



COMMONWEALTH OF AUSTRALIA

# Proof Committee Hansard

JOINT STANDING COMMITTEE ON THE NATIONAL DISABILITY  
INSURANCE SCHEME

(Public)

THURSDAY, 21 NOVEMBER 2019

CANBERRA

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## **JOINT STANDING COMMITTEE ON THE NATIONAL DISABILITY INSURANCE SCHEME**

**Thursday, 21 November 2019**

**Members in attendance:** Senators Carol Brown, Hughes, Steele-John and Mr Andrews, Ms Coker, Ms Payne, Mr Wallace.

### **Terms of Reference for the Inquiry:**

To inquire into and report on:

- a. the implementation, performance and governance of the National Disability Insurance Scheme;
- b. the administration and expenditure of the National Disability Insurance Scheme; and
- c. such other matters in relation to the National Disability Insurance Scheme as may be referred to it by either House of the Parliament.

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**STYLES, Ms Jess, Senior Policy Officer, National Aboriginal Community Controlled Health Organisation**

**TURNER, Ms Patricia, Chief Executive Officer, National Aboriginal Community Controlled Health Organisation**

**Committee met at 08:30**

**ACTING CHAIR (Senator Carol Brown):** I declare open this hearing of the Joint Standing Committee on the National Disability Insurance Scheme in its inquiry into NDIS planning, supported independent living and general issues around the implementation and performance of the NDIS. These are public proceedings, although the committee may determine or agree to a request to have evidence heard in camera. I remind all witnesses that in giving evidence to the committee they are protected by parliamentary privilege. It is unlawful for anyone to threaten or disadvantage a witness on account of evidence given to a committee, and such action may be treated by the Senate as a contempt. It is also a contempt to give false or misleading evidence to the committee. If a witness objects to answering a question, the witness should state the ground upon which the objection is taken and the committee will determine whether it will insist on an answer having regard to the ground which is claimed. If the committee determines to attest on an answer, a witness may request that the answer be given in camera. Such a request may also be made at any other time.

I remind those who are contributing that you cannot divulge confidential personal or identifying information when you speak. If you wish to supplement your evidence with written information, please forward it to the secretariat after this hearing.

I now welcome representatives from the National Aboriginal Community Controlled Health Organisation. Thank you for appearing before the committee today. Would you like to make a brief opening statement?

**Ms Turner:** Good morning. Thank you for the opportunity to appear. We have already made a written submission to the committee, so I hope that that answers most of your questions. We are here to elaborate on any other points that the committee may wish to put to us.

It's important that we point out that we serve Aboriginal and Torres Strait Islander people through our local and regional Aboriginal health services that are community controlled, with some 145 organisations spread throughout Australia. We represent their interests in terms of policy and leadership. We work closely with both the bureaucracy in Canberra and the minister responsible, where we have a very professional and productive ongoing relationship.

Aboriginal and Torres Strait Islander people are twice as likely to experience disability as other Australians. So there are nine per cent with a severe condition compared to four per cent for non-Indigenous people. Currently, 5.7 per cent of NDIS participants are Aboriginal and Torres Strait Islander people, with 16,417 active participants as of 30 June this year, which is considerably less than the percentage thought to have a significant disability. The percentage of NDIS participants who are Aboriginal is indicative of the numbers of Aboriginal and Torres Strait Islander people with plans; however, it is not necessarily representative of the extent to which Aboriginal and Torres Strait Islander peoples are receiving assistance under those plans as a result of appropriate services not being readily available. I will leave it at that at this point. We are pleased to take any questions from members of the committee.

**ACTING CHAIR:** Thank you, Mr Turner. Ms Styles, did you have any opening statement?

**Ms Styles:** No.

**ACTING CHAIR:** Then we will proceed to questions. In your submission you talk about the ongoing training and professional development of planners. There is a vision statement in the NDIA reconciliation action plan. Did your organisation have any input into that plan?

**Ms Turner:** No.

**ACTING CHAIR:** Do you know which Indigenous organisations had input into that plan?

**Ms Turner:** No, I'm sorry. I don't know.

**ACTING CHAIR:** What is your view of the reconciliation action plan?

**Ms Turner:** I haven't read it. I expect that to be adopted by the organisation that has it and will put it into action. I'm sorry, but I just haven't had the time to acquaint myself with it. I have had dealings with senior officials in both the department and the NDIA.

**ACTING CHAIR:** So your recommendation here is around having appropriate cultural awareness training for planners and LAC staff?

**Ms Turner:** Yes. We think it's important that agencies and officials who work directly with Aboriginal people or have a role in assessing their claims—in this case for the NDIS—have some cultural intelligence in relation to the way they work with our people. Often in remote areas where we have the least number of services specialising to provide for people with disabilities many of our people speak English as a second language at least, and therefore it is important to know the family structures, the community structures and what is important in those circumstances. So cultural awareness is an important factor in engaging with those communities.

**ACTING CHAIR:** Do you have any examples of where there have been issues around planners who may not have an understanding of the participant they are dealing with?

**Ms Turner:** I don't have any specific examples. I'm not monitoring the way that individuals engage at the local level. But it has been difficult, according to our local members, to get an understanding from some of the existing staff. We have had breakthroughs in some areas which have been excellent. For example, in Western Australia the negotiation with the NDIA meant that our Aboriginal community controlled health services, of which I think there are 23 in WA, were able to negotiate for direct funding, which is what I advocated when I first met with NDIA and the departmental policy officers, to enable them to work with local community connectors and the access and evidence coordinators. Our services in WA have been block funded to deliver those services, including the early childhood assessment for those between nought and seven, a new program rolled out by the NDIA. We regard that as extremely important because we believe, if children get the right developmental support between the ages of nought and seven, that it will make their lives much more productive and they will be much more able to deal with the future. So those arrangements are quite unique in WA, and our call is for those arrangements to be rolled out nationally to our services.

We're one of the few in the remote areas of Australia. The Aboriginal community controlled health services provide some 90 per cent of health coverage in those regions. So we're out there, where the states are not. We have relationships with other providers, like RFDS for evacuations and state clinics, where there are state clinics. They are few and far between. For example, in the Northern Territory and in Western Australia, the state health departments are negotiating with our sector to resume or to take control over the services that are currently provided by the states. That's happened in the Northern Territory, with three clinics from three communities transferred from the Northern Territory health department to Miwatj, an Aboriginal medical service which is located in the Nhulunbuy-Yirrkala area. They provide just about full comprehensive primary health care across that area, plus they have NDIS arrangements in place.

**Senator HUGHES:** Ms Turner, thank you for your statement. We heard some testimony in Adelaide earlier this week around the Northern Territory and some of the challenges being faced by remote communities within the Northern Territory. We were discussing it in terms of travel allowance and the ability to access funding for travel. Some of the issues around that include providers sometimes taking advantage of it and charging travel for every participant they see, when we know they're going out to places to see multiple clients. We discussed the idea of a more centrally located support coordinator working within remote communities or remote areas. For example, if five or six participants require a speech therapist, that support coordinator could work with those participants to source the therapist, but it could be done through a central support coordination management system. This would be just for those remote locations, to aid better access to services and supports. Do you think that's something that—

**Ms Turner:** Would be beneficial?

**Senator HUGHES:** Yes—instead of this blanket cry for increasing travel allowance from providers actually looking at it from that support coordination side?

**Ms Turner:** I think it's always best to have what I might refer to, generally, as a hub-and-spoke model for service delivery. It's very difficult in remote locations to get the level of qualified and experienced staff who can deliver the services. Therefore you're more likely to get them in a regional centre with more facilities. I think it's a good idea to have a coordinated approach to service delivery for the extremely remote clients. But, if you live at Jigalong, for example, which is in remote Western Australia, and you have to go to Newman, which is a mining town, it's a thousand kilometres. And whether the travel is by charter or even by vehicle—which may not be the most comfortable way for someone with a disability to travel—there's just no coverage of that extremely high cost of travel to get to the centre in the first place.

**Senator HUGHES:** Was that supported previously, before the NDIS rolled out?

**Ms Turner:** No. People had no access to disability services to speak of, apart from local health staff and other people who were qualified to assist—but mainly it's been left to community and family members to assist those with disability.

**Senator HUGHES:** With your access to remote communities, what sorts of numbers of participants would there be? Are we looking in the tens or in the hundreds?

**Ms Turner:** No, it would be in the thousands.

**Senator HUGHES:** Thousands of people in those remote areas requiring access to the NDIS?

**Ms Turner:** No—well, it could be.

**Senator HUGHES:** So the town you suggested—I'm sorry; it's a thousand kays from Newman?

**Ms Turner:** Jigalong.

**Senator HUGHES:** Jigalong, sorry. How many people are there?

**Ms Turner:** I can't tell you off the top of my head. It's a small community. It's been a central community for people living on outstations, but, off the top of my head, I don't know.

**Senator HUGHES:** But ballpark—hundreds, thousands?

**Ms Turner:** Oh no, hundreds.

**Senator HUGHES:** And how many people do you think would be there that are affected by disability requiring NDIS? I'm trying to get a sense of whether or not, in some of these communities, we need to look at the participants' travel side so that we're offering, or enabling, something from the participants' side in remote communities, or whether we can look at the more coordinated approach of bringing people out to them. I'm just trying to get a sense of some of the numbers.

**Ms Turner:** Well, it could be five, it could be 10, and it depends on whether you include children with developmental delays from the age of nought to seven. Of course, if you're working with children from the age of nought to seven, you then involve parents and so on, so there would be a more localised need there. However, for the adults with a disability, the cost of their travel is what is so prohibitive, even to get to Newman—which is, itself, a remote location.

**Senator HUGHES:** And that's why I'm just looking at whether we're better off going to them or bringing them out. That's what I'm trying to get a sense of.

**Ms Turner:** You often have to bring them out because of the lack of—

**Senator HUGHES:** Equipment—

**Ms Turner:** Yes, or personnel. There's a combination of the coordination of getting a cohort of people into the service plus the cost of the travel for the individuals to get there, which has not really been understood by the system.

**Senator HUGHES:** I just want to touch on one more point, if I can. Some other testimony that we heard, and that was backed up again in Adelaide, was surprising to me the first time I heard it. It was a request to potentially not make the value of plans visible to some participants—and this again came from the Northern Territory—because there was a misunderstanding that the value of plans could actually be accessed. People were turning up to providers and going, 'Well, can I have my money now?' So there was a misunderstanding of what the system actually is. That was supported again on Monday in Adelaide—that there is some misunderstanding of what figure on the NDIS plan is actually indicative of. It's not actually access to cash; it's the value of services that you're able to claim. So I'm just interested in whether you've had any of the same feedback.

**Ms Turner:** I'm well aware of these types of expectations in many other circumstances—I used to be deputy CEO of Centrelink, so I understand that dilemma—except that I believe that full disclosure is important to the family, and this is the role of the community connectors in being able to educate the local communities about the NDIS and what it is able to deliver. And I think there's a far greater role in that sense for communities and individuals with disabilities to have that very clearly explained: it is about the purchase of services to support their ongoing experience and to make life more comfortable. I've never believed in withholding information.

**Senator HUGHES:** I was really surprised when I heard that.

**Ms Turner:** Yes. I understand why people might suggest that, but I don't agree with it.

**ACTING CHAIR:** We're going to move on now, because we have only 10 more minutes with these witnesses, so I'll go to Ms Coker.

**Ms COKER:** I'd just like to thank you for being here today, Ms Turner.

**Ms Turner:** Thank you.

**Ms COKER:** My first question relates to a fairly damning statement you make in your submission:

The fundamental structure of the NDIA fails to put in place the necessary checks and balances to ensure that decisions and policies are not institutionally racist.

I'm wondering if you could elaborate on that and whether you have any suggestions about how this could be overcome.

**Ms Turner:** When the NDIS started, I had meetings with very senior officials and policy advisers—deputy secretary level—and with the NDIA. They came to meet me with other officials from the Indigenous affairs agency and the Department of Health. What they were suggesting was that they could just roll out the NDIA and we should see this as an entrepreneurial opportunity to grow Aboriginal and Torres Strait Islander small businesses. I said: 'Well, we don't operate like that. We have a whole network of Aboriginal community controlled health services around the country responsible for the delivery of comprehensive primary health care, and what you are better off doing is block-funding them to be the service providers and ensure not only service provision but the connection to all of the other specialist services that are required.' They wouldn't have a bar of it, but now they've done it in WA. They have block-funded our sector right throughout the state, and they've also provided additional funding for the early childhood delays—that's for nought- to seven-year-olds.

So my view now is that this should be rolled out for our sector nationally because it's a much more effective model. Already, since this started, individuals who've never, ever had access to disability support services have now been fully assessed and are very eligible to receive those, and arrangements are being made to ensure those services are there at places like Halls Creek and Bidadanga. Bidadanga is on the west side of the Kimberley, not very far from Broome, and of course Halls Creek is on the border of Western Australia and the Northern Territory. Where we're rolling these new arrangements out, the referrals and the assessments are increasing markedly, because no-one's ever been out there and explained it in plain English and with the knowledge of the communities. Our health service staff already have a very sound knowledge of who's who in the communities where they work and also have contacts in communities where we don't have our own clinics or deliver comprehensive primary health care. Because of the nature of the work that we do, our services have a very clear understanding of the needs and the people who should be assessed for eligibility.

The other thing that happened was the changeovers and transitions between the states and the federal system coming into play. Western Australia was one of the later jurisdictions to swap over to the national scheme, which gave more time for them to work out with the NDIA officials what would be the best arrangement in Western Australia. So we are really going to press for that Western Australian model combined with the Miwatj model, where they had to start off funding disability community connectors out of their Medicare income. Our services have the right to utilise our Medicare income to reinvest in primary health care, not necessarily secondary specialist services, but it had to be done in the Arnhem Land region by our Miwatj health service because it wasn't forthcoming. They self-funded the initial start of the program, but not everyone's in the same position to do that.

It has been difficult to get through to the policymakers and administrators of the scheme. You're dealing with a completely different situation here. You're dealing with areas where there are very thin markets, as they call them. Also, the development of existing skilled staff and their training in the specialist area of disability services needs to be enhanced. There's a lot of talk about how we need to increase the skills and capabilities of service provision, particularly in those remote areas, but this shouldn't ignore urban areas.

In South-East Queensland we have the UIIH, the Institute for Urban Indigenous Health. By 2030 the population of Aboriginal and Torres Strait Islander people in South-East Queensland will surpass Western Sydney's, so that region will have the highest concentration of Aboriginal and Torres Strait Islander people in Australia. The needs of those people are very high indeed, and the UIIH would have a very sound understanding of what is required.

**ACTING CHAIR:** Thank you, Ms Turner. Mr Wallace, do you have a question? We only have a few minutes, and I know Ms Payne has a question too.

**Mr WALLACE:** I've got lots of questions, but I want to follow up on the last question that was asked of you, because I didn't quite understand your answer. The statement that was made was a very strong statement about institutional racism.

**Ms Turner:** Yes.

**Mr WALLACE:** I understand that there are obviously challenges in relation to service delivery in remote and regional areas, particularly in some of the areas your organisation works in, but, with respect, I don't think you hit the nail on the head in dealing with the institutional racism issue as opposed to the challenges of service delivery in remote areas. Can I get you to just revisit that and pull it apart a little bit, please?

**Ms Turner:** What I was saying is that when the NDIS was rolled out it was to benefit the bulk of people who had formerly had access to disability services. Aboriginal people never had access to a large cohort of those services. There were some, a few specialist services, in places like Western Sydney—

**Mr WALLACE:** We're talking about the old state-delivered model.

**Ms Turner:** Yes—but there were very few discrete Aboriginal service providers and limited access to mainstream providers. When the NDIS was rolled out, it was rolled out for the bulk of those people who had been utilising the old service providers under the state schemes, and that meant that a very large chunk of our people were not assessed and had no access to services, despite any reconciliation action plans—and we don't monitor them; that's Reconciliation Australia's job. We believe they had no idea of how to work with Aboriginal and Torres Strait Islander people, and, in our opinion, they didn't make any special arrangements. They may have adopted a reconciliation plan. Hundreds of corporations throughout Australia do that, but whether they live by it and enact it is another thing.

**Mr WALLACE:** Can I have a follow up, Chair, or are you pushed?

**ACTING CHAIR:** Just quickly.

**Mr WALLACE:** This might sound like a strange question, but it's one coming from a position of ignorance, self-confessed. There are many different—

**Ms Turner:** Multicultural groups?

**Mr WALLACE:** No, no—within the Aboriginal and Torres Strait Islander community there are many, many different cultures and—

**Ms Turner:** Yes, the diversity is huge.

**Mr WALLACE:** Yes, and some of the things you've been saying about the importance of cultural awareness and cultural training—does it create a challenge as far as how you train planners, for example, to be culturally aware when the range of cultures and languages is so broad?

**Ms Turner:** I think that it does provide challenges. Where there is direct contact with assessors and community connectors—frontline people—they really do need to have a good understanding, and that's best provided at a regional level. For national policy staff, there are people who are specialist in cultural awareness training who could handle cultural training—intelligence training, in my opinion—with senior people, who are less likely to have direct contact. I think there are solutions; I'm just not sure how vigorously they've been pursued.

**ACTING CHAIR:** We are out of time, but we will just go to Ms Payne.

**Ms PAYNE:** Thank you—just a quick one then. I was interested to hear you say that the NDIA's Remote Community Connectors Program has been successful. I just wanted to ask you to elaborate on why you thought that was a valuable program?

**Ms Turner:** No, I didn't say that. I said that, in WA, where the new funding arrangements—unique to WA—have been contracted in WA, there are community connectors on the ground, and evidence and access coordinators, and that is starting to make a huge difference. Were you pointing to something in the submission where I've said that?

**Ms PAYNE:** Yes.

**Ms Turner:** Where we've had some ability for community connectors to be out educating people about access to NDIS it has been valuable, yes. We prefer that to be done by our own people for a number of reasons: they have a much greater knowledge of the communities and the families within them. We think it's easier to train them in NDIS things than to train non-Indigenous people in Aboriginal cultural matters, but we still would like both. But we also see these as employment opportunities, expanding the skills of Aboriginal and Torres Strait Islander people no matter where they live.

**ACTING CHAIR:** Thank you very much for your evidence here today.

**BULKELEY, Dr Kim, Board Director, Services for Australian Rural and Remote Allied Health**

**GROTH, Mr Allan, Director, Policy and advocacy, Services for Australian Rural and Remote Allied Health**

**O'KANE, Dr Gabrielle, Chief Executive Officer, National Rural Health Alliance**

*Evidence from Dr Bulkeley was taken via teleconference—*

[09:04]

**ACTING CHAIR:** I thank you for appearing before the committee today. Would you or all of you like to make a brief opening statement?

**Dr Bulkeley:** Let me start by acknowledging the custodians of the land we meet on today. I'm on the lands of the Wangal people of the Eora Nation in Western Sydney and I also acknowledge the Ngunnawal people. I pay my respects to elders past, present and emerging, and extend that respect to any Aboriginal and Torres Strait Islander people at this meeting. As a board director of Services for Australian Rural and Remote Allied Health, SARRAH, I thank you for the opportunity to appear before this inquiry and to speak to our submission.

SARRAH is the peak body for rural and remote allied health practices in Australia and is a strong supporter of the NDIS and its focused on providing individualised support for participants with informed choice and control over their lives. Allied health professionals in rural and remote areas have been actively engaged in trying to facilitate improvements in design and implementation of the scheme to support participants as we move to full rollout. Allied health professionals provide services to people with a disability, their families and others to achieve goals in their lives including daily living, social and community participation, work, leisure, learning and relationships.

SARRAH and our members recognise the significant opportunities that the NDIS presents both for participants, who have more of a say over the supports they receive, as well as small business owners who run private and not-for-profit allied health services in rural and remote areas. However, our members are also informing us of ongoing issues associated with the planning process for NDIS participants. In rural and remote areas, we consider most NDIS participants to have complex needs due to the additional consideration imposed by rurality. NDIS planners must have highly developed skills and sensitivity to the rural context to develop plans that are fit for purpose in rural and remote areas. This has not been uniformly the case as reported by our members. The experience, training, understanding of the different rural and remote contexts has been, at best, patchy and, at worst, absent, with plans being developed that do not reflect the needs and aspirations of rural and remote NDIS participants. SARRAH is particularly concerned by an apparent lack of awareness of the contribution of allied health professionals, with planners not developing a strong relationship nor engaging in probing and thorough discussions with participants about the supports that may assist them with achieving their goals.

Access to allied health services has historically been problematic rurally, and the NDIS has the potential to level that playing field for people with a disability with thoughtful planning and delivery of services that are tailored to the rural context. This potential is as yet unrealised for many rural and remote NDIS participants. The consideration of the rural contexts including travel, service access and alternative service delivery options are a key part of good planning. For people living in rural and remote Australia, these are the reality, and effective plans must reflect the needs of the participant and informed assessment of what and how these services could be accessed by them. SARRAH strongly supports the need for planners to receive training and support to incorporate these complex and nuanced factors in the plans of rural and remote NDIS participants.

To conclude, SARRAH is a strong advocate for the NDIS and the potential of NDIS for people with a disability in rural and remote areas. We offer our support as an ally in the development of more responsive processes and training to enhance the skills of planners for NDIS participants in rural and remote areas:

**ACTING CHAIR:** Mr Groth, would you like to make an opening statement?

**Mr Groth:** No, I have nothing to add.

**ACTING CHAIR:** Dr O'Kane, would you like to make an opening statement?

**Dr O'Kane:** The National Rural Health alliance welcomes the opportunity to provide a witness statement for consideration by you today about the NDIS. Access to disability services is certainly one of the key areas of our strategic direction. We are a 41-member group. Those members of ours are health service providers, but they can also be from peak health bodies and health professional organisations. But we also have some consumers in our mix of members as well. Our membership's really diverse geographically but also reflects different aspects of the

health organisations as well as consumers. The allied health member organisations that contributed to our submission were mostly from the allied health professionals, so I just wanted you to be aware of that.

