult to navigate the Internet and to determine what supports are available to them. There are many people with a disability who are currently receiving supports and are automatically transitioning to the NDIS, however those who are not accessing disability services may find it more difficult to learn about the scheme and what it can offer.

Our members have also reported that the provider section of the NDIS website can be difficult to navigate, as providers are required to sort through an abundance of information to find what they need (such as a particular set of guidelines). One can only imagine how challenging it must be for participants to traverse information about the scheme, unless they have someone who can assist them.

A number of elderly parents of NDIS participants are unfamiliar with computers, which complicates matters when plans are not available in accessible formats or translated versions. Our members have also reported that Local Area Coordinators (LACs) often do not have the time needed to adequately support families and carers who are particularly vulnerable.

At present, many clients are receiving support coordination from organisations that provide the bulk of their other funded supports. What requirements will be put in place to ensure that participants are made fully aware of the range of services available to them, and thus minimise the risk of a potential conflict of interest?

### **Assistive technology (AT) / Equipment requests**

Some participants require supply of a particular item of AT urgently to ensure their ongoing needs are met. In many instances, it is necessary for the participant to undergo a plan review to have this item of AT included in their plan.

As part of the NDIA's new AT approach, a panel of specialist assessors will be established to undertake assessment of participants' AT requirements during the pre-planning phase. OTA hopes that suitably qualified occupational therapists, along with other allied health professionals, will be appointed to the panel. We are fully supportive of allied health professionals being involved as part of the pre-planning process, as this will ensure that what is included in a participant's plan is not solely dependent on a Planner's level of expertise.

### **Adequacy of funding**

OTA members have raised concerns about what happens when a participant does not have the necessary finances to hire equipment while they await a plan review. Some participants are hesitant about requesting a plan review, as they believe that they may not be allocated the same amount of funding that they received originally. OTA believes that a more flexible and responsive system around AT provision that is not linked to a whole plan review needs to be put in place.

### **Compensation for repeated work**

Concerns have also been raised by therapists about the lack of recompense when equipment requests are not processed correctly, or need to be resubmitted due to system failures. It is not appropriate to charge the participant for additional time spent resubmitting an application, however this means that therapists are often not paid for this work. One Victorian therapist was advised by

the State-wide Equipment Program (SWEP) that cost-recovery is not something that can be considered.

The length of time that it takes to process equipment requests is one reason why scripts often 'fail' – people's conditions can change in a short period of time, let alone the prolonged amount of time that it can take to get equipment funded.

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### ***c. the development of the disability workforce to support the emerging market***

#### **Planners**

We welcome the announcement that the development of plans will no longer be conducted over the phone but face to face. However, there are a number of challenges that remain regarding the planning process.

The quality of NDIS plans varies considerably from person to person, and depends on the Planner's level of experience and understanding of the breadth of services available to participants. Planners are recruited from a variety of backgrounds, and it is clear that they frequently underestimate the hours of therapy required for a participant to achieve their goals, which subsequently affects the quality of their plan. Nor do they understand occupational therapists' key role in the prescription and review of AT and home modifications.

Too often the quality of a plan comes down to how effective the participant or their advocate are at stating their needs during plan development conversations.

OTA believes that the training provided to NDIS Planners should be revised to provide for more comprehensive participant plans and to reduce the frequency of plan reviews. Our understanding is that the in-house training provided to Planners is very much focused on the policies and processes of the NDIA rather than the roles of health professionals who deliver supports. Planners should be required to have a minimum understanding of disability related function and goal setting, therapeutic supports and their value in assisting participants to develop key skills and enhance their independence. An important example may be the need to anticipate and include in a plan therapy time for the prescription of, and progression to, more supported AT, such as a motorised wheelchair for an individual with a progressive neurological condition. Should a Planner lack skills to anticipate this need, a plan review will be required.

A properly costed and comprehensive plan at the outset will minimise the need for unwieldy and time consuming plan reviews.

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### ***d. the impact of pricing on the development of the market***

#### **Travel**

OTA notes that there is a lack of clarity around the issue of claimable travel related to therapeutic supports. The 2017-18 Price Guide on the NDIS website that was updated as recently as 1 July 2017, states:

*Providers can claim travel time at an hourly rate for the relevant support item for travel in excess of 10km, up to a maximum annual limit of \$1000 per participant (per annum).*

OTA members have repeatedly been provided with different answers when they have approached the NDIA for clarity on how travel funding works. Some have been advised that the \$1000 per annum is shared by the entire therapy team, whilst others have been advised that each therapist can claim up to \$1000. If the funding is indeed to be used by the entire team, it is conceivable that one provider who sees the participant multiple times within a short period may fully expend the funds available, leaving nothing for another provider who may need to consult with the participant at a later date.