There wasn't sufficient data that we were aware of on workforce numbers relative to the demand from consumers, but one member organisation indicated that there was a shortage of local NDIS planners in rural and remote locations. The local presence of planners with good knowledge of services in schools and health facilities is considered important, as is the ability to build relationships with consumers needing their assistance. So you won't be surprised then that developing NDIS plans by telephone is not considered adequate, as it doesn't allow the planner to assess and incorporate environmental factors into the plan and may not be culturally appropriate for some consumers. I would like to add, having heard Pat Turner's words this morning, that I do think it is necessary for health practitioners to actually understand, be culturally appropriate and have what I would call cultural humility. From a research perspective, some of the work that I had done in the past was around cultural humility. I think those sorts of understandings are really necessary with people working through the NDIS.

Other feedback suggests that sometimes planning processes can be based on available services rather than on the needs of the consumer. A pragmatic approach can be necessary at different times, but member organisations also argue for the need to develop better service offerings in rural and remote regions. If services aren't identified clearly in the planning process then it's difficult to build a case for market development, and Pat Turner also spoke about thin markets in rural and remote areas.

The allied health member organisations of the alliance have concerns about the overall lack of knowledge of the roles and scope of many of the allied health professionals that are working in this space. Individual planners don't have the knowledge of what they can and can't do, so there are often inconsistent approvals for allied health practitioners to provide those services. Also, there is sometimes a lack of understanding by planners of the connection between disability and health. Inadequate knowledge, skill, experience and qualifications amongst planners means that plans don't fully address the needs and preferences of consumers, and some planners don't fully appreciate the full scope of practice of the practitioners. For example, speech pathologists and occupational therapists can be involved in behaviour management, but some planners do not acknowledge the full scope of their practice and use behaviour teams instead, which is unnecessary. I've got some examples there. I won't go into that now.

I think in the end planners need to be educated on the benefits of all the allied health providers that are available. I'll leave it there for the moment. I had some information around review process not working particularly well and reassessment processes, but I'll leave that till later if you have any questions in relation to that.

**ACTING CHAIR:** You can table your full opening statement if you like.

**Dr O'Kane:** Thank you. Do you have copies of the original submission?

**ACTING CHAIR:** We have your submission. Is this additional information separate from your submission?

**Dr O'Kane:** No. It's really trying to be a tighter summation of it, that's all.

**ACTING CHAIR:** Thank you.

**Ms PAYNE:** First of all a question to both Dr O'Kane and Dr Bulkeley and/or Mr Groth. You've both mentioned the lack of awareness of issues particular to rural and remote participants. Could you elaborate on some examples of how that's impacting on those participants?

**Dr Bulkeley:** I've done quite a bit of work in western New South Wales looking at different service design models. One of them is a therapy assistant model of service to try and increase the reach into remote communities. That involves working with developing a local workforce that then collaborates with other professionals who come in remotely or who may come in via telepractice or other methods. For example, with the planners not really understanding that model of service, the allocations of hours in the plans are not adequate to make that service model work well. To have an allied health assistant, a therapy assistant, in the town, there also have to be adequate therapy hours allocated in the plan to work with that allied health assistant to be able to implement programs in the town. That's different to if there were a side-by-side relationship in a metropolitan area, where the allied health professional was located with the therapy assistant in a day-to-day way. That's one example of a service model that the planners need to really understand to be able to allocate appropriately for a remote and rural service design.

**Dr O'Kane:** I'll give you an example that came up around the issue of assistive technology. I hope this sort of answers your question. There are some devices that are not being funded through the insurance scheme. There's also no insurance on particular devices that might be costing up to \$20,000. Those mechanisms are a little bit uncertain. But, in those remote areas, some of those particular devices don't get actually brought into the towns or

the small communities in time for people. There's an example that I talk about in the submission about a person in late-stage motor neurone disease who may need a device to assist with communication, but the approval process takes so long that their last stages are compromised. It can be very distressing for people. There was another example where a client was provided with a motorised wheelchair, but, in the planning process, there was a disconnection between the plan activities and the practical implementation, so there was ineffective communication between the support manager and the range of support workers that had a really good understanding about how to actually implement the plan. There wasn't sufficient training with the client on how to use that wheelchair, so the wheelchair wasn't used to its correct capacity. That was a bit of the planning phases not being well connected with the implementation. Does that answer some of your question?

**Ms PAYNE:** Yes. Thank you. Could you comment on how, as providers and allied health professionals, you've interacted with the planning process? For example, are you able to be involved where the participant has wanted you to be, and do you find that your advice is accepted by planners—those sorts of issues?

**Dr Bulkeley:** My understanding, from a range of colleagues, is that there has been a general lack of involvement of allied health professionals in the planning process, and at times reports et cetera are sought at very late notice, so that information exchange is not great. It is variable. There are some planners who are doing this well, but the advice is often questioned or not really well understood by the practitioner. For example—and this probably applies not just in rural and remote areas—for somebody who has multiple sclerosis, the occupational therapist has scripted a wheelchair for that person and included in that wheelchair a range of options, but it came back from the planner saying that the elevated leg rest would not be approved, because that was a medical issue, not a disability issue. The therapist had included that because people with MS often have issues with blood pressure and temperature control, so elevating the leg is part of managing that. So that request was only partially fulfilled for that person.

**Mr Groth:** If I could add a couple of things to Kim's point, there are some structural issues here that get to the heart of your question. One of those things is the availability of allied health services. If you go into rural and remote Australia, it varies a bit, but you are talking about a population that might cover half of New South Wales having the same number of allied health professionals as a couple of square kilometres of inner-city Sydney or Melbourne. The reality of this—there are some fundamentals there—is that people's exposure to allied health and their access to services in rural and remote communities, regardless of whether it is in an NDIS relationship or an underlying health one, is often very limited. That gets to the point about the participant's understanding. Relatively minor, if any, prior access to services may be very fundamental to that person's future capacity building or ongoing health and wellbeing.

There is that interface that is quite complex between health and disability, but the bottom line was there is a health system that is meant to underpin the NDIS. The NDIS comes through if you do not have that service capacity. In rural and remote communities, it comes as an extra thing, and it does not automatically create that connection that might be the thing that an assessor might take into account when assessing whether someone is eligible. So it can be a hurdle to eligibility and access in the first place and certainly a hurdle to then having a well-defined plan that touches on the issues that people really need—although they may not know to advocate for it. There is a precursor question about whether anyone knows to involve an allied health professional. It could be a very appropriate question, but no-one is there to advocate for it. And then there are questions about access.

**Dr O'Kane:** I want to acknowledge that I would agree with what Allan has said. I think what came through the feedback that we go from our members was that the involvement of allied health people in the planning process can be really inconsistent. It does really depend on how knowledgeable the planner is around the scope of the allied health practitioners in the first instance. My background is in nutrition and dietetics. There is often a very poor understanding of how nutrition plays a part in that, so a planner may not necessarily know to add in getting help or assistance from a dietician. It happens across so many other areas as well. As Allan says, in small communities, are those services going to be available anyway, even if they are in the plan?

**Mr WALLACE:** Some of the evidence that the committee has heard previously is in relation to whether we should be looking at having a panel of private planners to address the issue of some of the shortcomings of planners having a lack of competence in particular areas. One of those areas might be, for instance, an expertise in hearing impairment or dealing with rural and remote health. I am keen to get ideas from the three of you about whether you see that as a viable option, or does having paid private planners providing those specialist services actually create a can of worms?

**Dr O'Kane:** Can I just ask for some clarification around that. Are you talking about a localised level? Is that what you mean?

**Mr WALLACE:** It could be local.

**Dr O'Kane:** Or are you having some sort of centralised system of a group of—

**Mr WALLACE:** It could be local. It could be centralised. To overcome some of the shortcomings we hear about, of inconsistency in plans, should we be looking at a model where we have a panel of privately funded—sorry, that's not right—private planners funded by the NDIS? Does that answer your question?

**Dr O'Kane:** Yes, it does. I'm not sure whether that would be the best way to go. I think you can train up people. If you have good training packages for people, then the planners that are out there on the ground could be upskilled in ways that we've talked about so that they have a good, clear understanding of who all the available people would be to design the correct sort of thing for each of those consumers that they have to come across, but it does need really good, strong training programs that are rolled over regularly. Like, you don't give a new planner some education once-off. It's got to be ongoing and built into their program. Whether this idea of having a group of private planners is a better way to go—

**Mr WALLACE:** What sort of shortcomings do you see in that sort of model?

**Dr Bulkeley:** Could I add something in there.

**Dr O'Kane:** Yes, go ahead.

**Dr Bulkeley:** I have some concerns with that model. Seeing the lack of availability of people in rural and remote areas, if you're trying to bring in another kind of identified group or isolated group, that's just dividing the existing expertise within the community already, and that purchaser-provider issue I know keeps on coming up. So I would have some concerns about a rural private planner group having some problems in that regard, but they do need to be locally responsive. I think a central panel would be problematic because there is such difference between remote and rural communities that you have to understand the issues—200 kilometres down the road might be different, for example. I think one of the fundamental things for me in terms of improving the existing planner capacity is around funding opportunities for collaboration with existing service providers and local people who have the disability skills and knowledge and understanding. People are unable to bill for any of this—existing service providers and people with knowledge in remote communities are unable to bill for any of that collaborative work. So looking at setting up some mechanism for that to occur to inform the planner and support the planner in developing their skills and understanding of the community may be a better alternative.

**Mr WALLACE:** Through you, Chair, Mr Groth is chomping at the bit.

**Mr Groth:** I am, I am. I get excited. Those reservations, I think, are very reasonable. However, I also think that if the objective of such a panel is to improve the quality and capacity of those decision-makers and to support planners to actually comprehend at least the clinical or the support needs or the health professional needs, having them access a panel of those people, whether they sit within the NDIS—this gets away from the question of are they private or otherwise. The first question is: is there a mechanism that enables them to make a better decision about the needs of the participant and to be informed where there's clearly lack of other input from other health professionals? I think that would be a brilliant idea, and I think it would also save a lot. I think it would be improve outcomes for participants, but I also think it would front-end some of the work that presents later, down the track, with appeals and the need to review things. So, as an administrative thing, I think it is a really good idea.

There is an issue about how you'd set it up so it doesn't diminish existing rural and remote service capacity, because they are stretched now, and that's one of the problems with servicing. Where you do have someone, they are already trying to service a community with four or five times the people of counterparts elsewhere, and they have to travel a long way to get there, so you can imagine that's difficult. If it's a professional support that works with local clinicians, doesn't replace their role and helps inform planners on how to utilise those services and get better plans and realistic access to services that would be genuinely therapeutic and beneficial, then I think that's a very worthwhile investment. Because allied health is funded and structured the way it is, in some professions it's 70-odd per cent private sector—small businesses, anyway—and that's always a challenge. So anything that eases their administrative load and increases service capacity would be good. And I think that private element could certainly be brought in, because that's often the workforce. The other workforce that's out there is often state based health system funded, so they're unlikely to participate in that way. I think the principle about what you're trying to achieve with it is a very good one.

**Mr WALLACE:** Just to put on the record, I'm not suggesting that that's the way to go; that's just the evidence that has been received.

**Mr Groth:** In terms of the outcome for the participant and the best possible efficiency of the system and the best use of the services that are available, I certainly think it warrants looking at, as long as those other things are protected.

**ACTING CHAIR:** But the other point that has been made is that the professional development of planners is important, and you can do both of those things. You can have a specialised panel, but the need for training and ongoing professional development would be required for planners as well. Do you see that as something that would need to be put in place?

**Dr O'Kane:** I do think that that would be a good idea to put in place, but I do go back to some of Allan's points—Kim also raised it—about collaboration. In those smaller communities in rural areas, use your expertise that's on the ground and pay them, if they're going to be part of the private panel. You'd want to use those people there and allow them to work effectively together. How that would be all worked out—having this panel and how they get paid—would have to be thought through, but they could also be the group providing some of the professional development. That expert group could actually be part of that in a smaller regional or rural area.

**Dr Bulkeley:** Could I just make a comment there. I am working with Dr John Gilroy on an ARC project that is looking at this—the qualities, attributes, skills and experiences that planners in rural and remote locations require. Our project is just starting and will continue over the next three years, but, as part of that project, our focus is to really identify the particular training and development needs of planners.

**Mr WALLACE:** I put to the three of you that one of the concerns I have about what has been suggested as a private panel of planners is an integrity and a probity issue, insofar as the private planners are paid—obviously they are paid to deliver a good outcome for what would, in effect, be their client. I'm keen to hear from you whether you think that that is a problem and whether it's an insurmountable problem or whether it's a problem that could be overcome in some other ways. It's not directed at any one of you.

**Dr O'Kane:** Yes, there certainly does have to be governance over those things, because there's going to be a vested interest in planning in a way that's going to maintain a good outcome for the health professional. So there certainly would have to be some clear governance over the top of that. In larger cities and towns, I think you'll be able to find some ways in which to do that. In smaller places it could be more difficult, but I don't think it's insurmountable. You could find ways to manage it.

**Dr Bulkeley:** Can I just make a comment: the question for me is who is the client. At times I think there are pressures around reducing the cost of plans. So would this planner be engaged by the participant or by the agency? At the moment the agency is engaging all planners. So I just think we have to really think very carefully about who the client of the planner is.

**Ms COKER:** I think we all understand that it is challenging for people living in rural and remote areas to access allied health supports that may be in a plan. I'm wondering if you can give your suggestions on how we address this issue, but I'm also wondering: at times, do planners tailor a plan in line with what they know the services are in an area rather than for what the participant needs?

**Mr Groth:** I think that's a point we've referred to in our submission, and that was certainly some feedback we had from various of our members. I don't know how widespread it is. I wouldn't want to put a figure on it. You could argue that even a planner who is very familiar with an area is going to think, with the best intention in the world, 'I want to make sure this person gets access to something,' whether or not that is necessarily the best thing for the person. It's a human reaction. On the worst side it could be, 'Look, I couldn't be bothered and I just want to get a plan out.' On the best side it's, 'I want to do the best I can with what's available, and I'm being pragmatic.' I don't think that's a good way to go about planning, because if that's occurring to any extent—and I suspect it is—then the feedback and demand that that suggests to the agency gives a completely distorted view of what's actually required by the population based on what currently exists, which we know has huge gaps in it, so it reinforces the problem. In terms of guarding against that, there could probably be some procedural stuff in there. I don't want to suggest that it's massively widespread, but we certainly got that feedback, and you can understand why it might occur.

**Ms COKER:** Just to follow up: with the gaps in services in rural and remote areas, how do we overcome this?

**Dr Bulkeley:** Could I add a comment there: part of the research work that I'm looking at is alternative service models around allied health service delivery, including the therapy assistant model and telepractice. But there's also really looking at growing the local workforce and growing capacity in rural and remote communities around allied health and allied health pathways. That's a long game. There's a long game in this as well as a short-term solution. But it has been problematic for a long time. The potential of the NDIS is that there is a funding stream that has a lot more flexibility about it than existing funding models pre NDIS. So I think there is great potential to explore and understand different ways of delivering service, like that combination of outreach, telepractice and delegated practice models such as allied health assistance.

**Dr O'Kane:** If I could add something there as well, certainly the alliance has been looking at the whole notion of trying to attract more allied health professionals out into rural and remote areas. As Kim said, it's been a longstanding issue. How do you get around it? Really, what's happening with the ones that are out there is that they kind of cobble together a full-time position by doing some work, perhaps for hospitals that are state run. They might do some of their own private practice. They also might do some of the work for the NDIS, and they might do some work in aged care. But a lot of the funding streams are all varied. So it's my view that using something along the lines of the ACCHOs, where we get block funding—you might call it pooled funding—where you pool money between the Commonwealth and the state governments to support, basically, getting a multidisciplinary team that can do that hub-and-spoke model, or using telehealth as well. But, with telehealth at the moment, people have to pay for that. There are no MBS items for allied health professionals. I don't think we need to go down that path of necessarily having MBS items, because I think we're better off cutting through that and going to a pool funding kind of stream in particular areas around the country. I think that's really going to be the only way that we'll get enough allied health people to be available in the bush to provide NDIS services as well as other health services.

**Mr Groth:** It's a hugely complex issue, and I think there's a lot of misinformation around about what attracts and why we don't have an allied health workforce out there to the size we'd like or should have. There are a lot of allied health professionals we know of who would like to work out there. They stay out there despite the fact that it costs them in terms of profitability and everything else, but they want to work out there. We also know there are lots of students who want to go out there, but, as Gabrielle said, there's not always the funding and employment structures that enable that. So some of those things are a driver of that.

There a range of things you could do about it, even with NDIS, because people do. Anything that creates extra demand on a pushed service to register with this, anything that eases their registration and reporting services, will probably attract more people to do NDIS services, who might already be there, or make it a more viable thing. So you can do things with existing small practices. There are other options, as Gabrielle said. This predates the NDIS. The funding system for health through MBS and the public system and everything else didn't evolve to support the allied health model. So, while things like NDIS can really make that a viable option and help, it needs to be worked in a way that's flexible enough for people to use those funding streams and make it viable for them to do it out there. It's a bit more difficult.

**Senator HUGHES:** Mr Groth, I was interested in your point just then with regard to the services not being in existence pre the NDIS and being underfunded by the states. One of my concerns, and what we are hearing as well, is a bit of a confusion over state responsibility with regard to health, but also in the provision of allied health services via community health. I know that there were areas in my home state of New South Wales where community health withdrew services from people with a diagnosed disability under the guise of, 'They should be seen by the NDIS,' even though there was no private provider in their town. So we were seeing blockages occur when community health should be picking up these children. Perhaps you can take it on notice: with regard to community health, has there been a bit of dropping the ball or avoiding the space by the states in the expectation that the NDIS will just pick up the slack, particularly when we do know that in rural and remote areas private providers don't already exist? Private providers didn't exist prior to NDIS, and they are not going to miraculously just appear in the first rollout. Where community health has potentially evaporated, shrunk and voided the space, I'd be interested in your feedback on that. The other point that I noticed through your testimony today was with regard to planners—correct me if I am wrong—suggesting specific therapy types. Planners are guiding people into therapy types, whereas, really, planning sessions are about goals and what people want to achieve, not necessarily about planners suggesting specific OT, nutrition or speech therapy types, as opposed to an overarching goal for an outcome without specific therapy types. I'm not sure if I misunderstood you there at all, but I felt that there was a suggestion that planners should be more experienced with allied health so that they can suggest therapies or consider therapy types, whereas really that's not the role of the planner. You can take them on notice because I know we're over time.

**ACTING CHAIR:** We are over time. Unless someone has a quick response, could you take Senator Hughes's questions on notice.

**Mr Groth:** Can I give a very quick response? I wasn't pinning any particular provider or any particular system about the allied health thing. It needs to be each area, whether or not it's community based. Even ACCHOs aren't necessarily funded well for allied health; it's a condition of it. State systems find it hard, and the MBS supports parts of allied health but not all. So there could be some coordination across those, although the circumstances you're talking about, in our understanding, certainly have occurred in spaces, but there is a range of reasons for that. We'll elaborate in an answer, I think.

**ACTING CHAIR:** Thank you for your evidence here today.

**BRUNORO, Mr David, Executive Director, Performance Audit Services Group, Australian National Audit Office**

**HINCHCLIFFE, Ms Jaala, Deputy Ombudsman, Office of the Commonwealth Ombudsman**

**MANTHORPE, Mr Michael PSM, Commonwealth Ombudsman, Office of the Commonwealth Ombudsman**

**REILLY, Ms Rebecca, Executive Director, Assurance Audit Services Group, Australian National Audit Office**

**SAWYERS, Ms Fiona, Senior Assistant Ombudsman, Strategy, Office of the Commonwealth Ombudsman**

[09:46]

**ACTING CHAIR:** Welcome. Thank you for appearing before the committee today. I remind officials that the Senate has resolved that an officer of a department or agency of the Commonwealth or of a state or territory shall not be asked to give opinions on matters of policy and shall be given reasonable opportunity to refer questions asked of the officer to superior officers or to a minister. This resolution prohibits only questions asking for opinions on matters of policy and does not preclude questions asking for explanations of policies or factual questions about when and how policies were adopted.

Would any or all of you like to make an opening statement?

**Mr Manthorpe:** Yes, I would, if that's okay. Good morning, senators and members. I thank the committee for the opportunity to appear at the hearing and I'd like to make a few opening remarks building on the submission that we provided. As part of our broad oversight role of Commonwealth government administration, my office has oversight of the National Disability Insurance Agency and its subcontractors. I note that the NDIS Quality and Safeguards Commission separately regulates NDIS service providers, so we don't have oversight of them. As an ombudsman's office, we consider and handle complaints—you don't have an ombudsman without complaints—about the NDIA's administrative actions and decisions. We look at the processes followed by the agency and consider whether they are fair and reasonable.

In 2018-19 we received 1,711 complaints about the NDIA, which was a 12 per cent increase in complaints compared to the previous year, but we recognise that the number of NDIS participants has grown substantially, and so an increase in complaints of that volume isn't necessarily indicative of a deterioration of experience in the scheme; indeed, it was a lower increase in complaints than in the previous year. The most common issues raised in complaints were about reviews and planning, which I think will be of interest to this committee.

There are some limits to what we can do that shape how we engage with issues. Firstly, decisions of ministers are outside of our jurisdiction. That means, therefore, that we don't investigate complaints about policy decisions associated with the NDIS. Secondly, we don't generally consider the merits of administrative decisions if there's a better pathway for citizens to pursue and, in the case of the NDIA, there is an established internal review process and then a binding independent external process through the AAT. What we therefore focus on is how the program is administered, and sometimes we do systemic investigations when we get complaints about a variety of aspects of how it's administered. We did that with respect to a report we did last year about the handling of reviews by the NDIA.

We've observed a number of issues in relation to plan gaps, including inconsistent processes for responding to plan gaps, a lack of clear communication about those and a lack of guidance or training for staff about those. Where we have opted to investigate individual complaints about planning or reviews, the NDIA has been responsive to our office's feedback and suggestions, and we seek to maintain a constructive relationship with them.

The other thing that I think I should mention that has arisen since we last appeared before this committee is that, in the most recent budget, the government announced an additional \$2 million for my office over four years to support the implementation of the Participant Service Guarantee, which will allow us to provide further oversight of some of the issues that we'll see. We envisage that we will use the additional funding to support more NDIS participants to pursue complaints about the time frames that are established through the service guarantee. We will be looking, in various ways, to monitor the NDIA's performance against the Participant Service Guarantee, and we might investigate and, where appropriate, publicly report on systemic issues that we might see in that space, and we are working with the Department of Social Services and the NDIA about the development of the Participant Service Guarantee. Indeed, we have put in a public submission to that process as well, if that's of interest to you. We're happy to take questions in due course.