It is paramount, and also best practice, for functional assessments to be conducted in the participant's environment in which they live and participate. The potential for an occupational therapist, in particular, to have restricted access to a participant's environment due to travel constraints will restrict service provision and potentially compromise clinical outcomes. While therapists can try to see multiple clients in the same geographical area on a particular day, this is not always possible and does not give participants choice and control over their supports – in this case, choosing where they would like to see a provider.

OTA requests that further clarity is provided as to how travel funding should be claimed. In addition, we would support an approach whereby a provider can request increased travel funding in exceptional circumstances. There are, and will continue to be, instances where the \$1000 of travel will not be adequate to meet the participant's needs. It is not best practice for a participant to not receive adequate support to achieve their goals due to inadequate travel funding being available to the provider.

### **Report writing**

Just as occupational therapists must travel to consult with clients, they are also obliged through professional registration to complete written documentation more often than other allied health professionals. It is vital that functional assessments are recorded to enable participant progress to be reviewed and reported on at a future time. In addition, there is considerable administration required around the design of home modifications and the prescription of AT.

Occupational therapy providers understand the importance of developing a service agreement with each participant that clearly documents how the participant's funding will be used to assist them in working towards their goals. It is frequently necessary for providers to educate participants that a portion of their funding will be spent on necessary reporting and completion of applications.

Medico-legal considerations and the requirements of the Australian Health Practitioner Regulation Agency (AHPRA) also dictate that thorough client records be maintained by our members at all times. So the paperwork burden is constant but, under the NDIS, often uncompensated.

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### ***f. market intervention options to address thin markets, including in remote Indigenous communities***

#### **Servicing remote indigenous communities**

There is ongoing concern about the availability of the disability workforce in rural and remote areas, particularly in the Northern Territory. There is limited opportunity for NDIS participants in the NT to exercise choice and control due to the lack of service providers in remote locations.



More needs to be done to improve the quality of service delivery in remote Indigenous communities, such as engaging more closely with Indigenous elders. Ensuring that providers are equipped to provide culturally responsive services to Indigenous Australians will remove many of the current barriers to servicing this client group.

OTA is supportive of the Northern Territory Government's Local Decision Making agenda – a ten-year commitment to transferring service delivery to Aboriginal people and organisations. Such an approach reflects the importance of collaborating with the Territory's Indigenous population to strengthen outcomes across a range of areas, while recognising the need for Aboriginal communities to retain their autonomy.

### **Funding models**

Many providers are unaware that the NDIA uses the Modified Monash Model (MMM) to guide funding in remote areas. The MMM uses seven categories to define the level of remoteness. The NDIA will provide additional payment of 18 per cent and 23 per cent for providers who travel to remote and very remote areas respectively. The NDIA does not provide an explanation of what criteria determine remote and/or very remote. It is not widely understood that the NDIA may enter into an agreement with specific providers to provide services to even more remote areas.

There is some degree of apprehension about the NDIA's reliance on the MMM, as this is a model that was designed to address the maldistribution of medical services in rural and remote areas. The MMM is not necessarily a useful measure of service delivery needs in the disability sector. There must be acknowledgement of the underlying differences between the primary health care and disability services sectors, and OTA advises the NDIA to exercise caution when using the MMM to guide funding. We recommend that a more nuanced funding instrument be developed that reflects the various business models currently being used in rural and remote areas (eg. fly-in-fly-out services).

### **Other issues**

Further consideration should also be given to how non-traditional models of service delivery can benefit clients in rural and remote locations (eg. telehealth).

Concerns have been raised about the provision of NDIS services in regional parts of Queensland. For instance, there have been reports of vehicle modifications being declined because there are taxis in a particular area – despite there being only one disabled taxi (that can accommodate a wheelchair) available. Other issues include the NDIA's unwillingness to investigate cases of equipment being prescribed incorrectly, and a shortage of providers in Cairns ahead of the scheme's impending roll out. There has been a noticeable lack of provider registrations in Cairns, despite provider readiness forums being held. This has placed added pressure on already stretched providers in Townsville (located more than four hours from Cairns), as clients are sourcing potential providers in other areas.