**ACTING CHAIR:** Mr Brunoro, do you have an opening statement?

**Mr Brunoro:** I have a very short statement. We put in a submission highlighting two of our previous audit reports, one of which, published in November 2016, was on market development, and the other, published in October 2017, was on scheme access. That was some time ago. I think that, in a rapidly changing environment, some of the findings of the report may no longer be relevant, so that may limit some of the information we can provide to the committee. However, our submission didn't highlight a more recent report that was tabled in June this year on fraud control arrangements, and I would be able to speak to that also.

**ACTING CHAIR:** Thank you. Mr Wallace.

**Mr WALLACE:** I would love to talk to you, Mr Brunoro, about the fraud control arrangements. Can you give us a rundown on what your office has recommended to the NDIA on those?

**Mr Brunoro:** Sure. The objective of this audit was to look at the overall effectiveness and compliance of the NDIA's fraud control arrangements. The conclusion was that they were largely compliant and largely effective. However, there was more work to do. It was a rapidly changing space, and we saw active and proactive evolution of their fraud control arrangements during the course of the audit.

**Mr WALLACE:** Can I just confirm, before you go any further: when we're talking about fraud control, are we talking about it within the NDIA or are we talking about it across the whole service delivery arrangement of the NDIS?

**Mr Brunoro:** The latter—so, across the whole service delivery. As I've mentioned before, the findings were that they were largely appropriate; however, there was some more work to be done to make them fully effective. It was a rapidly maturing management environment, and they were taking actions to increase their fraud control systems. We found that they had a risk register and some projects dedicated to fraud control. However, there was a need to consolidate and review some of those documents and essentially produce a single source of truth, if you will, to strengthen management of their arrangements so they had a clearer line of sight about whether fraud control treatments were addressing the risks that they had identified down to within their tolerance levels.

There was some work to be done on data analytics and data matching that was underway and some review of their larger projects within the NDIA to look at whether they did have impacts on fraud control—positive or negative—and to link that back to their single source of truth. The audit had six recommendations, all of which were agreed by the NDIA. I understand from their audit committee that three of those recommendations have already been closed. So they were actively working on those recommendations. I can speak to them, if you wish.

**Mr WALLACE:** Yes, thank you.

**Mr Brunoro:** The first, as I have already mentioned, was related to essentially cleaning up and working on their risk registers, looking at the risk assessments, removing process controls—for example, ones that were relying on legislation as a control rather than an active control—and regularly updating the risk register. The NDIA agreed to this recommendation. The second recommendation was on fraud detection methods, focusing on plan data analytics and data-matching activity as a priority and on a continuing basis going forward.

The third recommendation was about compliance with investigation policies—for example, improving the case management system so it could be more efficient and effective in supporting their fraud officers and undertaking some quality assurance reviews of their investigations. The fourth recommendation focused on the overall project management, as I mentioned earlier. There was a large number of significant projects, some of which were dedicated to fraud improvement and some of which may have had impacts on fraud—positive or negative. So it was reviewing those projects, identifying fraud elements and linking that back to their management of fraud in a central way.

The fifth recommendation was on providing regular reports to the executive leadership team and the board so that they had a clear management focused oversight of the activities of the entity. The sixth recommendation was to continue to improve their recording and reporting of more detailed fraud data, including to the Australian Institute of Criminology annual reporting census. I would note it is not a requirement for the NDIA to complete that, but they do complete it. So those are the six recommendations.

**Mr WALLACE:** Thank you. I will come back to you if there's time.

**Ms COKER:** Good morning, everyone. I'm wondering if the Ombudsman could elaborate on key issues that are occurring in the review process and any suggestions on solutions there.

**Mr Manthorpe:** I might start and then my colleagues might chip in. First and foremost, the thing we have been working on over the last couple of years has been the fact that, as the scheme has been rolling out—and obviously the NDIA has been under pressure to roll out the scheme at a considerable speed and therefore get

plans in place for a very large number of people—the pressure has been on. If the plans aren't perceived by the participant to be up to scratch then they may seek a review. That's led to an emerging backlog of review requests. So the first issue has been this very substantial backlog of reviews that have needed to be dealt with whilst the agency is focusing very hard on plans. So that was an issue that we called out in the report that we did last year. At one point in time, the backlog was in the order of 13,000. We understand that the backlog has now come back down to something in the order of 5,000. So we concede they are making progress there, but there is still more to do. So that is one issue.

Some other issues have been around reviews being delayed or plan gaps coming into existence between when a plan is scheduled to come to an end and when a review is done to initiate or extend the plan. Here, too, echoing Mr Brunoro's comment about a rapidly changing environment, we know the NDIA is doing work to try to get in front of that problem, but nevertheless we have had complaints about things like there being a gap between when a review was scheduled and when the review was actually done and that creating uncertainty about, 'What are my entitlements, funding and supports going to be during that gap and does the plan get extended or does the plan get retrospectively extended when the review is done?'

**Ms COKER:** In relation to reviews, do you believe we need to have a limit or time frame by which a review has to be complete?

**Ms COKER:** In relation to reviews, do you believe we need to have a limit, a time frame, by which a review has to be complete?

**Mr Manthorpe:** I think there has to be some parameters around when reviews are going to be done, yes. If a plan has a finite life and a participant wants their plan to be reviewed, that does have to happen sooner or later, and so parameters around that are important, I think.

**Ms COKER:** But they don't exist at the moment?

**Ms Sawyers:** No. At the moment the NDIA doesn't have formal KPIs around when section 100 reviews have to be done. Section 48 reviews are different. That is part of the issue with reviews—there are two types, and that creates confusion. Section 48 reviews are ad hoc reviews, something's changed in a participant's circumstances and they want to do something different. There are time frames around that. But, for the section 100 reviews, where a participant is unhappy with what's in their plan, there aren't formal time frames around that.

**Ms COKER:** Do you think there should be?

**Ms Sawyers:** Going back to the Ombudsman's comment—

**Mr Manthorpe:** Yes, I think the answer is yes. We think there should.

**Ms COKER:** Good. Thank you.

**Ms Hinchcliffe:** It's a matter of good administrative law and good public administration to be able to communicate with participants of any scheme about what their review rights are, the times for reviews to take place and have clear reasons for decisions. They're the kinds of things that we see and we make comments of across the Commonwealth agencies, similarly in this space with the NDIA.

**Senator HUGHES:** If I could come back to the forward side of things, I'm interested in whether or not there's any mechanism or anything that you've looked at with regards to providers? We're getting reports of two tiers of pricing, one if you have NDIA funds and one if you don't—price gouging, in effect. But I also think there are some issues around that if you're servicing people at different levels because they have funding versus what you're charging if they don't, but also volumes of providers that are increasing their workload considerably when NDIS participants become available to them, and then the service delivery around that.

**Mr Brunoro:** Sorry to interrupt. The ANAO hasn't done work in, at least, the performance audit area in that space. It would be a question for the NDIA.

**Senator HUGHES:** Coming to you, Mr Manthorpe, around the review process: the minister's announced a couple of points of difference when looking at draft plans and them coming into effect. One of the things we've been hearing here is that people are being able to review parts of their plan rather than their entire plan. So if there's one section that's not quite including what it should, participants are able to then go back through that process. Is that something that you think will reduce your workload with regard to complaints around reviews or help the system or move things along, particularly in that time frame perspective if we're obviously dealing with less substantial reviews?

**Mr Manthorpe:** That's right. Anything that can be done to make the system work more efficiently, we would welcome so long as the participants have the capacity to seek the review or the assistance that they need at a given point in time. So things like being able to do a partial review rather than a full review, if that works for the

participant and it cuts out red tape, we would say that sounds good. Similarly, I know the minister made some comments the other day about the notion of having longer plans for some people so that they don't have to review the plan every year and they don't get stuck in a cycle of—

**Senator HUGHES:** Certainty for the participant is increased.

**Mr Manthorpe:** endlessly trying to keep up. So long as people who need a regular review are getting that and so long as people who need a review at a point in time during the life of their plan can access that, then, in principle, that sounds to us like a pretty sensible thing to do. We will be interested in getting more briefing from the NDIA in the coming months about how that will work in practice, but in principle it sounds like a sensible thing. While the objective of this is not to reduce our workload, we get plenty of complaints about all sorts of things, so, if it reduces our workload, we would be very happy.

**Senator HUGHES:** To follow on from the question I asked Mr Brunoro around providers, are you seeing an increase in complaints with regard to providers putting different expectations on NDIS participants, changes to services they were receiving prior to NDIS plans, then things changing—prices, expectations, service delivery?

**Mr Manthorpe:** I don't think so, but that's probably because it's largely out of our jurisdiction. I commented in my opening remarks about role of the NDIS Quality and Safeguards Commission. They are the people that take complaints about providers. If there are complaints about providers, we sent them to the NDIS Quality and Safeguards Commission. We take complaints about the NDIA. Sometimes there is some overlap in the topics, but generally speaking they're outside our jurisdiction and we don't have a lot to say.

**ACTING CHAIR:** Just to let committee members and witnesses know, we have Channel 10 here filming—but, of course, this hearing is broadcast anyway.

**Ms PAYNE:** My questions are for the Ombudsman. To follow on from Ms Coker's questions: can you confirm that there are no time frames around participant initiated reviews but there are around NDIA initiated reviews?

**Ms Sawyers:** To clarify: no. Section 48 reviews can be either participant initiated or NDIA initiated. Where something may have changed in the circumstances of an individual, the NDIA may know about that and seek to initiate a review, or the individual may seek to initiate the review, whereas the section 100 reviews are where the individual is unhappy with what it is in their plan and are seeking a review of the plan.

**Ms PAYNE:** Could you comment on what you see to be the systemic issues driving the complaints you receive around reviews and planning?

**Mr Manthorpe:** A couple of them I've already mentioned. One is this issue of delay in accessing a review and that leading to a backlog of people waiting for a review, so we get complaints about that. We may have some more detailed data. Ms Hinchcliffe, do you want to go to that, if we have?

**Ms Hinchcliffe:** Following on from what the Ombudsman has just said: delay is a major cause of complaints for us both in the planning space and in the review space. In relation to planning issues, we see delay in relation to the NDIA making their decision as being the highest cause of complaints to us. We also see complaints around what are perceived as wrong decisions being made and, again, around failure to provide advice or around inconsistent or conflicting advice. Those are the types of issues we see complaints around in the planning space.

**Ms PAYNE:** How much difference do you feel participants being able to see, comment on and change a draft plan would make?

**Ms Hinchcliffe:** We're aware of the announcements that have been made about that. One of the things we would generally say is that transparency in process and transparency in decision-making are really important principles in good public administration. It seems to me, without seeing the details of exactly how that will work, that this potentially does provide more of that transparency. We will be interested to look at the time frames around that to ensure that it doesn't create further delay in people getting a finalised plan that they are then able to operate under and have the financial supports under. We will continue, as the Ombudsman has already said, to seek some briefings as to how that will work in practice and provide some comments back to the agency if we see concerns about that creating further delays.

**Ms PAYNE:** As you would be aware, they have been running a soft launch of joint planning in Adelaide. At the Adelaide hearing we were able to question the NDIA about whether that really would deliver on what participants and others have been calling for as an opportunity to see draft plans. What role do you think training for NDIA planners and local area coordinators has in contributing to these issues?

**Mr Manthorpe:** I don't think we have a very granular comment to make on that other than that it's self-evidently important that planners, decision-makers, reviewers, everyone in the system, is adequately trained to do

the job. Listening to the previous witnesses this morning, it's evident that there is a need to continue to focus on that issue and ensure that the folks who are delivering the scheme are doing so on a really sound basis. I think it is self-evidently a good thing. How much needs to be done, precisely what needs to be done, I'm not sure. I don't think we have a good visibility of that.

**Ms PAYNE:** You mentioned that the NDIA have been responsive to your recommendations. Do you feel that they've adopted some of the recommendations you've made about these ongoing issues?

**Mr Manthorpe:** Yes, they have. By and large when we make recommendations to agencies—not just the NDIA but most Commonwealth agencies with respect to which we exercise oversight—agencies do accept most or all of our recommendations. A good example is the report we did about reviews which called out the issues of delays and a number of other administrative problems that we saw. In the review's report that we put out last year, we made—from memory—20 or so recommendations, all of which were accepted by the NDIA. I understand from their submission to this inquiry that they've indicated that they've now implemented most of those. They have been reporting to us about implementation, and we are in the process of having a look for ourselves to form a view about how far along that implementation path they are. But I'm very confident that they've been taking our recommendations seriously.

**Ms PAYNE:** Would you say that you've seen evidence of that implementation in a reduction of the complaints that you hear?

**Mr Manthorpe:** We haven't had a reduction in complaints. As I mentioned at the beginning, in the financial year just finished we had an increase of about 12 per cent on the previous year. But in the previous year we had an increase of something over 200 per cent. We saw a sharp spike in complaints in 2017-18, and in 2018-19 we had a further 12 per cent increase in complaints. So the acceleration of the increase has slowed, or decelerated, whilst the scheme is rolling out at considerable speed. I think that might answer part of your question. Have I missed something in your question there?

**Ms PAYNE:** It was just to get a sense of whether, in terms of your recommendations being implemented, you have seen that in issues being resolved.

**Mr Manthorpe:** I've said what I'm able to say about the response to the review recommendations. The other manifestation of progress is the reduction in the backlog that I've talked about in terms of the review process. Obviously we think it would be good if there were no backlog, but a smaller backlog is better than a bigger backlog. We've also seen that they are doing work around these issues like extending plans rather than having a gap. So they have been listening to our views—and I'm sure other people have been expressing similar views—about how you need to clarify what to do if a plan comes to an end. What continues? What doesn't continue? What entitlements, rights, supports and so on does someone have? They have been taking steps. For example, I think in September they announced an intention to extend plans by 28 days if they were about to expire, with a view to getting the reviews done during that period. I don't know how successful they've been at doing that, so that's another thing that we'll be watching, but I can see that they are running hard to try and get ahead of some of these issues, some of which are the issues we are raising.

**Ms PAYNE:** Do you think that it's common for NDIA offices to make decisions based on their own policies rather than whole-of-agency policy or practice?

**Mr Manthorpe:** I'm not sure I'd use the word 'common', because I don't think I know enough to say that, but we have certainly identified, in some of the complaints that come to us, a sense that there are inconsistencies from one office to another. That might be because the scheme started, as I said, at pilot locations, and practices and procedures may have grown up in those locations that might not have been quite as joined up and nationally consistent as you would want or hope for. That's not to be critical of the offices, but it's the sort of thing that you could imagine could have occurred as the scheme was rolling out initially. So we do hear about inconsistency. I know that again the NDIA is doing work to try and get around in front of that, but it is an issue that comes to us.

**Ms PAYNE:** In the complaints you see about reviews, would it be your observation that with reviews, particularly—I forget the section—the NDIA initiated regular review, there is an imperative through those reviews to reduce plans?

**Mr Manthorpe:** I don't think I can comment on that. Do we have any insights?

**Ms Sawyers:** We've only had some anecdotal discussions that go to a range of issues. Individuals, or organisations that represent individuals, might see that there have been plans reduced from one year to another, but it's been anecdotal information, with not enough information there about what was actually going on behind that decision to reduce those plans. Certainly, in the complaints that we've seen, I'm not aware that we've seen particular evidence that suggests there is an imperative to reduce the value of the funding that's in plans.

**Mr Manthorpe:** Yes, that's right. I wouldn't say it never happens, but, when I think about the categories of complaints we get, they're more often about the administrative processes, the delays and things of that kind. We also get complaints about handling complaints. People complain to the NDIA about something, and they're not satisfied with how that was handled, so then we get a complaint about that. So those are some of the areas where we see complaints, I think, more prevalently than the issue you've just raised.

**Ms PAYNE:** We've had a lot of evidence raised through this inquiry that people who are engaged, articulate and able to advocate tend to fare a lot better than those who are less able to do so. Is that something that you feel could be addressed through improvements to the planning process, or is that something you see in your complaints?

**Ms Sawyers:** Again anecdotally, when we've gone out and talked to organisations, we get that kind of feedback: that people with higher levels of education, and people with experience dealing with government agencies and bureaucracies, are better placed to be able to navigate the system. But, in terms of what we're seeing through our complaints, again we're not seeing evidence of that so much. As Ms Hinchcliffe said, the majority of our complaints tend to be about delays. As to whether or not it's that some of those people are not necessarily coming to us with those kinds of complaints, we're not in a position to say.

**Mr Manthorpe:** I think I would make two comments, though. One is that it does go to the issue of training. If you've got well-trained frontline staff, they're more likely to correct for that risk, if I can put it that way. So I think the training piece is important in that space, first of all. The second point is that, in the context of the role we are going to pick up associated with the participant service guarantee, I am hoping that that will give us a little bit more capacity than we currently have to look at some of those thematic issues. We haven't planned what they might be yet, but—after just listening in this morning to the previous witnesses who, among other things, talked about the challenges in rural and remote Australia—I note that we are a small office. We are based in Canberra and the major state capitals. We don't have a presence out there, but perhaps, through the funding we've secured in relation to the participant service guarantee, we might be able to conduct studies or reviews that go to issues of that kind. I know that doesn't give you a contemporary answer, but I understand the point you're raising, and it is the sort of thing I would be interested in getting to grips with.

**Mr WALLACE:** This question is probably best addressed to Mr Manthorpe; but I don't want you to feel like you're not loved, Mr Brunoro, so if you have anything to add I'd be keen to hear from you. You may have heard me ask of the witnesses before you a question relating to the probity issues around the suggestion that we've had of establishing a private panel of planners that could specialise in certain areas, whether it be Down syndrome, hearing impairment or dealing with people who are living in remote or regional, rural Australia. Do you see any administrative probity issues with planners who are paid a fee for service and who would generate their own income by virtue of perhaps getting a good name: 'You should go and see John Smith because John Smith gets really good plans'? Do you see any issues with that sort of a set-up?

**Mr Manthorpe:** This is the sort of question that arises in the Senate committee inquiry that's going on about service delivery in the Australian Public Service, to which we've made a submission. You might like to read our submission, which goes to some of these issues of principle. I'm not familiar enough with what is going on in the NDIS space in relation to that specific issue to be able to make a comment on the specifics of the NDIS, but what I would say is that, in principle, if you're going to go down that path, you would need to make sure you cover off some risks. Some of the risks that would jump out at me would be risks around trying to achieve value for money and risks around conflict of interest. To give you an example, a historic example, at a point in my career I used to help run what was then called Job Network, and an issue that arose in that space was private Job Network providers wanting to refer clients to their associated entity, training providers, as a way of generating revenue—

**Mr WALLACE:** Keeping it in-house.

**Mr Manthorpe:** That's right; that sort of thing. You can understand why they might have been motivated to do that, but it didn't necessarily mean that it was the best outcome for the jobseeker or the taxpayer. I'm not saying that those risks aren't manageable, but they would be the sorts of risks you would need to contemplate.

**Mr Brunoro:** I would add one comment that goes to helping address those risks, which is a common theme in audit reports. Whether it's a program that's been initiated by public servants or outsourced, so to speak, where the private sector has a very strong assurance framework over the providers, there needs to be a second checker—for example, risk based or statistical surveys of what is actually happening on the ground—to not only look for conflicts of interest et cetera but ensure the processes are being followed and that the documentation of those processes is available.

**Mr WALLACE:** Wouldn't there be a fundamental commercial imperative on the part of the planner to ensure that the participant got a really good plan? I mean, I can see it opening up a can of worms. You might get a situation where it becomes a circuitous arrangement, where a service provider refers the participant to a planner, who then puts a plan together that would involve, particularly in a small regional area, that provider getting work out of it. Do you understand my concerns?

**Mr Manthorpe:** I understand the concern. I would just reiterate the point of principle that those are risks you would have to work out how to manage. I simply don't know enough about the specific context in which this is being contemplated to comment on it directly, but I think there's a set of principles you would need to work through, and, between Mr Brunoro and I, I think we've outlined some of them.

**Ms COKER:** My question is directed to the Commonwealth Ombudsman. In the submission by Maurice Blackburn, it was stated that:

This review and appeals framework is anathema to the NDIS being truly held accountable for producing and defending plans which fall far short of the "reasonable and necessary" supports required by the legislation.

Is this reflected in the evidence that you've seen and experienced? What are the key reforms that you believe are required to ensure that we have accountability and transparency, and, importantly, that we expose systematic problems so that we can meaningfully address these in the long term?

**Mr Manthorpe:** I'm just trying to think of whether there is anything I can say in response to that that adds to what we have already said. As a matter of good administration, transparency is a good principle to start with, as Ms Hinchcliffe pointed out before, and that goes to transparency, particularly, for the participants, to understand what is being put to them and so forth. Review rights, appeal rights and things of that kind that are accessible and real and important—some elements of that are already, clearly, in place. Whether more needs to be done, I'm not sure. I don't think I have any further comment to make on that.

**Ms Hinchcliffe:** The only thing I would add is: what we're seeing through the complaints, as we've talked about, are issues that go to delay; transparency; people being clear on what the time frames are for their reviews to occur; and the backlog, which is causing delays. So it is those kinds of issues. It seems to me that that submission from Maurice Blackburn is going a little bit further than the things that we have seen. But I echo the things that the Ombudsman has just said about the issues that we have been calling out, about clear communication with participants, timeliness, transparency about the process, a clear understanding of how their review rights work and for those reviews to be conducted without delay.

**Ms COKER:** As to the key things that people have complained about and you've identified as being issues, have you been able to have a meaningful role in having a voice to expose what those issues are and then getting change within the NDIA to improve the system?

**Mr Manthorpe:** I think we have, within the lane that we occupy, which is fundamentally about the administration of the scheme. In some ways, the submission you just quoted from goes to whether or not the overarching policy of the scheme is right or good enough, and that really gets a bit outside where we normally engage, because, quite apart from anything else, our act doesn't permit us to investigate actions of ministers, and that means government decisions about how a program might run at the highest level are outside our jurisdiction. What we therefore focus on is: how, whatever the program is, it's actually being administered, and whether that administration is being done as fairly and reasonably as possible, and, within that construct, I would contend that we have. The report we did about reviews, I've mentioned a couple of times this morning. There is the other day-to-day work we do on individual complaints. We can't investigate them all; we don't have the resources to do that; but, where we investigate complaints and make recommendations about particular individual circumstances back to the NDIA, we see, by and large, that they respond positively to those recommendations. So I think we have a limited but important contribution to make.

**ACTING CHAIR:** Mr Manthorpe, is the Ombudsman's office providing any input into Mr Tune's review?

**Mr Manthorpe:** Yes, we are. We've written a submission. It covers some of the issues that are in our submission to this committee. It's publicly available. If the committee would like, we could provide it to you on notice.

**ACTING CHAIR:** That would be most welcome.

**Mr Manthorpe:** Sure.

**ACTING CHAIR:** Mr Brunoro and the ANAO?

**Mr Brunoro:** I'm not aware of whether we've provided an input to that or not, but I can take that on notice.

**ACTING CHAIR:** Thank you. In terms of the information that you put out regarding the 1,700-odd complaints that you've received, do you provide information around the categories? Is that all on your website? Could I find out how many may have been complaints around participants zero to six? Is that the sort of information?

**Mr Manthorpe:** We have some information in our annual report, which was tabled a couple of weeks ago, that goes to the granularity of different types of complaints. I'd refer you there, but if there's a particular thing you're after—

**ACTING CHAIR:** No. I'm just interested in whereabouts most of these complaints are falling. I know you said it's planning, but I just wondered whether there was something particular—zero to six, for example—or it's just more general than that.

**Ms Hinchcliffe:** In terms of the age group of people?

**ACTING CHAIR:** Yes.

**Ms Hinchcliffe:** We don't report on that within our annual report and we wouldn't necessarily collect that data all the time. I'm happy to go back and see what data we do have in regard to that.

**ACTING CHAIR:** If you could, that would be great.

**Ms Hinchcliffe:** I'm not sure that we'll be able to give you much help there, but we'll have a look and see.

**ACTING CHAIR:** Thank you, and thank you all for appearing here today.

**Proceedings suspended from 10:31 to 10:41**

**ASH, Ms Lindsay, Senior Solicitor, National Disability Insurance Scheme, Legal Aid New South Wales, National Legal Aid**

**FINLAY, Ms Jackie, Senior Solicitor, Civil Law Division, Legal Aid New South Wales, National Legal Aid**

**ACTING CHAIR:** Welcome. Thank you for appearing before the committee today. Would you like to make a brief opening statement?

**Ms Ash:** Firstly, we'd like to thank the joint standing committee for the opportunity to appear today and to contribute to this inquiry. We appear as representatives for National Legal Aid, which itself represents the eight state and territory legal aid commissions around the country. Assisting people with disabilities is a core part of what we do. All legal aid commissions provide advice and representation, in a variety of courts and tribunals, for people with disabilities. Since the scheme began, we've been providing assistance to hundreds of applicants in AAT appeals.

Participants in the NDIS become our clients because something has gone wrong for them in the claiming process. We work at Legal Aid New South Wales. At Legal Aid New South Wales, almost every matter that we've run in the last year in relation to supports has resulted in increased funding for a participant—in many cases, a substantial increase. But, on average, we're finding that those matters are taking close to a year to resolve. In the most extreme case, it took two years for a decision about a plan for a six-year-old child with severe disability seeking funding for therapies and an adapted stroller.

This means that it is common for a plan to have run its course before a decision is made about what it should contain. This cycle of reviews gets in the way of participants getting the support that they need. Our clients tell us that what they want from NDIS planning is better communication, more focus on their individual needs, clearer information about what's being funded and why, consistency from year to year, and clear, quick and fair processes to challenge decisions.

In our view, a lot of these things could be achieved through very simple changes to policy and practice. The changes that we want to highlight for the committee today are, first of all, specialist planners. It's our recommendation that there should be more planners with specialised knowledge and training about particular disabilities—for example, mental health conditions—and there should be more specialist planners for participants trying to transition from custodial settings.

Secondly, planners should take a participant's previous plan as a benchmark and should not ask a participant to start from scratch in demonstrating their needs at each planning conversation. We're frequently assisting clients whose second and third plans have drastically reduced funding for supports, where their circumstances are the same. We think this simple adjustment could allow participants and planners to spend their time in their planning meetings focusing on what's changed.

Thirdly, everything that's going into a plan should be known before it's finalised. That means what's being funded and why, what isn't being funded and why, what tools are being used to make that decision, and getting a right of reply if something isn't right. We think that this will allow simple errors to be picked up and give people a chance to provide more information if they need to, and it will reduce the number of unnecessary reviews. These recommendations are particularly important for supported independent living funding, where our clients are reporting that they can't get the information that they need to exercise the choice and control that should be offered by the scheme.

Next, there is a need for a different simplified planning process for assistive technology supports, home modification and specialist disability accommodation. These are the types of support where technical knowledge and multiple steps might be needed before they can be approved. Our clients are reporting to us that they are going round in circles trying to get these types of supports and to get the equipment that they need.

Lastly, there is a need for some changes to the review system. As you have heard from witnesses already today there are two-ways to challenge a planning decision available under the NDIS Act, and even though they are quite different they are both called reviews, which is leading to confusion for participants, for the NDIA and also for the tribunal about what is being sought. National Legal Aid recommends that different terminology is used for those types of reviews. We are referring to scheduled and unscheduled plan reassessments and reviews as the procedure that leads someone to the tribunal. Further, we recommend that legislative time frames for review processes be introduced to provide certainty for participants for the NDIA and also the tribunal. Specifically our recommendation in relation to internal reviews is that it be mandated that they be made within 60 days and that there be a process to expedite it if it is urgent. These changes have the potential to make the system more efficient for the NDIA and to significantly improve the experience of participants in the planning process.

**Ms COKER:** Thank you very much—very succinct and useful suggestions there. I'm interested in the draft process. We've had a soft launch which is encouraging a draft to be presented to a participant, looked at and then come to a second meeting where it can be discussed and finalised. Have you been involved at all with your clients who've been through the soft-launch process?

**Ms Ash:** No, not yet.

**Ms Finlay:** In the early days when the scheme was first introduced in the pilot areas, they essentially did that process. I don't think it had a title then. But clients were given a draft plan with 'draft' written across it which then meant someone spoke to them, they could identify mistakes in outlining their life situation and their informal supports and it was also an opportunity for someone to ask, 'What's that line item mean?' and essentially the person would say, 'That \$22,000.05 represents three hours of self-care a week.' So it was an opportunity to fix up mistakes but also a useful tool in training participants to understand what a plan looked like and how it could be used.

**Ms COKER:** At the last hearing in Adelaide I attended, a number of participants said that their draft had been presented to them, but it was like, 'Take it or leave it,' not a real discussion around the draft and improving it so that it was a plan of reflected need. Can you just comment on the role of the draft and how you feel that could be best implemented for the participants' welfare?

**Ms Ash:** The role of the draft plan should give an opportunity to correct very easy mistakes and also for the participant to go through what is being funded and what isn't. There's an example in our submission in relation to a support where all that was needed in order to get it over the line was a conversation with the person who was recommending it about why. Those sorts of things, if they were part of the draft plan process, would really reduce unnecessary reviews. It should be something that does have the potential to change the plan; otherwise, as other witnesses have spoken about this morning, it could create a potential for further delay. It should be something where somebody can have a chance to review their goals and the information that's been put in the plan about them but also to understand and address what is and isn't in the plan.

**ACTING CHAIR:** The minister has spoken about draft plan summaries. Are you aware of that terminology and what that means?

**Ms Finlay:** No; I just saw the stuff in the press. I'm not sure what that would mean. If, for some reason, that doesn't give the detail it is probably not that useful, because I think it is the detail that is important. If it is just top-line figures, I don't think that really helps participants. It's the thinking behind it that people want to know and understand.

**ACTING CHAIR:** We will ask the department exactly what that means. It would be useful for this committee to know.

**Mr WALLACE:** Thank you for coming in today. One of your recommendations is that an existing plan shouldn't be reduced at the review unless there are obvious circumstances that would suggest that the level of care is no longer required in that particular area. You also said earlier—I'm not sure whether or not you said it was anecdotal evidence—that there is a concerning number in the second and third reviews where the funding was being reduced. Can you just put some flesh on the bones of that comment a little bit more? Is it anecdotal evidence? Do you have some stats to back that up? How prevalent is that particular issue?

**Ms Ash:** I don't think we have any statistics about the number that we see, but we have spoken to clients who are in that situation. It may be that a matter is settled in the tribunal, which involves a fair bit of evidence and explanation or even a decision of the tribunal that a certain level is required. Then a client would return to us or seek assistance from another service with a reduced plan the following year or the year after. I don't have specifics about statistics, but it is certainly something that we have seen from our clients.

**Ms Finlay:** We'll get copies of their three plans as part of, say, tribunal proceedings and you can see the drop. They are often ones with quite high packages, I think it is fair to say—someone who needs 24/7 care. You see \$350,000 and then it will be \$280,000 and then it will be \$220,000, without any detailed explanation. In fact, even at the Administrative Appeals Tribunal stage we won't get an explanation for the drop in the amounts that are funded.

**Mr WALLACE:** I think it is important for us as an oversight committee to be aware if that is a prevalent problem. So I am trying to elucidate from you whether it is in fact prevalent or whether, in all of the matters that you have run, you have come into it a few times. There is a big difference.

**Ms Finlay:** I think it comes up fairly regularly. Of course, as National Legal Aid, we are there when it goes wrong. So, obviously, the subset of people we see are where things aren't successful. It is fairly prevalent within

that subset, but of course that doesn't reflect the overall experience. We don't get anyone if it is going well. We don't get good news stories.

**Ms Ash:** And there are some areas where there haven't been multiple years to compare.

**ACTING CHAIR:** Do you get funded money that is earmarked for NDIS clients?

**Ms Finlay:** Yes, we do. The Department of Social Services, as part of its disability advocacy policy area, funds the disability advocates under the National Disability Advocacy Program and it also funds Legal Aid Commissions specifically for NDIS appeals matters. It is not permanent, ongoing funding. We've had a three-year contract and previous to that we kind of got ad hoc funding.

**ACTING CHAIR:** When does your current contract—

**Ms Finlay:** June 2020 is when our current funding agreement runs out, and we are waiting to see if the funding will continue.

**ACTING CHAIR:** Is that funding amount adequate for your case load?

**Ms Finlay:** Our experience is that this year it is. I think it was one of those things that nobody knew what the demand would be. Initially the funding was inadequate, but the department has increased the funding and, from our perspective, the amount that we have got is fairly reasonable. We're used to working within fairly tight constraints.

**Mr WALLACE:** I don't know if I have ever heard a legal aid lawyer say that before.

**Ms Finlay:** Only because of where we came from. I'd like to reflect on the good growth that we've had.

**ACTING CHAIR:** Before I hand over to Ms Payne, you talked about having a defined time limit on review processes. You would be aware of the participant services guarantee, which will be implemented on 1 July next year. Do you have any input into the consultations that are currently being undertaken?

**Ms Ash:** Yes. We've produced a submission for that inquiry as well and we've recommended the same time limit. We've been asked to provide information in relation to a number of different time limits along the way, and in relation to internal reviews we decided that 60 days would be appropriate.

**Ms PAYNE:** Thank you very much for coming today. From the issues that you see—I note your recommendations for solutions and will come back to those—could you comment on what you believe to be any systemic issues that are driving, across the board, the issues that are raised with you. What's causing these problems that people are having?

**Ms Ash:** As a starting point, it's new and it's unknown and there's a lot of exploration to do to work out what the appropriate procedures would be. I think in general we're quite supportive of the objects of the act and the way in which the planning process is framed in the legislation, but there are issues with the implementation of that and the procedures that have been put in place to make that happen. That starts with the planning process, the recommendations that we're making around ensuring that that is focused on the individual and ensuring the right people are in the room. It starts with specialist training and making sure that people understand particular disabilities and how multiple disabilities can compound the situation for a person and understand different arrangements for living; then it flows through to how quickly those decisions are being made, how much information is being gathered in internal review stages to change something if something has gone wrong; and even then into the tribunal as well, in terms of making sure that people continue to be at the centre of the review process and of the planning process all the way through.

**Ms PAYNE:** One of your recommendations was that the previous plan should be a benchmark from which we work on. That seems so obvious, but obviously it's not happening. Could you elaborate on that issue. Are you hearing that when people have their review they basically start from scratch? We've been hearing across the inquiry that things are taken out for no apparent reason or that things need to be justified again. Could you comment on your experience of that issue and why you've made that recommendation.

**Ms Ash:** Yes, we certainly get reports that people have had a very detailed original planning conversation and then, when they have a subsequent planning conversation, they might assume that things that aren't discussed are included or they may not elaborate as much as they did initially on that assumption, and then what is produced is something that doesn't represent a continuation of what they had previously. They might consider that the conversation was to talk about things that have changed or are new—a new piece of equipment they might need, an increase in therapy—and understand that they don't need to go back over the things that they had before. I think our clients would say that that's their experience.

**Ms PAYNE:** Do you feel that that's because of an approach that is aiming to reduce plans in a systematic way?

**Ms Ash:** I don't think I could say that. I know that there are clients of ours who have told us that their plans have been reduced, but I don't think I could—

**Ms PAYNE:** Okay. We've heard evidence to this inquiry that suggested that a large proportion of appeals to the AAT are settled before they get there, and it's been proposed that it would be helpful to have that made public for the information of participants and planners about what sorts of things are being found as reasonable and necessary or are not. What would be your view on that?

**Ms Ash:** I think it's useful to know what's being settled. Particularly, in our submission, we draw attention to some instances or issues where something that might be considered a settled point of practice is reargued in the new matter. An example I can think of is in relation to hearing aids and what level of technology people might need, and what other services and programs they might be accessing. We might go through a process with somebody and have a fairly settled idea about what is expected of a person to show in relation to that sort of support, and then start again from the start when it comes to the next person. Certainly, having some transparency around what has been agreed would help people to know what decisions to make in their matters and would help with more consistency in decision-making.

**Ms PAYNE:** Another thing that has been an almost constant theme across evidence is that there's a real divide between people who are articulate and well supported, or able to advocate, versus people who are less able. I assume that you must see that, of course. Do you have any recommendations for what might help to address that issue?

**Ms Ash:** I think that has to start at the start of the planning process. In our submission there is some discussion about what should go into pre-planning—and that really should involve a good and thorough evaluation of the person's circumstances and who should be involved in helping them to put forward their needs in a plan. There's an example in our submission of a person in an institutional setting, where their family members and other people were not included in planning processes. That's something that could easily be avoided if there's an evaluation at the start of who should be there and what the person needs in order to make that process as useful and meaningful as possible.

**Ms Finlay:** I think the funding for support coordination is really important for people who don't have significant family support or who maybe haven't had a lot of experience of dealing with the disability sector. It's a very new way of working, where you go out there and find people that you think are best suited for you. You negotiate hours and series of care. From our experience, a good support coordinator can result in people getting the most out of their funding; they get the most support. They get the support in the best way they can use it, and the money is used creatively. Those support coordinators are really crucial. If people are without them, in our experience, often the money mightn't be spent in the most beneficial or clever way. Certainly, for some clients, we think that sufficient support coordination funding is crucial.

**Ms COKER:** Legal Aid plays a very important role in representing people with disability. Is there anything within the system that needs to be improved to support the role that you play in supporting people with disability who are unhappy with a plan or having an issue around their plan?

**Ms Finlay:** Our experience in the litigation space is that, outside of the individual particular AAT matter, where we have a relationship with the agency—or any government department that we're assisting clients to resolve disputes with—we have a mechanism to raise systemic issues. Currently, the National Disability Insurance Agency has a working group for NDIS appeals—and National Legal Aid has a seat in that teleconference with some of the peak disability organisations—and it really helps the individual solicitors who are supporting our clients. It's an opportunity to say, 'We've got legal aids from around the country and people are giving the same messages—my client is saying this, and mine is saying this in WA and the Northern Territory.' We feed that back up and say to the manager of the NDIS appeals, 'This is something that we're experiencing,' and we find that that's a really beneficial way of resolving those systemic problems, and it can help with the individual advocacy.

**Ms Ash:** I would only add that we're supported by disability advocates who really have a deep understanding of what's going on with their clients and who help us to communicate with them to try and get the best outcomes for them through the process.

**Mr WALLACE:** I think it was you, Ms Finlay, that commented earlier about disability advocacy services. Can you just outline to me precisely what you mean by 'disability advocacy services'? Are you talking about advocacy that will help someone develop a plan or are you talking about advocacy services in the AAT?

**Ms Finlay:** Our experience is working with the advocates in the AAT and also the internal review—essentially the DSS funded NDIS appeals advocates who assist people and tell them that there is a review process

if they are not happy, help them with the appeal form, help them negotiate with the agency and get them to us. Our experience is that most clients come to us with an advocate. We don't get many who come without one. Our experience is that vulnerable clients aren't aware they can challenge decisions if they're not happy. They might complain to the Ombudsman, but they don't always realise they have these review rights. So there are those advocacy services. As Lindsay was saying, they are crucial for getting the clients to the stage where they can get their dispute resolved but also in how they do it with all of us. They help with communication issues. It works best where DSS has funded an advocacy organisation that is in the person's geographic area. Unfortunately, there's not a complete geographical spread. There are services that might have to cover really large areas and so they don't get to do face-to-face contact. But certainly the ones that do face-to-face contact go to a person's home, help them dial in to the conference and help them go to the doctor and get the report. I think that really improves the experience of people with disability.

**Mr WALLACE:** Is it your view that the disability advocacy services are adequately funded?

**Ms Finlay:** No, I think it's fair to say that they're not. I think partly it is a geographical thing. As I say, there are advocacy organisations in various parts of the state, but then there will be whole other geographical areas that are not covered. A couple of the peak organisations are based in Sydney. They are state based, but I think their view would be that they don't get sufficient funding to actually cover the state.

**Mr WALLACE:** Would the services that those advocates provide have to be done face to face, though? Couldn't much of their advice be provided, say, over the phone?

**Ms Finlay:** I think so. Our experience is that, certainly once you've had some face-to-face connection, yes, you can do a lot of follow-up work via telephone or email. But the face-to-face connection is a really important starting point. For some people with particular disabilities that really is the best way for them to engage with someone. I think it is particularly an issue with our group of clients. Their disabilities mean that often they really are precluded from participating in things unless there is some face-to-face contact. But I know a lot of the organisations will go and do one home visit and then, from then on, might do things over the phone with the person.

**Mr WALLACE:** Depending on the person's disability?

**Ms Finlay:** Yes.

**Mr WALLACE:** I understand that.

**Ms Finlay:** But I think it's fair to say that NDIS participants don't just need advocates at the Administrative Appeals Tribunal stage; they really need them at the lower levels of review. They'll never get that opportunity to get up there without that support.

**Mr WALLACE:** Some would argue they need additional assistance in the plan preparation as well.

**Ms Finlay:** Yes, certainly. That isn't funded currently, to the best of my knowledge. There isn't a specific funding stream. Obviously there's the general advocacy funding that is provided to NDIS providers, but there isn't a particular program, as far as I know, that is funding advocates at the initial planning stage.

**Mr WALLACE:** I'm not sure if that's right.

**ACTING CHAIR:** In your submission around the participant services guarantee, did you touch on participants that may be in custody and time lines around their needs?

**Ms Finlay:** Yes, we did. Our proposal is broadly that people should have plans within 28 days of, I think, the final information being provided. I'm not sure exactly what period it was, but we certainly did have a time frame. I think the concern for people in custodial settings is—I can only speak from the New South Wales experience—but the guidelines or the agreement between the New South Wales government and the NDIA is that, six months prior to a person's release, the planning process can start. As we go to in our submissions, particularly for people in mental health facilities, they often don't have a release date, because, in fact, they need to be fully supported before a release date would be given. So our recommendation is that really they should just be starting planning once they become a participant in the scheme, and there shouldn't be this reliance, because, of course, you can get NDIS funded supports within a prison or within a mental health facility. You may need less than if you're in the community, but you can still get some funded supports.

**ACTING CHAIR:** Thank you for appearing here today and thank you for your evidence. Thank you.

**NICOL, Mr Marcus, Director, Monitoring and Reporting, National Mental Health Commission**

**OFEI-FERRI, Ms Sandra, Acting Director Mental Health Reform, National Mental Health Commission**

**STEVENSON, Mr Tony, Chief Executive Officer, Mental Illness Fellowship of Australia**

[11:12]

**CHAIR (Mr Andrews):** I now welcome representatives from the National Mental Health Commission and the Mental Illness Fellowship of Australia. Thank you for appearing before the committee today. I should remind officials that the Senate has resolved that an officer of a department or agency of the Commonwealth or of a state or territory shall not be asked to give opinions on matters of policy and shall be given reasonable opportunity to refer questions asked of the officer to superior officers or to a minister. This resolution prohibits only questions asking for opinions on matters of policy and does not preclude explanations of policies or factual questions about when and how policies were adopted. Would you like to make some opening remarks?

**Mr Stevenson:** Yes, thank you. I would like to focus on three particular issues today. Firstly, is the NDIS reaching the people that it's meant to reach—that is, people with a severe mental illness? Are those people's needs being understood well and is the operation of the scheme designed appropriately to meet the needs of people with a psychosocial disability? In relation to the first point, we have 715,000 people in Australia living with a severe and complex mental illness, and we have currently 28,000 people in the scheme with a primary psychosocial disability. The target, as we know, was 64,000, so we're well short of that. People just aren't getting into the scheme. We don't have a nationally consistent assessment tool that will help us understand, of those 715,000 people with a severe and complex mental illness, who is eligible for the NDIS and who is not. We also rely on certain legislative requirements, such as permanency, to help define that eligibility, and that's not a relevant term for people with psychosocial disability. We've made recommendations in a number of submissions around those key points.

I wanted to focus on a couple of headline points in relation to: is the NDIS reaching the right people? We're well short of the targets. Ten thousand people who were participants of the previously funded Commonwealth programs are still in transition. They're still in limbo. Certainly the Department of Health is working on a process to continue that transition, but we're very concerned because those transitional programs are only in place until the end of the financial year.