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### ***g. the provision of housing options for people with disability, with particular reference to the impact of Specialist Disability Accommodation (SDA) supports on the disability housing market***

Questions have been raised around how informed Planners are of the availability of Specialist Disability Accommodation for participants and the approval process for this housing support. In Western Australia, for example, it does not appear to have been included in any plans. If Planners are aware of the availability of SDA, are they also informed of the criteria? There are concerns that

Planners may not have the requisite skills and knowledge to recognise the pressing need of some participants for this support – particularly where there are ageing parents of children with a disability. In the event that these parents are no longer able to care for their children, where they are going to live becomes a key concern.

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#### ***h. the impact of the Quality and Safeguarding Framework on the development of the market***

OTA believes that the NDIS Quality and Safeguarding Framework, once fully implemented, will greatly simplify the verification process for registered allied health professionals such as occupational therapists. Our main concern however, is that the states and territories may seek to duplicate or even override the framework by implementing their own verification schemes, which will result in more red tape and added costs for small business owners and sole traders.

As an example, the Victorian Government has announced that it will establish an independent, legislated registration and accreditation scheme for Victoria's disability workforce. A public consultation was recently undertaken to ascertain community views on the potential features of such a scheme, and the Victorian Division of OTA provided a response. OTA does not support the inclusion of professions that are already regulated under the National Registration and Accreditation Scheme (NRAS), which is administered by AHPRA, in a state based registration and accreditation scheme. This is a needless layer of bureaucracy which, by forcing some providers out of business, will likely restrict consumer choice. It is therefore incompatible with the philosophy of greater consumer choice and control which underpins the NDIS.

Moreover, the potential creation of de facto 'panels of preferred providers' (in this case, those who can afford to undergo third party verification for certain supports) effectively excludes those who, despite having the necessary skills and qualifications to deliver supports, simply cannot meet the verification costs.

Bruce Smith from the Department of Social Services (DSS) indicated at a recent meeting that he accepts the third party verification process could act as a potential barrier to allied health professionals registering to provide Early Childhood Intervention Services (ECIS). Despite this, the Victorian Department of Health and Human Services, in a letter to Allied Health Professions Australia (AHPA) dated 15 September 2017, stated the following:

*"... all providers of the NDIS registration group 'Early Childhood Supports', including sole and small providers, are required to undertake third party verification to confirm their capacity to deliver services to the required standard."*

The Victorian Government has indicated that sole and small providers are not expected to demonstrate the same level of documentation and process as larger organisations. OTA requests further clarification around how compliance will therefore be met by this group.

During AHPA's consultation with Mr Smith at the DSS, a discussion was held about the potential to realign the ECIS funding under Therapeutic Supports for sole providers. OTA would support this initiative.

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***j. any other related matters***

**Funding arrangements**

OTA is concerned that as arrangements currently stand, the Australian Government bears all the risk of any cost overruns, but not all the control. This is the result of the scheme's hurried design and, unless addressed, threatens the scheme's long-term viability. All Australian governments should accept this reality and come together in a spirit of cooperation to design a funding arrangement that more closely ties authority to manage risk with funding liability.

**Interface with mainstream services**

OTA considers that the NDIA should not only report on, but address, known boundary issues relevant to mainstream and disability service interface as they are playing out on the ground. One example of this issue is the interface between the NDIS and education. Occupational therapists working with school-aged students with disabilities report vast differences in access to therapy services for children living in different jurisdictions across Australia.

Currently, the provision of therapy services is determined by a state or territory education department's policy regarding access to its schools or by a given private school's willingness to allow therapist access. It is important to note also that therapy can involve facilitating a student's work in the classroom and/or participation in extra-curricular activities. This is a very complex field, with levels of access varying widely between jurisdictions and schools. It is currently unclear how these complexities will be managed under the NDIS, given that state and territory governments, and their education departments, will ultimately decide which, if any, clinicians will have access to classrooms and playgrounds.

However, discretionary access to NDIS-funded therapy services in the school environment, based upon principal and school jurisdiction preference, means that the education/disability interface is seamless for some, and acts as a significant barrier to both funding sources for therapy for others. Such inequity needs to be addressed via a national disability scheme.

OTA believes there should be a coordinated interdepartmental approach between the NDIA and each state education department to provide policy and funding clarity around the implementation of the NDIS in educational/school settings. This should involve the creation of a specialist taskforce to reduce uncertainty around the interface between the NDIS and education, and to ensure that students have consistent access to therapy supports across different life domains. It should also ensure students and families understand how to navigate funding resources for these supports.