In terms of whether people's needs are being understood once they're actually participating in the process of seeking eligibility—and, I guess, the focus of this committee this morning is around planning—we have a number of concerns about the level of training and awareness of planners and the process that people go through for the NDIS to get an understanding of their needs and how that's translated into a plan. Again, we don't really have a specific process of planning that meets the needs of people with a psychosocial disability.

My third point is around the operational aspects. We have been saying for quite some time that the recovery approach is the most appropriate approach and one that has the greatest potential for enabling people with a severe mental illness to participate in and contribute to the community. Over time, government support for people with a severe mental illness will be reduced because people will have been able to improve those aspects of recovery—their personal resilience, their connection to family and friends, and their connection to the community.

We're very encouraged by the decisions that have recently come out of the Disability Reform Council. I think that government as a whole, as represented through the Disability Reform Council, has listened to a number of these concerns around the recovery-oriented approach. The DRC has now resolved to bring recovery, as an approach, back into the NDIS. It will provide a new role, called a recovery coach, to be funded through packages, and will, as I understand it, set an appropriate price for that position. In terms of the operational aspects, I'm pleased to say that there is certainly some improvement happening in that area.

**CHAIR:** Thank you, Mr Stevenson. Mr Nicol or Ms Ofei-Ferri?

**Mr Nicol:** I'll just give a very brief introduction to the role the commission plays in this space, which is probably a bit different to that of other people you've heard from recently. As you know, the commission has a role in government of providing independent monitoring and reporting on the mental health system in Australia. In doing this role, we focus largely on the key reforms that have been happening in mental health in recent years, which include reporting on the Fifth National Mental Health and Suicide Prevention Plan, Primary Health Networks and the NDIS.

With regard to the NDIS, I think there are a couple of key challenges specific to psychosocial disability that probably don't apply to a number of other disabilities in this space: participants often have very complex needs,

depending on the severity of illness, and the episodic nature of psychosocial disability is also a significant difference when compared to other more physical disabilities. The commission is continuing its role in monitoring the impact of the NDIS on all people with psychosocial disability. That includes people who re-enter the scheme and those who do not.

There are a number of key issues that we identified in our submission, including the lack of data about participants with psychosocial disability—this is an ongoing issue for us; the variability in planning outcomes for participants with similar experience—again, it is complex for psychosocial disability, but where you have two people who appear to be fairly similar you often see significant differences in the planning outcomes; and the lack of flexibility in the planning processes themselves, which isn't focused on the recovery-based approach that we would like to see for psychosocial disability. Additionally, not all plans are providing appropriate supports, or they do not include this concept of support coordination, which is a key issue.

The key measures that we identified to help improve the NDIS were to build the capacity of NDIA workers to ensure that the plans are responsive to the episodic nature of psychosocial disability, which, as I said before, is one of the very complex parts of this space, and to increase supports for the participants with psychosocial disability during both the planning and the review process. That need can be very different for someone with a psychosocial disability compared to someone with a physical disability. Through the concept of evaluation we would like to see an evidence base built on what works for NDIS participants with psychosocial disability and to use this evidence to improve both the planning and the review outcomes.

Our specific recommendations for the planning process itself and the NDIA for people with psychosocial disability are that the NDIA should publicly release information about the outcomes of both the complex needs support pathway and the psychosocial disability service stream. We'd like to see support coordination included as a standard item for all plans for people with psychosocial disability. Finally, we'd like more data publicly released about participants for psychosocial disability, including information about the planning review outcomes, plan utilisation and the extent of support coordination plans, and the current rates of expenditure of supports in plans.

I'd say, for us, the key issue with our work in the NDIS space is the lack of information available to us for psychosocial disability and the level of detail that is made available, and the irregular nature of the reporting. The NDIS has made significant improvements in its reporting in its engagement with us, but I think we have just seen the first really good cut of data for people with psychosocial disability in the last couple of months. If we could see something like that on a regular basis and know that it would happen, so we could track progress over the course of time, it would be incredibly helpful. Thank you.

**CHAIR:** Thank you, Mr Nicol. To, Mr Stevenson, and I think to you, Mr Nicol: this scheme is an insurance scheme, so it's based on an actuarial approach to it which is consistent with the recovery model in psychosocial illness. Do the changes which the DRC has accepted, Mr Stevenson, sufficiently reflect that basis of the scheme, and can you perhaps elucidate on that a little bit more? Thirdly, is there more that could be done in terms of developing that aspect of the scheme?

**Mr Nicol:** I guess at the heart of an insurance approach is that the right sort of investment is made at the right time. So the greater that you can target the intervention at the most timely moment is going to produce the best outcome, so that's how I see an insurance approach working. If a company had a higher than normal rate of accidents and their insurance company was looking at that, would they just keep repairing the vehicles or would they start thinking about what the company can do to better educate their drivers, or are there other pressures that are causing the accidents? So it's a more timely, more strategic intervention which will achieve the desired outcome in the long-term. We believe that a recovery approach has been proven to have done that. We've had a number of years, with the support of the federal government across many administrations, to nurture the recovery approach. So we have got evidence to suggest that building the individual capacity and resilience of that person; building the supports with family and friends, which is what we will call upon when we need help, and get people connected into the community, which often will be in the area of getting them into stable housing; the support to enable people to live well; and, potentially for many people, a pathway into employment—all of those things are going to over time reduce the need for additional government support. When you think about the high cost of support that a lot of people with severe mental illness are getting—acute hospital care, or perhaps spending time in prison, or spending long periods of time being homeless—that all costs the government. I know that often that is the state government, not the Commonwealth government, but a recovery approach can reduce outliers in all of those areas. So we've always said that recovery is the best friend of the NDIA. If we can get the recovery approach working well, in essence, that means more capacity building than core supports. We want to get to the heart of what is causing people's reliance on core supports, if you like, and reduce the reliance or the dependency

on those, and increase people's individual capacity and the way in which family, friends and the community get behind them to meet many of their needs over time.

So I think the decisions of the DRC are very close to the mark in relation to all of that. I think that there still needs to be work. Let's identify what is a good outcome from the DRC, and that is the recognition of recovery so that packages that are funded can be packages that support a recovery approach rather than a transactional dependency core approach, if you like. They've recognised the role of a recovery worker by designating this recovery coach position. At every point in which a support worker interacts with a person with severe mental illness, whether it's just through transport or some sort of fairly menial type of support, they are actually building all of those connections—the individual resilience, the connection to family and friends, the connection to the community. It's incidental to all of that support. So, to see all of that come through a recovery coach, where, through the pricing, we can employ people with the right qualifications, the right skills, we need to ensure that they're not working 85 per cent of their time face to face with clients, we need to reduce the billable hours component to make those positions sustainable, we need to provide more supervision and so on. We believe that can be accommodated fairly well within the price that hasn't been published but has been talked about, so that's good.

Where the NDIS pathway needs to improve is that we need to be engaging more; we need to be outreaching to find people. It's almost like a task force type of approach. We don't just rely on that person to front up to the NDIA and go through the process. We need to be finding the people; we need to be engaging the people who know that person. That could be the local police officer, because they're picking them up every week and taking them to emergency. You've got the emergency department people who are seeing people quite frequently, or the homelessness support worker. These are the people who can provide that background and fill in those missing pieces, because a person with a severe mental illness has many, many individual barriers to engaging with the NDIA. Anosognosia is the clinical term for lack of insight that people have about their own illness. There's fear of dealing with government. There's the fear of stigma, which they've always experienced in those sorts of situations. The extent of their illness often prevents them from going through the process. They withdraw. After a while, you can't find them—we don't know where they are—but somebody within their local support network knows where they are, because they are there supporting that person in those residual programs, those homelessness programs or whatever they are.

So I think we can do a lot more to target and identify people, bring them in to the process, support them all the way through and get the knowledge that exists within other sectors, along with the NDIA, to then, as a bit of a task force, if you like, start getting those people into the scheme. There are still 10,000 people who were previous participants of Partners in Recovery, PHaMs, Day To Day Living; they are nowhere near ready to get into the scheme yet; they're in limbo. The department believes that, by the end of this financial year, there will still be 3,000 to 5,000 of those. They need to get that packaged level of support to help them get into the NDIS or to be ruled out, because that's the only way they can be eligible for an alternative support program.

**CHAIR:** Mr Nicol, you said that the more recent data has been better. Is the data that's been collected adequate to base the actuarial work on to ensure that we do get the investment approach working as best as it can?

**Mr Nicol:** Just to clarify, you're asking me about the investment side?

**CHAIR:** Yes.

**Mr Nicol:** I don't know that I know that space particularly well. You probably know it better than I do. But I think it's probably sufficient to make the assessments at this stage.

**Ms Ofei-Ferri:** In terms of the data that has been released so far, the NDIA released a report specifically about participants with psychosocial disability a few months ago, and we've been calling for that information to be made public for quite some time, because we believe that it's important that the public have an idea of who's accessing the scheme and some of the issues that are arising within the scheme. The actuarial side of things is really a matter for the NDIA. We don't really deal with that side of things.

**Mr Nicol:** No.

**Ms Ofei-Ferri:** The information that was released has been quite useful. I think that it would be great if there were a little bit more detail about participant outcomes. As to whether the NDIA actually have this information or not, we're not sure, so in the future we're calling for perhaps, as data is released, a bit more information to be included so that we can really consider these outcomes and look at it over time to actually identify some of the things that are going on, because right now a lot of what we're reporting is based on things that we've heard from various forums—

**Mr Nicol:** Other sources, yes.

**Ms Ofei-Ferri:** and also submissions that have been made and reports that have been released. For the actuarial area, I think that's something that the NDIA can properly respond to.

**Mr Nicol:** I think the gap in our information is really the patient outcome data, effectively. At the moment, as of this new release of information, we've got quite good data on people's access to the scheme—more so than we've had before. For the commission, given our role in government, we'd like to see outcome data accumulate over a period of time so that we can track and see whether the people entering the NDIS, for example, are achieving better outcomes than would otherwise have been expected.

**Senator CAROL BROWN:** I just want to talk about the draft plans. We've received plenty of evidence, not just in this inquiry but in previous NDIS inquiries, regarding the need to give participants draft plans. Is that something that your organisations agree with?

**Mr Stevenson:** Yes, it is. The process of fronting up to a planner and being able to fully express your life's goals, I think, is unrealistic. I come back to the recovery approach once again. Under the Partners in Recovery and PHaMs approach, a person would probably spend about three months with a support worker. If you like, that could be regarded as a type of draft plan. I don't think any of us can come to an appointment with somebody and talk about, really, what are the deep-seated barriers to us achieving our life's goals. I think the current process continues this oversimplification, if you like, of a person's disability, their life's goals and the support they need, and that's why we tend to get more core supports. If a person says, 'Look, I've got no friends; I'd love to go to the movies every Tuesday night,' then, through a very superficial process, they could end up with a plan where somebody can collect that person and take them to the movies. A recovery approach would see that person eventually—it might be in 12 to 18 months—accessing the internet to find out what movies are on, feeling comfortable to leave the home, knowing how to use public transport, budgeting in order to go to the movies and even developing a friendship network of people who enjoy the same sort of movies. So they're achieving their goal, which is a far deeper goal than what they might say in a one-hour planning meeting. So that period of time, with a draft plan, gives that person an opportunity to build up some trust and rapport with a support worker, who can start to peel off all of those layers to really help that person to have a much deeper and more enduring plan for themselves, in terms of how they're going to achieve their goals. I think that's the sort of thing that can be achieved through a draft plan, and, at the end of that period, I think we'll have a far better long-term plan for that person.

**Senator CAROL BROWN:** Did you wish to comment?

**Ms Ofei-Ferri:** I think also, related to that, is the importance of the planners having the skills and the knowledge in mental health to be able to identify the right questions to ask to build that rapport with participants as well. I think that's just an important element of ensuring that the plan is appropriate and effective.

**Senator CAROL BROWN:** The minister announced, earlier this month, that a draft plan summary will be provided, I think from April of next year. Do you have an understanding of what is meant by a 'draft plan summary'?

**Mr Nicol:** No.

**Ms Ofei-Ferri:** No.

**Mr Stevenson:** No, we haven't been involved in any discussions on the specifics of that.

**Senator CAROL BROWN:** When changes are made to the NDIS and announcements are made by government, how do you receive that information? Are you advised by the department?

**Mr Stevenson:** Not directly. We monitor the website to see changes that are coming through. Often there are media releases, depending on the significance of that. And we do rely on the communication across the peak bodies as well.

**Senator CAROL BROWN:** So not directly from the NDIA or from the department?

**Mr Stevenson:** No, not directly. It's also important to note that participants in the scheme rarely get that sort of direct communication. Sometimes that pits the participant against the service provider, because the service provider is enacting a change that has been advised through the NDIA, and the TPP is an example of that. Often, that becomes a sticking point between the provider and the participant because the participant feels that that is coming from the provider, not through the NDIA.

**Ms Ofei-Ferri:** From the commission's perspective, as a government agency, we do engage regularly with the NDIA and the Department of Health and social services about a range of things, but, in terms of the detail of the information we get, it depends on how much they can share, as well.

**Senator CAROL BROWN:** Thank you.

**Mr WALLACE:** Thank you very much for coming in. My question is to Mr Stevenson. You spoke in your opening about 715,000 people being impacted by a severe and complex mental illness but only 28,000 being in the scheme, so this goes to your first point. You also said that there is no national assessment tool re eligibility. Can you just unpack that a little bit for me, please.

**Mr Stevenson:** Yes. The Productivity Commission has updated the figure. In their draft report they have indicated that there are 715,000 people with a severe and complex mental illness. There are two further tiers of that group; it is broken down into a group of 290,000 that have greater severity and complexity, and around 65,000 who require ongoing interagency support—that means support around all of those critical social determinants: housing, employment and a whole range of things—who would not have any or certainly not very much other support through family et cetera. So the question, really, for government as a whole—and I am including state and territory governments too, of course—is: 'How, as a system, do we support those 715,000, and how do we then stream the right people into the NDIS?' because the NDIS was modelled on 64,000. We are comfortable with that in the sense that the NDIS, we believe, is the continuation of the reforms that started with the closing of institutions. There has always been a group of people with severe needs, with complexity, that need absolute lifetime support. They need investment in all aspects of their lives to achieve a quality of life that we all expect. If that's 64,000, that's fine. We then would need to see an appropriate level of support for the rest of the 290,000, the rest of the 715,000. We don't have an evidence based assessment tool that can help stream people—that is, the people who absolutely are the target group for the NDIS—into the NDIS. The K10 is used. It is not perfect. It's—

**Mr WALLACE:** It would be very subjective, I would imagine, for the assessor?

**Mr Stevenson:** Yes, so it is important that we have that type of tool. That tool, when it's designed for its purpose, which is the NDIS, would adequately understand functional impacts of that person's mental illness. So it is a tool both in assessing the most severe and complex but also in assessing then how does that translate to what the NDIS will do for that person in terms of their functional aspect.

**Mr WALLACE:** Is part of the problem that the NDIS is not about diagnosis; it's about the impacts on a person's life?

**Mr Stevenson:** Yes.

**Mr WALLACE:** So it is not a matter of saying, 'Well, you've got a particular mental illness; therefore, you should fall under the banner of the NDIS'?

**Mr Stevenson:** Agreed, yes.

**Mr WALLACE:** Therein lies the problem, right?

**Mr Stevenson:** It does, because there is no tool for functional disability as defined by the NDIS.

**Mr WALLACE:** Not only is there no tool, there could be no tool. Is that right? Is that fair to say?

**Mr Stevenson:** I don't believe there is one in existence. Is it possible to come to that sort of tool?

**Mr WALLACE:** Yes.

**Mr Stevenson:** I think the process of exploring that would get us as far as we could and establish a common understanding then of what that now means in terms of the NDIS. If we can't establish the right tool then we have to establish something else, don't we? That would be my approach to that. I think we would set off with an expectation that we understand what it is we need, and we'll gather the evidence and the people who can inform us in getting to that point. What we learn from that process, if we don't get to that point, would have to then inform some sort of alternative or some sort of agreed pathway to take beyond that, I would imagine.

**Mr WALLACE:** For those unfortunate people that are suffering from mental illness but don't quite make the grade, so to speak, for the NDIS, what lies ahead for them?

**Mr Stevenson:** Well, that's really the task of the Productivity Commission and the government in considering its recommendations from its final report. We have been proposing a national psychosocial recovery program that sits around the NDIS. We do have some commitments in place. The Commonwealth has a range of transitional funding, continuity of support, the national psychosocial program and the transition component of that. The states and territories have some funding outside of the NDIS as well. So our proposal has been to use those commitments to start establishing a national psychosocial recovery program. The Productivity Commission is certainly approaching it along those lines as well. They have come up with some preferred models which I think are very much open for discussion and debate, but we would see the future for that group of people as coming out of the governments' consideration of the Productivity Commission. We will be, as we have been, meeting with the commissioner and putting forward our views about that.

**CHAIR:** Thanks, Mr Stevenson. Mr Nicol or Ms Ofei-Ferri, do you want to add to any of that?

**Mr Nicol:** The problem I suspect we really have is that we know who's in the NDIS and we very loosely know who's in primary care, via the limited data available from GP visits, but what's often referred to as this missing middle—which is the gap between going to see your GP, getting your prescription for your antidepressant and then the emergency department—is a section of the community that is well described but not well defined. Until we have some sense of that need, I think it makes it very hard to plan for how to address that gap.

**Mr WALLACE:** The NDIS was never intended to cover the full spectrum by any stretch of the imagination.

**Mr Nicol:** No; I guess the problem is that, because we don't know that group, it may be that there are people who could and should be in the NDIS and who are not. I think we just don't have a sense of what that need is. We know that the numbers are short—the numbers anticipated to be in the scheme are not there—and we don't know all of the reasons as to why we haven't met that target number.

**Ms Ofei-Ferri:** On that point: one of the challenges with mental illness or psychosocial disability is that this particular group of people still need to access services within the mental health system and the broader health system—really understanding the role of the NDIS, what they are responsible for, versus the role of the mental health system, whether they can actually be distinguished. I think it is really hard to separate them. This is where some of the work that is coming out of the Disability Reform Council will be really useful and will go some way to addressing in terms of that mainstream interface. We'll be watching that closely over the next 12 months or so.

**Ms PAYNE:** I was going to ask a similar question to Mr Wallace around those federal programs and the transition. What are the time frames around the response that you've mentioned?

**Mr Stevenson:** We have the continuity-of-support program, which essentially is ongoing but obviously needs to be put onto a more sustainable pathway into the future. We have the transition funding, which was due to finish at the end of last financial year and was extended to the end of the current financial year. There are still 10,000 people in that particular program. That commitment ceases on 30 June 2020, so there are still 10,000 people in limbo. The department believes 3,000 to 5,000 people will still be in that category at the end of June and the department is engaging with a range of stakeholders to consider what a longer term or more sustainable arrangement could be. On the basis of the work that's being done, options will be put to government about what could be done for the ongoing support of that group.

We are very supportive of the approach the department has taken. We know the minister understands the situation for that group of people. That to some extent is an unintended consequence of the process and needs to be resolved. Steps will need to be taken for a process, potentially, to identify funds within the system or additional funds that might be needed to continue to support that group, but we don't believe in open-ended transition. We believe that the legacy programs, if you like, need to be rolled into something more sustainable, based on a true assessment of what the government's role or responsibility is for that group and whether there are support options elsewhere in the system—a more sustainable way of continuing to move through that transition process.

**Ms PAYNE:** Thank you.

**Ms COKER:** Good morning. Mr Nicol, could you expand on your statement in the intro about the need for more responsiveness to the episodic nature of mental illness—that that's going to be of value.

**Mr Nicol:** The key issue is that, based on the timing of an assessment, you could be anywhere from feeling absolutely fine to feeling desperately in need of help. Unlike a physical disability, with a psychosocial disability, given that variability, the timing of an assessment in conjunction with the timing of where a person is in their illness can be critical. You can go for long periods of time without an issue whatsoever and then be unable to work for an extended period of time. That issue has not been a fundamental part of the assessment process. We know that the NDIA has stepped up its training on psychosocial disability for the people doing the planning assessments in order to address that. Given the model was initially based on permanent physical disability, that was the approach with which assessments were initially undertaken. The NDIS certainly worked very hard to try to move towards a better understanding of people doing assessments and take into account the fact that how someone is presenting on the day is not necessarily a reflection of the last six or 12 months of their life, nor the future. You might want to add something.

**Ms Ofei-Ferri:** I think you've covered it. It's also important to note that it also relates to how participants use the funding within their plans as well. Mr Stevenson talked about how many of the plans are heavily weighted towards core supports, whereas, for many people with psychosocial disability, the supports they need are around capacity building and that kind of stuff. Being able to have a bit of flexibility within the plans and being able to move funding to areas that they need is really important.

**Ms COKER:** What you said is actually reflected in my own electorate of Corangamite, in Victoria. A number of people with psychosocial issues have come to see me and said that, in their plans, they've basically been cut off from funding. They've had to go through significant reviews. They've been asked things like: 'Can you drive? Can you cook? Can you do things like that?' They can. At times they're very good at arguing their own case, but I suppose what it comes down to is: do planners who are dealing in this area at the moment have the necessary training? And do we need to have, across the board, specialist planners in the area of psychosocial disability?

**Ms Ofei-Ferri:** One of the recommendations that we made was around the release of information about the complex support needs pathway and the psychosocial disability stream. There have been some trials around that—how they have worked. One of the reasons we recommended that was that both of those include specialised planners, so people will have a greater understanding about psychosocial disability and its impacts. I think that, right now, we don't know what works or why it doesn't work, and vice versa. It will give an indication of whether these specialised planners are actually effective for this group. We have to acknowledge that the NDIA are actively working on building the capacity of their workforce right across the board in terms of understanding mental health in general, but they're also investing in building the knowledge of the specialised planners as well. So I think it will take time for us to see the impacts of that. But certainly I think specialist planners are very important for this cohort.

**Mr Nicol:** Then it comes down to the availability of our outcome data. If we can see the benefits of this specialised planning approach and have that information available to us and know that it produced a better outcome for clients, we would be able to say, 'This is what you need to do; roll it out nationally.'

**Ms COKER:** So a bit of a data around it to show evidence of success?

**Mr Nicol:** Yes, the effectiveness.

**CHAIR:** Thank you for your submission and for coming along today and discussing it with us.

**Proceedings suspended from 11:55 to 13:23**

**AIKMAN, Mr Hamish, Head, People and Culture Division, National Disability Insurance Agency**

**BROADHEAD, Mr Peter, Group Manager, Participants and Performance, Department of Social Services**

**LYE, Mr Michael, Deputy Secretary, Disability and Carers, Department of Social Services**

**McNAUGHTON, Mr Scott, Acting Deputy Chief Executive Officer, Government, Communications and Stakeholder Engagement Group, National Disability Insurance Agency**

**NEVILLE, Ms Liz, Acting Head, Markets, Provider and Sector Development Group, National Disability Insurance Agency**

**RUNDLE, Ms Vicki, Deputy Chief Executive Officer, Participants and Planning Experience Group, National Disability Insurance Agency**

**WHITECROSS, Mr Andrew, Group Manager, Participants and Performance, Department of Social Services**

**CHAIR:** Welcome. Thank you for appearing before the committee today. I remind officials that the Senate has resolved that an officer of a department or agency of the Commonwealth or a state or territory shall not be asked to give opinions on matters of policy and shall be given reasonable opportunity to refer questions asked of them to a superior officer or to a minister. This resolution prohibits only questions asking for opinions on matters of policy and does not preclude questions asking for explanations of policies or factual questions about when and how policies were adopted. Would either the department or the agency—or both—like to make some opening statements?

**Mr Lye:** No, thanks.

**Ms Rundle:** No, thank you.

**CHAIR:** I want to ask you about some factual things in relation to planning. Of the plans that are submitted to the agency, in what proportion of those plans does the delegate actually have a face-to-face or even phone conversation with the potential participant?

**Ms Rundle:** Firstly, it's our intention that every participant would be given the opportunity to have a face-to-face meeting with a planner or a LAC. And if they—

**CHAIR:** Can I stop you there, Ms Rundle?

**Ms Rundle:** Yes.

**CHAIR:** There seems to be some confusion. The description 'planner' is used whereby that seems to include these days both an LAC and a delegate.

**Ms Rundle:** Yes.

**CHAIR:** So maybe I could be more specific in my question. What proportion of participants or potential participants in the scheme will have or do have a conversation either face-to-face or by telephone with the delegate?

**Ms Rundle:** I will give you a general answer and then possibly my colleague might wish to add something to that. I can't give you a percentage at the moment for that particular group that you're talking about. I can say on a general note, because that goes partly to the joint planning pilot that we have been running, we aim for the delegate to sit down as much as possible with the participant at the planning meeting. I'm sort of trying to pick a general figure but currently it would be around 20 per cent of our planners who look after our complex participants would do both the planning and also would do the plan approval with that complex participant, because the remainder of participants generally would be dealt with by LACs, and then the delegate would receive that plan for approval.

**CHAIR:** So that means, if I understand you correctly, that in about 80 per cent of cases the participant only has a communication whether in person or otherwise with the LAC?

**Ms Rundle:** Yes, but in saying this, I'm trying to give you a general view of the percentages. It might be a little bit different. We will have to go away and see if we can get the answer.

**CHAIR:** I don't need the exact proportion but, in ballpark figures, four out of five participants have a conversation or an interface with the LAC and not with the delegate?

**Ms Rundle:** Yes, except in instances where there might also be follow-up calls, where a delegate could call a participant. But in the general sense, the answer to that, I think is, yes, unless my colleagues—

**Mr McNaughton:** No, that would be right.

**CHAIR:** Was that always envisaged as the role of the LAC? There seems to be some different views being expressed about this. Originally the role of the LAC was providing information to potential participants but now the LAC seem to be overwhelmingly, if it is four out of five roughly—even if it is three out of five—doing the majority of the planning or the plan building, if I can put it that way?

**Ms Rundle:** That's correct. In trial, we didn't have LACs to speak of, except some like positions within the agency. But when we started to look at our model as we scaled up, we acknowledged that around 80 per cent of participants fall into a category that we call 'general' or 'supported'. They don't have the same complex needs that perhaps the other 20 per cent of participants may have. That does vary a bit. Our learning is that that is shifting around a little bit between different groups of disability. But in general, that was how we approached it. We then said that, because of the way that LACs are nestled within the communities and understand the connections between the community and mainstream and often had relationships with some of these participants through other means, they were best placed to deliver the general and supported preplanning and—you're right—develop all the information that would generate a plan. Then what happens is the plan is pushed through the system to the agency delegate, who then makes the decision. So the LAC planner isn't the delegate.

**CHAIR:** And the LAC's role has evolved. It effectively now has three functions: firstly, providing information to potential participants; secondly, building the plan; and, thirdly, monitoring and helping with the implementation of the plan for the participant.

**Ms Rundle:** That's right.

**CHAIR:** So, effectively, the LACs are the gateway to the NDIS, except in the complex cases.

**Mr McNaughton:** And early childhood cases.

**CHAIR:** And the early childhood—that's correct, yes.

**Senator CAROL BROWN:** The Brotherhood of St Laurence is now doing the early childhood cases.

**Ms Rundle:** Yes.

**Mr McNaughton:** We've got a few partners—you're right, Senator—who are doing both, but they often have different skill sets within their groups to do that.

**CHAIR:** LACs are obviously the crucial people in this scheme. I'm not diminishing the role of anybody else, but they're the ones with whom the interface between potential recipients and recipients of NDIS funding occurs. In terms of the organisations for which the LACs work, what are their KPIs?

**Ms Rundle:** We do have contractual arrangements with each of the LAC partners, and there are KPIs in the contract. I will need to get you the detail, if you'd like the detail of the KPIs—

**CHAIR:** Yes, thank you.

**Ms Rundle:** but they go to things like volume, quality, timeliness—the sorts of things that you would expect to see in a contract—and a lot of subsets of those. We've been doing some work over the last six to 12 months trying to fine-tune those KPIs in the contracts for all of our LACs and ECI providers.

**CHAIR:** We'd appreciate it if you could provide the details to us.

**Mr WALLACE:** When you provide that information on notice can you provide information in relation to the touchpoints for how that LAC is paid?

**Ms Rundle:** I can probably answer that for you now. They're not paid on touchpoints. What happens is, for each of the partners in localities, we look at the service delivery operating model that we have in the agency, and the scheme actuary will look at the number of participants who are either coming into the scheme new or from states and territories, including plan reviews for participants already there in that group. We work out how many people we think that partner would need to support. Included in that is the ILC component, the 20 per cent of their contract that is about information linkages and community capacity. What we do is pay them on bulk, but we pay them regularly. We pay them at intervals during the year, but we don't pay them according to how many people they see at each point in the pathway.

**Mr WALLACE:** They don't get paid, for instance, on how many plans they might write?

**Ms Rundle:** We do have targets in the LAC contracts, but I would need to take that on notice and check that for you and get the details.

**Mr WALLACE:** If you can provide that information, that would be very helpful.

**CHAIR:** It's been suggested to us, and it might not be correct, that the LAC organisations, if I can put it that way so as to distinguish them from the individual person or organisation employing the LAC—again, the language is used a bit interchangeably here, so I'm trying to be more precise—get paid per plan submitted?

**Mr WALLACE:** And that that's the only time they get paid.

**Ms Rundle:** No. To my knowledge that is not correct.

**CHAIR:** Thank you. If you can provide us with that information, that would be useful.

**Mr Lye:** It's more like a block grant.

**Ms Rundle:** That's right; it's a block grant.

**Mr Lye:** I think it's a quarterly interval.

**Ms Rundle:** They're probably paid quarterly, but I'd just need to check that. But it is exactly like that; it's like a block grant. We've currently got a tender out for New South Wales because the contract for those providers has come to an end. Once we work through the tender process, we'll contract them for a period of time—a couple of years, two to three years—according to the KPIs. The payments will be made at intervals based on performance in the contract. But it's not based on an individual plan.

**Senator HUGHES:** Has there been any incentive for organisations that are LACs to keep people at the LAC level and not request support coordination to see them move into the NDIA's field of planning? Is there analysis of whether someone has complex needs and requires support coordination? There's no payment-driven issue for them to keep people within their organisation?

**Ms Rundle:** No, I don't think so. Particularly if you look at our complex participants, although they're not the group we're talking about, most of them will have support coordination in their plans. The general view is that an LAC would take the lead in implementing and supporting a person, so it's unlikely that an individual would need both a support coordinator and an LAC. But it's not true to say that it does not happen, because it does sometimes happen for good reasons.

**Senator CAROL BROWN:** Ms Rundle, what do you mean when you say that you're working towards participants being able to have face-to-face meetings with planners? What has been demonstrated is that sometimes the terminology is interchangeable. We want to make sure we get this correct, so what do you mean?

**Ms Rundle:** We mean whichever group you would expect to have the planning conversation with the participant, be it an LAC in the first group I talked about—that 80 per cent—or the complex cases. We would expect that participants can have a face-to-face interaction with the individuals they are helping with their plan.

**Senator CAROL BROWN:** So, when you say 'planners', you include LACs?

**Ms Rundle:** We do.

**Senator CAROL BROWN:** That's probably not what we were believing to be the case. I think it's fair to say that we were under the impression that you meant planners—

**Mr Lye:** Delegates.

**Ms Rundle:** Yes. I have to say that I think we haven't helped in that clarity at all, because over time we have used the terms interchangeably ourselves. We need to give thought to how we distinguish the roles of the agency, the planner, the delegate and the LAC. I think your observation would be pretty on the mark.

**Senator CAROL BROWN:** The LACs can't print out draft plans, can they?

**Ms Rundle:** At the moment, the only way the LACs could print out a draft plan would be to send that plan to their email—not an NDIS email—and print it out for a participant, which of course is not something that we'd encourage because then we know that it's been sent to an unsecure email. The chief information officer is currently arranging for something he's calling a 'bring your own device', which you may be familiar with, for the LACs. That will be available towards the end of January. That will allow them to print—

**Senator CAROL BROWN:** Regarding the system that's been put together for the NDIA, was it the Department of Human Services—

**Ms Rundle:** Yes.

**Senator CAROL BROWN:** It hasn't got the ability to allow a planner to print out a plan.

**Mr Lye:** It's locked down for security reasons rather than being not capable. I think that's the way we'd describe it.

**Ms Rundle:** The LACs are on different systems and different platforms, although they access our CRM, so their printers are not secure DHS printers in the same way that ours are. What we are trying to do is work out a

solution, and we have, that would enable them to print securely so that the security procedures are adhered to on the spot.

**Senator CAROL BROWN:** If we get down the pathway of providing a draft plan, you're working on enabling some sort of workaround for the LACs to be able to print out this document?

**Ms Rundle:** Yes. I just need to make one thing clear, though. With draft plans, you are talking about two things. One is printing the document, which I think I've answered. We've talked about draft plans and plan summaries in the past, and often we get asked: 'When will that be possible?' One of the things we are doing at the moment is evaluating the South Australian pilot and understanding the impact of that to see whether there are even better ways of giving people earlier visibility of their plans and having more input. It could be a draft plan, but it could be something that works better.

**Senator CAROL BROWN:** You mentioned 'draft plan summaries'. I hadn't actually heard that terminology before, but I may have missed it. I know the minister mentioned it a week or so ago. What does that mean? What's in them?

**Ms Rundle:** One of the things that we've been trying to do is fix the printing of draft plans. We were trying to work out whether there was also another way in which we could give participants earlier visibility of the conversation they had just had with the LAC and the planner so that they at least had something with everything they'd talked about and asked for or thought that they required, including their goals, captured in a document that they could take away at the end of the planning session so that at least there'd be an acknowledgement that this was a conversation that had been had between both the LAC and the participants. We were looking at that as another way of trying to get earlier visibility for a participant. But, as I was saying, what we are now quickly doing is evaluating the pilot in South Australia to make sure that that's the best way or whether there's an even better way.

**Senator CAROL BROWN:** But hasn't it already been announced that it's going to be implemented in April 2020, or have I got it round the wrong way?

**Ms Rundle:** Joint planning or—

**Senator CAROL BROWN:** No, the draft plan summaries.

**Ms Rundle:** Yes, it has. That's our intention. Our intention is to proceed with the commitment that was made. What I am really saying to you is that, if we find in the joint planning evaluation that we are doing that we can do things better and differently, we would always look for that opportunity. But we know that that's the commitment.

**Mr WALLACE:** Ms Rundle, I'm getting very confused about the difference between a joint plan and a draft plan. What's the difference?

**Ms Rundle:** The joint plan is the process by which the planning conversation takes place, and 'joint' refers to an LAC and a planner delegate sitting down together.

**Mr WALLACE:** With the participant?

**Ms Rundle:** Of course, yes—with the participant. A draft plan is what it says it is: it's a plan in draft form before it's approved.

**Mr WALLACE:** Yes, but I assume the draft plan would be when the LAC and perhaps the delegate would sit down with the participant and say: 'This is the draft. This is the direction we're moving in. What do you think?' What's the difference between that process and the joint planning process?

**Mr McNaughton:** That is the joint planning process. It's exactly as you've outlined. It's where all the parties are in the room and they can have a look and make any minor adjustments, asking: 'Have we captured the goals right? Have we got your outcomes? Have we captured informal support? Here's how your plan's shaping up with all the supports in it.' You can make any minor adjustments and you can approve the plan on the spot. That's the process of joint planning. You review the draft plan in that conversation and then make any adjustments if you need to, as I said. From what we saw in South Australia, we were able to approve about 90 per cent to 91 per cent of plans in that meeting. That is quite different to—

**Mr WALLACE:** Sorry to cut you short, but I have to catch a plane. Whilst that principle sounds very good, and it is worthy of further investigation, what some of the participants are saying is that they felt like they were having a gun held to their head, being told: 'We're in a joint session. This is the draft. This is where we're at. This is the plan. If you don't like the plan, we will have to go back to the drawing board and it's going to be another three months or so before we have this conversation again.' Some parents are saying to us they felt like they had a gun to their head. They felt like they had no other option but to say yes.

**Mr McNaughton:** That's certainly not the intent of how the joint planning should go. So if that is happening in certain cases then that's what we need to straighten up as part of our training for our LACs and our planners, because that is certainly not the intent. It is a genuine collaborative conversation that we should be getting out of that. The ones I have seen and heard haven't gone like that, but you are getting the feedback so it is something we need to look at. If we are going to roll it out nationally we need to get all of those things right.

**Ms COKER:** Thank you. I will try again. Partner organisations are, obviously, very important and the LAC role is very important in creating the plan. How do you work with an organisation to ensure that there is quality of process in developing that plan, that there is real rigor around the monitoring of a plan by the LAC and that there is sufficient discussion with the participant around implementation? From what I've gathered there is perhaps too much emphasis on submitting a number of plans at the detriment of the other two. Are there KPIs for an organisation? The other issue is around training of LACs. From what we have heard the level of training is not always sufficient to be able to create a plan. The next point around the LACs is the workload. It seems to be very variable. You can have one organisation which will have 100 case load and for the same amount of time as someone else who might have 65. If you can respond?

**Ms Rundle:** I might make a quick comment and then hand over to Mr Aikman about the training. The first question you asked—there were three I know, and I didn't write them down. The first one was—

**Ms COKER:** The first one was around how do you actually monitor the organisations and the processes?

**Ms Rundle:** The first thing I think we'd probably all agree with is that in transition, where we had large volume, it is fair to say that the experience of participants in some places was that they did feel like it was very fast. It wasn't considered. They felt rushed. I think there was a lot of pressure on everyone to get people in and get the volume in. What we've seen now is a gradual move to making sure that quality is the thing that we focus on. We always tried to focus on quality but sometimes we heard stories that that was lost. One of those things in the KPIs—a number of things—will go to quality and the quality of the participant experience. The other way that we find out about how participants feel about their experience is through the participant satisfaction survey. If you look at the quarterly report, we now have a new satisfaction survey which looks at every part of the planning process and people can tell us what they thought about every part of their journey. That is helping us get some insight into where we need to put in place better processes and better training. So that would be the first answer. The second one goes to training.

**Mr Aikman:** I think there's been quite a significant investment that's been made in training, particularly over the last 12 to 18 months. As Ms Rundle had said it is with the intention of improving the quality of the training of planners, delegates of the NDIA as well as partners. In particular—

**Ms COKER:** So LACs, for example, how do they get that training? Do you provide the training to them regardless of the organisation or does the organisation provide that training?

**Mr Aikman:** It is a combination. We have a number of facilitators that are NDIA facilitators but we also partner with the LAC organisations to deliver that training. In terms of getting consistency of that approach, we've developed a six-week training program. It's a mixture of classroom based self-paced learning, leader led training and on-job experience to improve all the ranges of things that people need to understand as part of being a planner. There are 18 modules within that program. There are a number of e-learning modules as well. It's really designed to ensure that planners have fully completed that induction before having interactions with participants.

**Ms COKER:** This is the LACs or the delegates?

**Mr Aikman:** It's both. In addition to that, we're also aware of feedback around understanding of participant needs. We put quite a significant focus around disability awareness across the organisation. We have a number of modules which everyone across the agency, and in partners as well, is expected to complete. It ranges from a number of different disability types. We've developed a number of modules—written documents and snapshot videos as well. These are about participants talking about their experience and helping to educate planners and LACs around what will work for them best in terms of the way in which to interact. We are doing these things to try and improve awareness across the whole agency and, in particular, for frontline planners.

**Ms COKER:** Is there any onus on an organisation, in the reports they provide to you, to show that the LACs are doing work that is of the required quality? Or is it all up to responses back from participants?

**Ms Rundle:** Quite a large part of the agency looks after the LAC contracts and also the relationships with all the partners. They get together and have best-practice discussions around what works and what doesn't. They do a lot of relationship management; they talk about their learnings elsewhere to other partners so that they can import those learnings into their practice. So we have a range of things that we do. We treat them a bit like our own

workforce. They are not our workforce but we include them as part of our workforce. We would expect the same standard, the same training—all those things are to be pretty much the same for them as they are for us.

**Ms COKER:** Do you think all delegates should see a participant at least once before they tick their plan?

**Ms Rundle:** They don't at the moment, as I explained earlier. This is why we are looking at joint planning. If they ever have a question, though, about a plan construction, they can ring the LAC and, if they wish, they can ring the participant. At the moment, that isn't the case everywhere because we've only just trialled joint planning. But, where we do joint planning, that's what happens.

**Ms PAYNE:** In Adelaide earlier in the week we had the opportunity to question the NDIA about the soft launch of joint planning and what will be rolled out going forward. I just want to confirm that in the joint meeting, if the participant is not happy with the plan that is put forward, the option is to go to review.

**Ms Rundle:** I would characterise it a bit differently. I hope that wouldn't be the trajectory, in fact. I hope the whole point of joint planning is to have the discussion; it's a bit like a partnership. If they don't agree with the plan, the planner and the LAC should be talking about what isn't working, why they think they need a particular thing, whether they have considered this or whether they have considered something different. But you would come to some accommodation such that they wouldn't go away and think they had to review their plan.

**Ms PAYNE:** That conflicts with what we heard at the hearing. The NDIA confirmed that, in instances where the participant wasn't happy, there isn't an alternative to go away and think about it again or come back. If they are not happy, it is a review. Then we had a mother of a participant present in the town hall section, and she said that she had to agree to a plan that she was not happy with because the alternative would've been months without any plan.

**Ms Rundle:** I can make a couple of points if it's helpful. The first point is: some of the experiences you've talked about are not experiences that we would want people to have. The second point is: I just want to make it clear about the act and what the act allows for, because the NDIA people present earlier in the week may have been answering a technicality, and they're right that, if a person has a plan that's approved and they're not happy with their plan, they can seek a review of that plan. The first thing they can do is to seek a review, but not a section 100 review, which I think is what you mentioned. They seek a different sort of review, which is: 'Can you have a look at my plan and have a look at the decision you made, and can we just work out whether or not you would reconsider those things?' Often we'll get a more senior person or someone else to look at that plan, and sometimes those plan decisions do change. So the NDIA people, if they did say earlier in the week that the next step is a review, were correct, technically. What I'm saying is that the whole point of joint planning is not to get to that point.

**Ms PAYNE:** So you'd envisage that there will be an opportunity for discussion. I understand that one of the learnings in what will be rolled out which is different to what's happened in the launch is that people will have access to the plan summary, but we also understand that the plan summary does not include the funded supports.

**Ms Rundle:** That's interesting. They must have talked about the plan summary earlier in the week—

**Ms PAYNE:** My understanding of the joint planning process that will be rolled out is that, after the participant meets with the LAC, they will receive a plan summary. Then they'll have the joint meeting with the LAC and the delegate, at which point they'll accept their plan or, if not, they'll go to review. But they did say that it's a plan summary, not in fact a draft plan that the participant will have prior to that joint meeting.

**Ms Rundle:** That's right. And so they'll have everything else—their goals, and the sorts of things I talked about earlier: their particular circumstances, what the supports are that they currently receive, and what other supports they might need. But that doesn't have a dollar figure on it, to my knowledge—not yet. Then the whole point of the joint planning meeting is that there's an alignment, a meeting between the LAC and the planner to talk about the plan, prior to meeting with the participants, so that they're ready to be able to talk to the participant. That's all part of the joint planning process. Then they can sit and talk to the participant about the plan and the value in the plan.

**Ms PAYNE:** So what's the reason they can't have the full draft plan?

**Ms Rundle:** With the dollar value in it?

**Ms PAYNE:** Yes, the full draft, for their full consideration?

**Ms Rundle:** I said earlier when I was answering Senator Brown that, whilst we're committed to giving draft plans by April, we've had some learnings out of the joint planning meeting, and they're all the sorts of questions we'll be asking, I think, as we evaluate the joint planning process.

**CHAIR:** Just on that: I specifically asked the NDIA officers: 'Was there any technical reason why the participant couldn't be given the draft plan, with the supports, prior to meeting with the LAC and the delegate?' and the answer was that there was no technical reason why this could not be done.