OTA addressed this issue in detail in our submission to the 2015 Senate inquiry into students with disability. In the Senate Committee's report, released in January 2016, recommendation 9, made to government, states: "The committee recommends the government work with states, territories, experts, stakeholders, school systems, parents and students to establish a national strategy to improve the education of students with disability". The full report can be accessed at: [http://www.aph.gov.au/Parliamentary\\_Business/Committees/Senate/Education\\_and\\_Employment/students\\_with\\_disability/Report](http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Education_and_Employment/students_with_disability/Report)

It is highly regrettable that more than two years later, with the NDIS roll out proceeding, there has been no concerted action on the part of governments to ensure consistency of access to the thousands of students in need of allied health services, in the classroom and playground where their learning and development take place.

It is also important to ensure clarity and equity around the expenses associated with the delivery of clinical services in schools. For example, will the cost of installing ramps and handrails for students with a disability in a government school be met by that school or deducted from the NDIS packages of the students?

Members also report the existence of a grey area between the NDIS and the state and territory health systems. For example when a person with a disability is discharged from hospital after a medical episode and prescribed an item of AT, is that equipment disability related and funded under the NDIS, or is it medical and funded by the health system? OTA was also advised by one occupational therapist that it has become virtually impossible to be funded for something as basic as wound dressings, despite a wound's obvious impact on a person's functional ability. The lack of clarity around whether a wound is health or disability related has resulted in clients being forced to spend around \$300 a fortnight on wound care.

There have been numerous instances of participants being unable to secure funding through the NDIS if the need for a particular intervention was not explicitly stated when their plan was first developed. It is clear that more flexibility is required to ensure that participants can easily access supports in line with their changing needs.

OTA members have also noted the system's insufficient capacity to accommodate the effect of health on disability and vice versa. There is a lack of continuity between health and disability related care, with medical records and therapeutic relationships being lost as a client transitions from one sector to the other.

Hospitals cannot continue to care for people simply because their NDIS plan has yet to be finalised and approved. As a result, people are being discharged without adequate supports, notably AT and necessary home modifications, being in place. This puts these people at risk of further accidents or falls, with attendant pressure on the health system.

### **The dismantling of traditional services**

OTA has noticed with concern the haste with which state and territory governments are scaling back or dismantling the supports and services on which disabled people have depended for decades. This course of action reflects a belief on the part of these governments that disability support is soon to become exclusively the concern of the Federal Government. This is not the case, and OTA shares the grave concerns of those caring for people who have been, and those who will be, deemed ineligible for the NDIS. What is to become of these people as their traditional supports and services are withdrawn?

Confusion over eligibility for the NDIS is perhaps most pronounced for those experiencing mental health problems. Given the lack of clarity around the access criteria for the NDIS for people with mental illness, it is clear that a significant number of people will be deemed ineligible. It is currently estimated that 230,000 Australians require ongoing support for severe mental illness, however the NDIS is designed to support just 64,000 people with psychosocial disability once full roll out of the scheme is complete.<sup>1</sup>

It is critical that funding for the scheme does not come at the expense of existing programs and services for people with mental health conditions. The growing focus on the NDIS has meant that other federally funded initiatives have become something of an afterthought, despite the fact that people with mental health conditions who are not eligible for the scheme are likely to significantly

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<sup>1</sup> <https://www.theguardian.com/australia-news/2018/jan/29/ndis-failing-people-with-severe-mental-health-issues-new-report-warns>

outnumber those who are. Following the release of the NDIS Quality and Safeguarding Framework in early February 2017, industry stakeholders immediately raised concerns that the rights of people with disability who are not NDIS participants would not be protected.

OTA members have also raised concerns about the cohort of those aged 40-55 years who have until now relied on individualised service agreements under existing programs. Unless these people continue to receive adequate support, be it under ongoing agreements or as part of the NDIS, they will inevitably end up in the hospital system. Similarly, essential services that have until now been provided to people in their homes must be maintained or these people will have to move from the community into aged care homes. This is particularly true of on-call services available at night.

It is feared that the transition of funding for federal programs and services to the NDIS will increase pressure on the very state funded services that it now appears are being scaled back, leaving many worse off. This is despite the Federal Government's commitment to ensuring continuity of care for those who are ineligible.

The dismantling of government-run disability services is undoubtedly a reflection of the growing shift towards patient-centred care and client choice. While OTA is supportive of the principles of choice and control that underpin the NDIS, it is crucial that these do not come at the expense of affordable and accessible services for those who are ineligible for the scheme.

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OTA thanks the Committee for the opportunity to respond to this inquiry.

Please be advised that we would be more than happy to elaborate further on the issues raised in our submission by testifying at a public hearing.