**Mr McNaughton:** The plan summary's really important because, when we unpacked why there were lots of unscheduled reviews at the start, it was because we haven't got the goals right or the informal supports, or we hadn't understood the role a carer played in their life. So there was quite a big proportion of plan reviews because those basics weren't right in the first place. After the first meeting with the LAC, that's where those issues are discussed, and that's why you get the plan summary. That's why we're testing. So we're getting the first foundation elements correct—

**CHAIR:** But a week later, Mr McNaughton—we seem to be going around this. I have this sense of *deja vu*, because I've sat in this committee in the previous parliament and we've had these discussions, and I feel like we're having the same discussion and hitting our head against a brick wall yet again. If we're going to have joint planning, then it's only fair, surely, to the participant and the family of the participant, that they can be given a copy of the draft before they turn up to this meeting, because, as other members of this committee who were in Adelaide and elsewhere on other occasions have been told, people feel they are pressured when they go along to a meeting and they're told: 'This is the plan.' They feel it's a take-it-or-leave-it exercise. They feel that if they don't take it then they will be put on the never-never for the next three, six, nine months until it is resolved and they are missing out or their child is missing out on support. Now I don't understand, for the life of me, why in this process a proper, fully detailed draft plan can't be given to the participant and/or their families a few days before they have that meeting. As I said, we were told there is no technical reason why that can't occur.

**Ms Rundle:** I probably conveyed it poorly in the beginning of the hearing that it is our intention to try and get the most information to a participant that they can have so that they understand exactly the discussion that's been had and the supports in the plan. The reason—

**CHAIR:** I hear you saying it is your intention, Ms Rundle. I don't query what your intention is. But between the cup and the lip, there seems to be a lot of spillage in the building of this program. If there is no reason why this can't be done, I suspect most participants would say to us, 'We would sooner wait another few days or another week and get the full detailed draft plan so that we can think about it, discuss it if need be with the OT or the physio or the support coordinator or the agency that we're dealing with, and then go to the meeting and be in a position to be able to resolve this in a way, once and for all.' I can't see, from the agency's point of view or the government's point of view, why this shouldn't occur because, surely, if you do that, it's going to reduce the number of reviews and it is going to reduce the number of cases that go to the AAT, *et cetera*, *et cetera*. It just seems to me this would be a cost saving to the government to be doing this.

**Ms Rundle:** I said earlier that one of the things we're doing is looking at the joint planning pilot. With all of this feedback, there are learnings now that are giving us cause to think about: how can we improve the joint planning process? That is why I said earlier to Senator Brown we would look at all of those things and that's what we're doing now. I wouldn't want to disagree with anything you have said in principle about the participant having the right to have everything as early as possible. We need to go away and take all of this feedback, including yours, and think about how do we make that happen.

**Senator CAROL BROWN:** So are you saying here that you're going to go back and look at providing draft plans, properly costed draft plans, now in conjunction with draft plan summaries? Is that what you are saying?

**Mr Lye:** Yes, we will do that. To be fair to the NDIA officers, when you go back and trace the work that's been done around the pathways and around the planning process, to correct for issues which we got extensive feedback on, the first iteration was the use of phone planning not being acceptable, that people wanted face-to-face interaction. Obviously that learning is trying to be addressed. I think the other thing is people saying that, through the LAC process, that plan gets submitted and the plan might be altered by a delegate for good reason but that might be a surprise. The joint planning is an evolution which deals with that. I think when decisions were made around what was the right way to do all those things, I don't think that they envisaged the need for draft plans to be provided to people. I think they thought the joint planning was the way in which you would do that. But obviously we're hearing your strong view on this. You're hearing that from people who have been part of the inquiry. I think, on that basis, we need to take that away and need to come back and say, 'We have looked at this and we'll do it,' or 'For whatever reason, we can't do it'.

**Ms PAYNE:** We have heard some absolutely shocking examples of planning meetings through this process. We've heard of parents being asked, 'Do you really need a wheelchair if you can carry your child around?' 'Why should we look at toileting aids when incontinence pads are cheaper?' We have heard of people being told to use

YouTube to teach their child Auslan. We've heard of people with two prosthetic eyes being asked to go and prove they are blind. Why is this happening? Why are the planners asking these questions?

**Ms Rundle:** Can I say that all of those examples are completely unacceptable. It is just so far from the experience we want people to have. It does go to the training and the supervision of our planners and remembering that our planners do the best they can. We've had a rapidly growing workforce, and I'd ask people to think about any other rapidly growing workforce anywhere that doesn't have the same—it's not good—issues with not always getting consistent decisions and consistent and appropriate and empathetic approaches.

**Ms PAYNE:** What training is being provided to address that gap? Are you saying that we need more staff at the NDIA?

**Ms Rundle:** No. I can ask Mr Aikman to talk about the training again, and go through it in a bit more detail if you'd like, but you know we were also given recently more ASL. At the moment, we believe we're still recruiting. Our experience is that we will have sufficient numbers to be able to do the sorts of things we need to do, but we also need to train them and get them working consistently. I would like to put a plug in for our planners. I realise it's not always perfect, but none of them mean any malintent. I just think sometimes it's very inappropriate.

**Ms PAYNE:** I don't mean to attack the planners. They need to be given the proper training to perform this very important job that they're doing. We've also heard from providers and disability groups they've offered to provide the specialist training on their particular area of disability or their particular area, like assistance aids, and that those have been rejected by the NDIA.

**Ms Rundle:** I'd love to get some examples, and we'd approach those organisations, because we've been doing a lot of work with organisations, including DANA, who has been helping us gather all of these videos of different disability types, with participants actually in the videos, and helping us understand how we can do it better. We've worked with motor neurone disease associations and right across the disability types—with the autism organisations. So, if there are any more examples, I'd be very happy to know about them.

**Ms COKER:** In relation to the LACs, do you have specialist LACs that plan for people who, perhaps, have psychosocial issues or particular complex needs? Do you have specialist planners, and is there a need for those?

**Ms Rundle:** We do. We have specialist complex people. We've got a cohort of planners that we call our complex planners and we have a group of planners who look after young people in residential aged care, and they are particularly trained in those areas. And, for psychosocial, we're just finishing rolling out our psychosocial training, and there are particular planners across the agency who've got more skills and a better understanding of people with psychosocial needs.

**Senator CAROL BROWN:** Sorry, Ms Rundle, do you have an understanding in terms of the LACs, who are doing 80 per cent of the case load, that they're often being described as generalists? Do they have specialist LAC planners embedded in their organisations? And, if so, what's the percentage, because I don't think I've met one that described themselves as a specialist planner?

**Ms Rundle:** I would actually need to think about that and ask. I think you'll find in all of the organisations there'll be people in them who gravitate more to working with some sorts of participants, because perhaps their background in the past has leant themselves to that. They could be an allied health specialist. They could have worked elsewhere in psychiatry. So you will find there will be pockets of people right across the LAC partners where they are more—

**Senator CAROL BROWN:** But there's no requirement then?

**Ms Rundle:** Not to my knowledge, but I actually would need to check that.

**Senator CAROL BROWN:** So, for the organisations that are doing 80 per cent of the case load, there's no requirement for them to have specialist training?

**Ms Rundle:** Can I add, though, that all the people with complex needs, who you'd expect to need the specialist training, get streamed into the agency to agency planners.

**Senator CAROL BROWN:** That's your view: that people in nursing homes, and other participants with very complex needs, go to the NDIA planner? That's my understanding.

**Ms Rundle:** That's right.

**Senator CAROL BROWN:** But it's your view that, for those 80 per cent that are dealt with by LACs, there doesn't need to be some understanding or specialist training in terms of the participants that are dealt with there?

**Ms Rundle:** I didn't mean to convey that, so, if I did, I'm sorry. No, I don't think that's right, because often a number of participants will turn up to an LAC, and some people have episodic needs and some people do actually

need more specialist support at some points. At that point, the LACs generally will contact us and they'll often ask us if that person can come into the complex stream. But it's fair to say that your observation—

**Senator CAROL BROWN:** I don't want to interrupt you, because I understand that pathway, but we've heard comments that participants and their families, where someone may have cerebral palsy, have been asked whether they'll grow out of it. That tells me that there is a general level of absolute misunderstanding of what should be a pretty straightforward situation. So where is the training, and what training is actually occurring, other than training around what the processes are?

**Mr Lye:** Could we take it on notice and get back to the committee on the training? There is a substantial amount of training which recognises some of the issues that you've raised.

**Senator CAROL BROWN:** Compulsory training?

**Ms Rundle:** Yes, a lot of it is. They actually can't work with participants until they do it.

**CHAIR:** That would be useful, Mr Lye, if you could, between the department and the agency, give us a full overview of what the training package is.

**Mr Lye:** Yes.

**Ms Rundle:** We're very happy to do that. We have provided it before in answer to various questions on notice, but we're very happy to do it again.

**Senator CAROL BROWN:** Today we're having a town-hall-style discussion where we'll actually be hearing from families. I just invite you all to stay.

**Ms Rundle:** Thank you.

**CHAIR:** I'm going to wind up at 2.15. We can have two quick questions.

**Ms PAYNE:** I have a quick question on transport. We're hearing again in these hearings that it's a real issue around the country that people actually don't have enough transport funding in their plans to access their other supports. Here in the ACT I met with a group of around 40 providers last week who were concerned about their clients. I've also heard from parents that they are thousands of dollars out of pocket paying for the transport to get their children to the supports they need. What's going to be done about this? Why was there a decision recently to not allow the core support funding to be used for transport?

**Ms Rundle:** I can make a general comment, and Mr McNaughton might want to go into detail. At the last Disability Reform Council meeting, in October, we agreed a position on transport and the funding of transport which would mean that we would provide more funding for participants, as a general rule, including recognising that, where some of the state taxi subsidies have been withdrawn, that has had an impact on our participants, and we would look at making that up. The detail of that is currently being worked out with states and territories and ourselves.

**Mr McNaughton:** That's correct. We are working with states and territories to make sure that we're looking at taxi subsidy usage and uplifting plans accordingly, so people will see an uplift in that, in recognition. We're also looking at the long term and creating better flexibility, to go to your point around how we can create more flexibility within core for people to make those choices. That is a big piece of work we want to do as stage 2. The immediate remediation is to uplift, using taxi subsidy data, as well as having a process in place if they're more complex transport needs and we want to be able to put that in place quickly, for escalations around specially modified vehicles et cetera. It's a big piece of work. We too have heard a lot that we need to do some work there, and that was the announcement recently that we're working on.

**Ms PAYNE:** That's good to hear.

**Ms COKER:** I have one quick question. It's around LACs and the number, on an annual basis, of LACs leaving the profession. We've heard that there's a massive turnover. That's really concerning, for one reason: you're losing all that expertise that people build up. But also it suggests that there are some significant issues. Are you aware of it? Have you got any thoughts about how we could improve this situation?

**Mr Aikman:** I will try to answer that question. I think it goes to something that Ms Rundle said earlier around the framework and what we're doing to work with partners on what good performance looks like—that is, around the contractual obligations et cetera that we talked about earlier. We are certainly aware of turnover across the agency, which we do measure. We can provide details on what that looks like for the agency. It's less clear to us across the partner network. I do believe—we will confirm this—that, in terms of getting transparency of what that looks like, in terms of turnover across partner organisations, it's something that we're looking at including as part of our performance framework moving forward.

**Senator HUGHES:** One of the things that we keep hearing as well is around inconsistency of plans—some people with similar needs getting very different plans; some people with higher needs receiving less than someone with fewer requirements. It's a little bit of pot luck, as it's described, as to what the plan ultimately looks like. Is any work being done to look at a more consistent approach? When you've got planners or delegates who don't actually understand a particular disability or elements of a disability and are making decisions, it can obviously have ramifications for the participant, but it also leads to a lack of consistency and surety for people about where they will end up.

**Ms Rundle:** That's a good observation. I have a couple of points. The first one is the work we're doing in the agency on the Scheme Actuary. We're getting quite a lot of data now. We understand how people are using their plans and the outcomes people are getting. We're starting to get a better idea of what might constitute a package, if you like—broadly speaking, because everyone is an individual—rather than individual line items. We'd like to be able to give people more flexibility in how they spend that. That's a piece of work that we're doing at the moment. The other thing that I would say is that it goes to the question we answered earlier. Unfortunately, we're still seeing some inconsistency in decisions because of the expertise of our planners and LACs.

**Senator HUGHES:** Could I ask a quick final question on the early childhood package? Ms Rundle, I'll be in touch with you if it doesn't work out. I'm dealing with a family at the moment. They have a child aged six. He's about to go to school and has very high, complex needs. He's still with an LAC. Now, having learned a bit of stuff, I don't think he probably should be. His first plan was incredibly insufficient because the parents didn't understand and I don't think the LAC did either. I actually sat in on the planning meeting via the phone to get a sense. The feedback I got was: 'Yes, this child has very complex needs. Part of his condition means that there's a fatal element when he has a seizure.' If he's not dealt with correctly, it could end up being fatal. The feedback I got from the LAC was: 'I'm not sure what we can do because he's in the early childhood cohort.' I just felt that was an extraordinary response. I've asked the family to stay in touch with me. It really concerning that the LAC hasn't elevated it to the NDIA because it's obviously very complex and it's a very rare condition. We're seeing children who have disabilities that include seizures et cetera, which are potentially fatal, being bundled off as though they have a developmental delay.

**Ms Rundle:** Yes. I agree with you. I don't understand why the child was in the LAC pathway, not the early childhood pathway. The other thing is that, if the child—

**Senator HUGHES:** The LAC is with Brotherhood of St Laurence, which we've now learnt is qualified to be—

**Ms Rundle:** ECEI.

**Senator HUGHES:** ECEI. The fact that they're not elevated to the NDIA with such a complex case is concerning.

**Ms Rundle:** Agreed. One of the things we've done—not recently but a few months ago—is refresh our guidelines for all of the ECEI partners to help them work out when children should quickly be identified as needing to be pushed into the complex pathway. That means they come to us, and we have our own early childhood complex planners. We've been looking at how well we've been doing. We think that, in the main, that is happening. I don't know why that didn't happen, but I'm very happy to take it offline and work with you.

**Senator HUGHES:** That would be great. Thank you so much.

**CHAIR:** I must draw this to a conclusion. Can I thank both the department and the agency for once again coming on and discussing these issues with us. I have no doubt that, sometime soon, we will have another such discussion. Thank you very much—yes, Mr Lye.

**Mr Lye:** Excuse me, Chair, I did not say at the start that Secretary Campbell sent an apology today because she had a—

**CHAIR:** We have had that conveyed to us, Mr Lye. Thank you.

**Mr Lye:** And we will have an officer staying for the town hall.

**CHAIR:** Yes. If that further information we have discussed could be provided, that would be very useful. We will now proceed to the town hall discussion.

**ALDCROFT, Mr Bill, Private capacity**

**CAHILL, Mr Shaun, Private capacity**

**COLLINS, Mr James, Private capacity**

**HANSEN, Ms Michelle, Private capacity**

**HERD, Mr Dougie, Private capacity**

**MAMALAI, Ms Sarah, Private capacity**

**NEWMAN, Mr Mark, Private capacity**

**O'DEA, Ms Karna, Private capacity**

**WARN, Ms Verity, Private capacity**

[14:21]

**CHAIR:** I welcome everybody who has joined us today. I remind you all that these are official parliamentary proceedings. A *Hansard* record will be prepared, and discussions are being broadcast. We have microphones at the table. People are welcome to come to the table. There are also roving microphones. If you want to say something, raise your hand, and we will try to make sure everybody who wants to has an opportunity to say something. Given the time constraints we have and that we have a further witness to hear from in relation to these hearings after this, could you keep your remarks to three or four minutes. The committee will try not to interrupt. We will try to use this as a listening exercise. If you can be succinct, that would be helpful to us as well. Can I ask you not to divulge confidential personal or identifying information when you speak. If you want to supplement what you say today with other further information, it can be forwarded to the secretariat after this afternoon.

The general issues we are discussing include the NDIS operations, but specifically at the moment we are looking at planning and the operation of supported independent living. I know that is a broad range of subjects, but these are the two that we are specifically concentrating on at the present time. If you do not wish to be filmed—there is no filming at the moment—could you raise your hand to indicate to the media that you do not wish to be filmed, otherwise I will accept that you are happy that this is a public proceeding and you might be filmed.

**Ms Hansen:** I am the owner of and a social worker with Making Connections Together. I would like to firstly say that, even though the ACT is a trial state for the NDIS and is one of the first, from my point of view, it is one of the most poorly acting ones, especially in regards to LACs. The so-called mental health expert with the LACs here has refused to acknowledge several participants' mental illness, saying that, in his opinion, they do not have a mental illness, despite psychiatry diagnoses and medication. One of my clients has spent most of the last two years in a mental health unit, because she cannot come home, but he again said that she was not eligible to have supports under the NDIS. I find that the planners here, in all areas, have a very low education on what a client needs. To them, a schizophrenic is a schizophrenic. Everybody is the same. You try and explain to them that everyone is going to have a different baseline, but they're not interested. The early education team that does the planning here has recently refused to do an early review, despite the NDIA telling them to do one for a child who's got a change of circumstances. They're saying: 'She's four months, and her annual review is coming up. That'll do. We'll wait until then.' Some children need an hour a week for physio, OT, speech, the whole lot. But, in the end when we get the plans, we're lucky to get an hour a week across the board for all five or six services. Some services won't take them on, because they get three months into the plan and there's no funding left, and nine months later they'll see them again, when the child is back to where they are. There is a total lack of understanding of individuality, choice and control.

I have another client who has a very rare disability. I've been told by senior management here in the ACT at the NDIA, 'That is not a reason to go to the complex team.' There are only 10 people in Australia with the illness. They are only acknowledging her blindness, not her hearing impairment or her muscle degeneration. They say that's irrelevant. It's just constant—my clients are great, but I am just sick of fighting to get them basics. I don't even care about above basic any more. If I can get them a basic, decent plan, I think that's a victory. Whether it meets their needs 100 per cent—I've given up thinking that a plan will be given that will meet 100 per cent of the client's needs. I'm happy if I get 60 to 70 per cent of their needs met. It's just not happening here in the ACT.

**CHAIR:** Thank you for sharing that with us. If there are any specific cases—I know I have asked not to divulge information, but—

**Ms Hansen:** I've put some of these to the Minister Stuart Robert and to Bill Shorten. The only way I'm getting responses is to send emails to them. Then I get responses from the NDIA, because reviews are not being done or acknowledged within 28 days.

**CHAIR:** Of those ones you referred to generally, if there are any further details that you would like to forward to the secretariat, I'm inviting you to do so. That would help us in terms of trying to tease this out to make the system work better.

**Mr Aldcroft:** I'm from QuestCare. I want to speak briefly on the issue of transport. We represent over 260 participants and support participants in the ACT. I don't think the NDIS appreciates the immediacy of this transport issue and the impact that it's having on participants. We are finding now that the NDIS is giving a quite adequate amount of supports for people but they are unable to access these supports because they are not able to use their core supports for transport. This has been an issue that's been brewing for a long time. It's basically been enforced by the NDIS, on my understanding, since around 1 July.

We are in a position now where we have clients who cannot access their basic supports—doctors, shopping, physio and general social activities—even though they have a considerable amount of money in their supports, because they are not deemed as flexible. A simple matter, I believe—but obviously not!—would be to allow people to have complete flexibility in their core supports so that they have absolute choice as to how they use them. I understand that there's been talk about this happening with capacity building and about various other ways that this would be intermingled, but, at the moment, people are either getting NDIS funding directly paid to them, which is X amount of money every fortnight as a contribution towards their transport, or it was, up until recently, something that we providers would do as a direct translation from their core supports into kilometres. This was never the kosher thing to do, but it was certainly the common thing to do. We've been doing this for a long time. This has ceased. We've contracted our participants and said, 'We can no longer do this because of a decision by the NDIS or because of an enforcement by the NDIS.' And now we've left them in a position where they are effectively getting adequate supports with no way to access those supports.

**CHAIR:** Thank you, Mr Aldcroft. If there are some specific examples you would like to forward to us to flesh out in more detail what you've referred to now then please do so. Now who is next?

**Ms Mamalai:** I am a participant. Just to follow on from what Bill said, I'm on the NDIS because I have brain injury. I want to reinforce what he said, because just as an example my GP is 40 kilometres from where I live. So when I think about going to the GP, which is quite often, I have to factor in a \$40 trip. I don't work and that's a big problem for me.

**CHAIR:** Thank you for sharing that with us.

**Ms Mamalai:** I have the funding in my core supports. I've actually just had my review, but I'm unable to use that funding to get me to my appointments. I use my funding every day. My appointments are all over Canberra. The benefit of the NDIS is that it gives you independence, so to have that and then lose it is a problem.

**CHAIR:** Thank you.

**Ms Mamalai:** Thank you.

**CHAIR:** Now to Mr Herd. We'll get to you all, I hope.

**Mr Herd:** I'd like to make a few comments in two capacities. I am an NDIS participant and have been since 11 September. I will come back to that in a minute. I am also chief executive of Community Connections incorporated here in the ACT. We provide support, coordination and plan management, and other supports to over 200 NDIS participants in the territory. I'd like to say some words about planning as it affects me personally but also affects the people that I know—my support coordinators in the organisation support.

I am an enthusiastic supporter of the National Disability Insurance Scheme. I'd like to make a statement of how enthusiastic I am. Before I knew that the agency was going to be based in Canberra I accepted an offer of employment from the then chief executive officer, David Bowen, to work for the agency. And only after I had accepted the offer did I realise I was going to have to move from Sydney to Canberra to work for the agency. I was a member of the senior executive service of the agency that launched the scheme on 1 July 2013. I'd have gone anywhere in Australia to work for the National Disability Insurance Agency, because I think almost all of the people with disabilities and their families I have ever met or worked with believe that the National Disability Insurance Scheme is an enormous step forward for Australia, and for people with disability here, and we are all enthusiastic about it. I've worked for the agency here in Canberra for almost two years and it was one of the most enjoyable and exciting experiences of my life.

I think I've said this in a public inquiry to the ACT Legislative Assembly, I think my former colleagues in the agency have done a terrific job under extremely difficult circumstances, largely because of the speed of the rollout but also—I said it in my submission to your committee—because of the unreasonable and unnecessary staff cap that was imposed on the agency a number of years ago, which is the source of some of the problems that many people I work with, and for, still support.

I might say a few words about my own circumstance. As I said in my own personal submission, I made my application to join the scheme on 6 January this year, and it was eight months before my plan discussion took place. It says in the NDIS Act that the agency should be given a reasonable time. I think there is no definition anywhere in any dictionary that's ever been published that says an eight-month delay is reasonable. It clearly is not. Mothers have given birth in less time than it took for my plan to be produced. I understand that that is perhaps unusual, but I've still never had an explanation as to why it took eight months, although I did ask.

I got my plan sent to me by email from a local area coordinator. I never saw it until it was sent to me, even though the plan is written in the first person singular. I resent that. I think it is unacceptable that I should only see my plan once it has been agreed by someone I have never met, whoever it was that made the decision. I had a 90 minute conversation with a local area coordinator. She passed on the information. I'm sure she did it very faithfully. Before I met her I filled out planning booklet No. 2, which the agency provides. I think I may actually have been involved six years ago in helping to finalise the text for that document. But it was genuinely helpful for me to fill it out and give it to my local area coordinator.

There's not a direct relationship between what I put in planning booklet No. 2 and the plan that I received. I think I should've seen the plan that I received before it was signed off. When I applied for a mortgage when I moved from Sydney to Canberra to live in the house that I now live in, the person in the bank showed me what they were going to send up to head office before they sent it. Forgive me, but the Australian parliament had a royal commission into the performance of banks. If a bank can perform better than the National Disability Insurance Scheme's arrangements, I think we have to ask a question about what is wrong with what's being done. And it is very simple: just show it to me, have a conversation with me and let me, as a sentient human being, contribute to the finalisation of the plan. I don't think that's an unreasonable observation, and I've never met anyone who does. I'm taking too much time, of course. Everyone who's ever met me knows that I do, so forgive me.

**CHAIR:** I'll give you about a minute more so I can get through some others.

**Mr Herd:** Thank you. Two things I should say: the announcements last week by Minister Roberts, I think, were very warmly welcomed by a lot of people with disability—participants and their families. Many people have said to me since, 'Why has it taken so long for some of these things to be announced by a minister in the way in which they were?'

The other thing is—and I'll quote you, Chair, if I may, because I heard you say it just a few minutes ago—that there's a bit of a distance between lip and cup. Those of us who listened to Minister Roberts's speech last week want to see Minister Roberts's promises delivered in detail. Listening to the exchange a few minutes ago in answer to your question about transport, the points that were made by the people in the meeting that I attended last week here in the ACT around transport were not simply about the transition between wheelchair-accessible taxi schemes and the cover that they would get through the National Disability Insurance Scheme; they were about participants getting from A to B on a daily basis where most members of the public don't have to use transport. Their transport-cost needs derive from their disabling condition, not from whether or not public transport is available. I'm concerned that there's already some slippage between what Minister Roberts said and what we might see next July.

We support, in Community Connections, 200 individuals and their family. Many of them struggle with the planning process; all of them struggle with the review process. Many people find it a stressful and anxious experience for them that sometimes has to be repeated time and time again. And I'll declare an interest here. There are two things that would help people negotiate their way through the complexity. One is good support coordination, so I'm calling out an advert for the service I provide. We want more of it, and we want to it be permanently funded in people's plans as and when they need it. And the other thing, which just has to be said because it's absolutely critical, is that people with disability and their families need independent advocacy—someone who will sit by them all the way through the process. This is not an NDIS responsibility, I know. It needs to be adequately resourced and funded because, without independent advocacy, people with disability will come off second best because even the best system creates a power dynamic that the person with disability is always going to be on the wrong end of. It's an equalising force in a difficult, complex relationship, and it therefore should be funded to the best of the government's ability.

I say all of that as a friend of the National Disability Insurance Scheme and one who wants to see it become the thing that the Australian parliament said unanimously, six years ago or seven years ago, that it wanted to be successful. We are advocates and supporters of the scheme, and we want you to help us deliver the scheme that we all wanted to get in the first place. My sincere apologies for taking up too much of the time of this meeting. Thank you very much for the opportunity.

**CHAIR:** Thank you very much for sharing those experiences and observations with us. We appreciate it.

**Mr Collins:** I'm 82 years old. One of the problems I have is wondering what's going to happen when we pass away, and I think that that's a concern for many parents. I had a few things to say, but I got rather confused when I heard how I think the people in the NDIS think the scheme's working. My son has had brain damage since birth and recently had to have two toes amputated because they found he had a condition which creates clots. But what happened was that my plan was due for renewal on 11 October, and on 16 September someone from Feros Care came out and did a review. When it came to about 9 October, I was worried as to why I didn't have a new plan, so I sent an email to the person in Feros Care. I never received a response, so I rang up the NDIS on 11 October and they said, 'Your plan's been extended until 8 November, so we'll give you some extra money.' That was good, but then I got a letter on 26 October saying that my plan would start on 22 October. I'd also like to suggest that, when the person from Feros Care come out to review my plan, my son was actually in hospital, so that person never saw my son.

So my concern is lack of communication. I can't see why the NDIS couldn't have advised me before 11 October that they decided to extend my plan. Also I think there's a lack of transparency, because when I got my plan it was quite different from what I put forward, particularly in relation to areas of capacity building. I had a few doubts about how they worked out the money they had. So I was able to ring up someone in NDIS and they were able to explain that to me. That was quite helpful, but I do feel that there is a lack of transparency. Being at arm's length by using Feros Care makes it very difficult. I was listening today and I was wondering how the system is supposed to operate. What happened to me was nothing like I thought before I heard the people from NDIS here. Is this how the scheme is supposed to work? It doesn't seem to be the way it is being applied in my case. Last year I put in an appeal. I was successful and I got more money. So I know there is that avenue. The situation at the moment is that my son has lost two of his toes and the doctors are rather concerned that he may lose more toes. I am not sure what is going to happen. Do I need to put in a change of circumstances? My main concern is a lack of transparency and also a lack of communication between NDIS and participants.

**CHAIR:** Thank you very much, Mr Collins. There are officials from the NDIA here. If you wish to raise with them your specific circumstances, please do so. We will now go to the lady in the mauve top.

**Ms O'Dea:** I have two 'kids'—one is 19 and the other is 30—with quite severe autism. I tend to go to the meetings because my two kids are minimally verbal—or pre-verbal or whatever euphemistic term you want to use. I've had very good plan meetings, so I want to put in a plug for the NDIS. They do get rude letters from me occasionally—and the minister. My kids are in the complex pathway stream. If anyone is autistic and they have issues with the terminology—my kids are low functioning. They are never going to get a degree or a Rhodes scholarship or anything like that. But I have put in a submission. It is mainly about SIL. I am moving into SIL for my son. My daughter was with ACT Disability Services years ago, and she's in a fairly good situation.

You are going to have to break the nexus between providers owning the houses. There are too many parents with difficult children. My friend and I are going to go into a housing arrangement for our two boys; they are similar. We went and saw one bloke and we both rolled our eyes. He was a dud! He was going on that he had had a boy there for nine days. I thought, 'Mate, those are the sort of people you are often going to get in SIL.' Providers really shouldn't own the homes. ACT Housing are going to have to step up to the plate. My friend's son has been on the waiting list since 2015. I write nasty letters, and the vitriol is getting worse and worse and worse. We expect to get a house. We have given them a deadline. Otherwise, either you are getting them on your doorstep, with all their goods and chattels, or the ACT Office for Disability is going to get them. That's a threat. You are going to have to break the nexus. The housing should not be owned by the provider; it's not a good situation. Too many of them in New South Wales—I can name the providers; you probably know them yourselves—

**CHAIR:** Please don't do that.

**Ms O'Dea:** No, I won't. There are media reports about them. They put people out—and often a sister or a brother is now the guardian because the parents are dead. So you are going to have to realise that the provider should not own the housing stock. It's not fair. And you are also going to have to improve the providers who take on the difficult ones. You have been told ad nauseam that you need a provider of last resort. Relinquishment is

still happening. The children and young people with a disability—500 people have been dumped since the NDIS started. That's usually a sign that parents are in despair.

It also has a rolling effect on children. My boy goes to a very good respite provider in Canberra. There used to be two respite cottages. One is now occupied by two people who have a similar condition to him. But that means they are mixing the big ones with the little ones. My boy is six foot two. I don't really want him sharing a respite place with kids who are younger because if he pushed them or knocked them over it would hurt them. It also penalises parents like me who are still caring.

I've been doing this for 30 years. When we had problems with the respite provider, your office got an earful. I rang up and you got the whole Karna download dump! And that situation was improved.

But you've got to really have a provider of last resort. You've got to start improving providers who take on the ones with challenging behaviour. There are so many kids with severe disabilities who have challenging behaviour. Most of them are on the autism spectrum, but not all of them.

I agreed with that older man who was talking about parents dying. I go to a mature-age carers group at Carers ACT, and an older father said: 'Maybe you're going to have to have somebody who takes over when the parents die and helps,' unless there is a sibling or a cousin or someone who is prepared to take them on, who becomes the parent—I don't mean takes them on and looks after them, but who remembers their birthday and Christmas, and who goes into bat for them with the NDIS and fries people.

I can still do it. I'm 59. If you screw with me, I'm your problem—I've said that for many, many years. But I'm ex public service, and, as my husband said, I've got the Irish tendency and I'd rather have a fight than a you-know-what! So I'm happy to advocate, but a lot of parents aren't. I think you're going to have to realise: some parents are hopeless and some participants are hopeless, and they're the ones who need the advocate.

I've actually used an advocate recently, ADACAS. They have been really good. I'll be honest: some of the submission I wrote and gave to you lot was nicked from ADACAS, because I agreed with them but they articulated it better than I did. But I can see these issues, and my lived experience is only as a parent of two autistic children with very severe autism. There's a lot that can shift for themselves, but there's a hell of a lot who can't.

Please don't tell me just 'insurance commission'. On the insurance commission: if there's no provider, you could have millions and millions of dollars and where do you go? And look, God's not going to come back and clear them—unless you're going to fund the second coming, which is not going to happen, they're not going to be improved.

So you're going to have to start thinking about all these things, like 500 kids dumped. There were probably 500 dumped under the old system. But you need to collect statistics on relinquishment, because that's important. I think relinquishment shows despair, and a lot of parents do.

I've got a husband who's pretty useless, but he helps as far as men are able. Most men are useless—I'm sorry; I'm being blunt.

But you've got to understand: you're going to have to start looking at these things. You're going to have to start talking to parents—particularly elderly parents, because what happens when they die? I don't mind how you're going to work it out, but you're going to have to realise this. Maybe the NDIS is going to have to be in loco parentis for some of these older people. I don't know how you do that. I'm sorry; I've got no idea. I've got a normal daughter amidst two very severe ones, and I've got one of her little cousins who'll probably help. I can do it now, but when I go, there's just going to be a vacuum. That'll probably be good for you lot—you'll get some peace!

But you really are going to have to consider all those things. I'm sick of coming to meetings and going over the same ground. It's time you started thinking about, not just paying lip-service to, these things: having a provider of last resort; making sure providers do take on the really difficult ones—and there's a lot of parents with really difficult ones—and what happens when parents die, and not just having some provider who thinks about—

**CHAIR:** I—

**Ms O'Dea:** I'm sorry. And don't worry about the philosophy. You're going to have to start on it, because a lot of parents are 80 or 90. I've seen a 90-year-old mum who's still looking after a child. What happens to that kid when mum dies? Well, the 'kid' is not a kid; they're 60. I don't know! I'm sorry; I shouldn't—

**CHAIR:** That's all right. Can I say: thank you very much for your submission and thank you for your frank comments today. We appreciate it. Now I'll go to this side, to the gentleman in the khaki shirt.

**Mr Newman:** My name's Mark Newman. I'm a man, and I'm a full-time carer for my wife. I just want to make a couple of comments, particularly about the lack of process. We're in year 3 of our NDIS plan, and I have to say: it's been very difficult to engage service providers during the first couple of years. We do live out in a country area, and it's very difficult to get people, particularly from Canberra or even Queanbeyan, to come out and support us, and it's taken me three years to find somebody who's prepared to do that.

The lack of process, particularly in our last interview, was quite disturbing. We spent over two hours in an unconditioned room, with a LAC who didn't know us, wasn't aware of my partner's condition and didn't really have any empathy for my partner's condition. In the end I had to leave, cutting the interview short, because she was in tears because we had sat there for two hours talking about her condition, all the issues she had and all the things she can't do, which to somebody who's in that sort of state is quite confronting.

I share the concerns that the plan is only seen on paper once it's approved and delivered. We have no real input into reviewing that or going through it a second time. I do self-manage our plan. I have to say that works pretty well for us. I really don't have much choice, because there aren't too many providers who are prepared to manage the plan for me out where we are. We've had a fair bit of difficulty in engaging some of the other primary suppliers, particularly where my partner's vision is concerned. We've written numerous emails and had numerous phone calls, with absolutely no actual contact from those people to this point in time.

Lastly, just to be quick, we have some psychological support for my partner included in our plan. That involves taking her to people who have skills to try and help her understand what's happening and where ultimately we're going to be going. Those are even more disturbing to try to sit with and work through, because, even though they do share some of the empathy that I certainly have with my partner—my wife—and understand where she's going to go, she can't communicate. She doesn't understand what the process we're going through is and finds it very difficult to get any value out of it whatsoever. So I think there are some positives and negatives, but I think the LAC process certainly does need a fair bit of looking at.

**CHAIR:** Thank you very much, Mr Newman. Now the lady with her hand up.

**Ms Warn:** My name's Verity Warn. This is my support person, Sara. Sorry. There's a lot.

**CHAIR:** Take your time.

**Ms Warn:** I'll try not to do that. I am here to share my experience both as a carer and as a participant. I self-manage both plans. I had such high hopes when I first learned about the NDIS. The very concept of individualised planning was enough to get me on board. Our family was without support before NDIS. So I felt relief and optimism for our future. My family has been engaging with NDIS since 2016. We have funding that we didn't have before, and we are grateful for that. But I want this committee to understand that this has come at a significant personal cost. There is a massive power imbalance, and it needs to change. Bureaucrats sit in distant rooms making decisions that affect the quality of our day-to-day lives. With the stroke of a pen, they decide whether or not families will experience a good year or a terrible year. These decisions are made about us without us. By design, the person making the decision has no contact with us and therefore no understanding of us. This model is the antithesis of good disability service practice, and it needs to change.

NDIA staff question who we are, our every last decision and our thought processes. They can invade our privacy. They can ask us any questions they like. We have literally been told that, because we have our hands in the government purse as participants, we give up our right to privacy. Let's be really clear here, NDIS is not welfare. Participants are not recipients. Participants don't receive money from NDIS. NDIS is an access and equity program which pays for support services we need. People who need heart surgery don't have to prove it or apologise for needing it either. It is not appropriate to tell us that we should be apologetic about having a disability. They decide what we do and don't need and remove funding from our well-proven support services when it suits them.

We are expected to meet specific deadlines, but NDIA experience no consequences for extended wait times. This year I waited 10 months for a light-touch review to even be acknowledged. They challenge our veracity and integrity. They condescend to us and assume we are incompetent. We have been bullied, berated, intimidated and lied to. We feel diminished and dehumanised. They take away our autonomy by micromanaging us and telling us how we should live.

Against the principles of the NDIA, we live under constant threat that they might remove our self-management without explanation. This would take away our right to make decisions about our support services. Against regulations, they remove funding if it's not spent in the previous plan. As psychosocial participants, we are expected to fit the function model instead of the mental health recovery model. We are required to develop skills

and miraculously improve and then be able to drop our supports, even though we're accepted in the NDIS because we have a permanent disability.

We can't have a single point of contact and a direct phone number or an email address, but they can call us at any time from a private number and expect us to jump. We have had official complaints ignored. When we complain about our complaints being ignored, we continue to be ignored. We have had evidence ignored. We have gone to great lengths to arrange multiple reports and documentation only to have it dismissed. They are stuck in a loop. 'Please provide more evidence,' they say, so we find yet another specialist and arrange yet another report, and they respond just by saying, 'Please provide more evidence.' They don't tell us what's lacking in the prior evidence or what questions remain unanswered, so we are left to try to estimate what it is they are looking for.

The NDIA are supposed to be providing funding to meet needs based on recommendations from specialists. Why are unskilled, unqualified people allowed to veto specialists' reports? A disparity I find concerning is that they are more than willing to pay huge amounts of money for countless expensive reports but not smaller amounts for reasonable supports. I say fund supports before reports. They must stop wasting our tax dollars on the over-reliance on unnecessary bureaucracy. When the NDIA are in the wrong, it is impossible to have their errors corrected. I have been trying to correct details listed on my daughter's plan since its inception. In contrast, if we slip up in the slightest, we have learnt to expect to be punished. The double standard is mindboggling.

NDIA staff have made decision-making incredibly difficult. Nothing is predictable. It doesn't matter how well we know the rules. From one day to the next, we have to work at the whim of the NDIA employees we interact with. No matter how wrong they are, they are always more right than us, simply by virtue of working at the NDIA. For example, we were told by an NDIA delegate that psychotherapy is not an evidence based therapy, and it is; that psychotherapy is not funded under the NDIS, and it is; and that the only valid form of psychological therapy is straight up psychology, when it is not. Everything she said on that topic was either incorrect or highly inappropriate, but, at the end of the day, this was a delegate speaking to us, so her word was gospel. Afterwards, we were left wondering whether to follow her incorrect instructions, which could lead to trouble for us because she was wrong, or whether to go back to the rule book and ignore her, which could lead to trouble if she personally ever reviewed the plan—a catch-22 situation.

This was not an isolated experience. It has become very difficult to make decisions about support services because we're not sure whether the next person we deal with will follow the rules properly. For us, the stakes are high as we could lose our choice and control if we step wrongly. While we struggle like this for every dollar, we hear about the new CEO receiving a six-figure pay rise just eight days after starting in the role and we hear about \$23 million in executive salaries. This contrast is shameful.

The real impact. I have complex post-traumatic stress disorder. This came in part from a childhood full of abuse, where I was constantly under threat of random unpredictable attacks and at times my life was in danger. Part of this experience was never knowing when the next attack would come or what it might look like. A large part of it was about not having any power over my situation and not being able to escape my circumstances. These days, the NDIA play the role of the random attacker in my life. They pop up at unpredictable times with random attacks that threaten my stability and safe enjoyment of my life. They wield power over me that makes me feel helpless. They disregard my need for autonomy and they take it away at times. They leave me feeling hypervigilant. Far from my original hopes, the NDIS have become a threat to my health.

The level of stress they create is tolerable. It is currently unsustainable for me to stay in the system. They are not providing equity or opportunities for me to improve the quality of my life.

In late 2018 I asked for a two-year plan so that I could have a break from all the stress—a chance to recover. They gave me my two-year plan but with one year of funding. At that point I was defeated. Any further engagement with NDIS was out of the question for me so I did not fight. I figured out a way to hobble together a life for the coming two years with my limited budget. I am a year into my current plan. My health has significantly declined. I have lost capacity to continue my volunteering activities, which made me useful and purposeful. I have lost capacity in a number of other areas too. I have very little hope for a positive future and I feel helpless to escape my circumstances. I feel defeated. My inner eternal optimist has broken down and NDIA's practices and processes are to blame. It is plain that this system is not dissimilar to the insurance industry, designed to wear us down and ultimately make us give up. They have won. I have given up.

When I think about my plan review at the end of next year, or any other potential interactions with NDIA personnel, I'm quite clear that I would rather be dead than deal with more of this. I think of suicide whenever I imagine further engagement with NDIA. To protect my health I imagine walking away when my review time comes next year. It is a catch-22 though because then I'll be on my own again.

I know I'm not the only one who feels this way. I mix with a large group mental health NDIS of participants. A lot of people are struggling with feelings of suicide when they are dealing with NDIA. At the end of the day, I can't decide whether we're all suffering at the hands of cruel stupidity or stupid cruelty. It is certainly cruel and it is frequently stupid. Thank you for listening.

**CHAIR:** Ms Warn, thank you very much for sharing your experiences with us. There are people from the NDIA here—

**Ms Warn:** I have zero interest in talking to anyone from NDIA.

**CHAIR:** I was going to say if they can help you I hope they would. Who would like to share?

**Mr Cahill:** The plans are too inflexible. They're not adaptable to fit emergency participants needs and wants. They obviously have to wait for their next yearly planning meeting. Plans and money, in my opinion, can't be interchangeable where they can't be used for the above emergency needs and wants, like immediate respite if the participant needs it. If participants want to transfer to another agency it's a little bit difficult, as you're accused of being a traitor or being involved in treason.

**CHAIR:** Thank you very much. We appreciate that contribution. Ms Mamalai?

**Ms Mamalai:** Hi, again. I just thought I might take the opportunity to mention in this forum that I've sent a proposal to the NDIA to have brain cancer added to the list of eligible conditions under the NDIS. I don't know; I just thought I might mention it at this forum. I won't go into details, because I know we're over time, but there are so many reasons. At the moment, patients are having to describe themselves as having a brain injury rather than brain cancer, because brain cancers are not listed.

**CHAIR:** Thank you. I understand what you're saying.

**Ms Hansen:** Can I just add one thing. I would like to say that Verity is not the exception to the rule. Having a good plan in the ACT is the exception to the rule, and it's very rare. Unfortunately, the majority of people are in Verity's situation, and we need to stop it. I'm just so angry on her behalf. We're just not fighting enough to get this done properly. To the people at the NDIA and Feros Care and all the LACs: stop saying that you know the legislation, because you clearly don't. None of you have read it. Otherwise we would be having better outcomes for participants. I am sick and tired of having to put in my support letters parts of the legislation which they clearly don't know in order for them to still say, 'Go away.' If another LAC tells me, 'We don't care what the legislation says; we will just do what the NDIA tell us'—we've got to start using the legislation. It is what is law. It is what you're doing. That is what you're supposed to be giving. I will bend over backwards for every client I've got, but I am sick and tired of going home and crying for them because I can't do enough to get them a decent plan. I've had enough of it. I'm sorry.

**CHAIR:** That's all right. We hear your frustration, Ms Hansen. Thank you very much for your contribution. If there are no further contributions, I thank everybody who has participated this afternoon. I know we were trying to keep it fairly short. There is a time constraint we're under, but we do appreciate contributions that people make, both in this open forum here and in the other ones we've had around the country. It helps us to get a better understanding of this scheme—which, as the gentleman in the pink shirt said, we're all supportive of—in trying to make it work better for people who have disability in Australia. I include amongst those who are trying to make it better those from the agency itself. They're committed to it as well. Thank you very much to everybody who has participated. It helps us in understanding the issues and hopefully helps to frame the recommendations that we can make to the parliament to make this scheme a better one. On that note, I'll close this public hearing.

**Committee adjourned at 15:12**