



Office of the Public Advocate

Submission to review of Transitional Arrangements for the NDIS

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Abbreviations

DHHS	Victorian Department of Health and Human Services
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
OPA	Office of the Public Advocate (Vic)
the Principles	<i>Principles to Determine the Responsibilities of the NDIS and other Service Systems</i> (2015)
SDA	Specialist Disability Accommodation
STO	Supervised Treatment Order
VCAT	Victorian Civil and Administrative Tribunal

Recommendations

Recommendation 1

The *Principles to Determine the Responsibilities of the NDIS and other Service Systems* should be reviewed to ensure they address key interface problems that have arisen since full scheme roll out commenced.

Recommendation 2

The *National Disability Insurance Scheme Act 2013* (Vic) should be amended to clarify and acknowledge the role of state and territory appointed substitute decision makers, particularly where there is no suitable person to appoint as plan nominee.

Recommendation 3

In situations where a participant has a significant cognitive impairment, the NDIA should amend its policy requirement that service agreements need to be signed by, or on behalf of, participants.

Recommendation 4

The National Disability Insurance Agency should enable an institutional login for state and territory appointed public advocates/guardians and administrators/financial managers, so they can access relevant participants' information.

Recommendation 5

The National Disability Insurance Agency and the Victorian Department of Health and Human Services should ensure that Community Visitors can access relevant information about participants living in Victorian Specialist Disability Accommodation in order to enable them to fulfil their safeguarding role under the Disability Act.

Recommendation 6

The National Disability Insurance Agency, in collaboration with State and Territory Governments, should address the 'thin market' problems already appearing in relation to accommodation and services available to people with complex needs.

Recommendation 7

The NDIA, in collaboration with State and Territory Governments, should urgently address gaps in clinical service provision for participants with a history of offending behaviours. In doing so, the NDIA and State and Territory Governments should work to ensure the long-term sustainability of highly skilled and specialised disability support services which work with participants with complex needs.

Recommendation 8

The National Disability Insurance Agency should introduce "intensive support coordination" as a funded service based on the traditional comprehensive case management model, to ensure that the NDIS has the capacity to respond to emergencies.

Recommendation 9

The National Disability Insurance Agency should provide access to contingency funding to enable support services to respond to participant crises.

Recommendation 10

The National Disability Insurance Agency should develop an approach to build flexibility in plans to respond to the fluctuating needs of participants with cognitive impairment, including allowing for minor adjustments to be made without the need for a full plan review.

Introduction

The Office of the Public Advocate (OPA) welcomes the opportunity to submit to the Joint Standing Committee on the National Disability Insurance Scheme (NDIS) inquiry into transitional arrangements for the NDIS.

OPA takes this opportunity to highlight some of the more concerning transitional issues in Victoria, the consequences of which will likely continue following full NDIS implementation, unless legislative reform and clearer policy direction is achieved. These relate, in the first instance, to the maintenance of current quality and safeguarding arrangements in Victoria during transition.

In Victoria, particularly since the 1980s, reform has attempted to improve service delivery and practice in terms of human rights. Despite the NDIS's profound potential to transform the lives of people with disability, OPA is concerned that the critical gaps that are appearing place people with disability at increased risk of violence, abuse, neglect and exploitation.

About the Office of the Public Advocate

OPA is a Victorian statutory office, independent of government and government services, that works to safeguard the rights, interests and dignity of people with disability.¹

The Public Advocate is appointed by the Governor in Council and is answerable to the Parliament.

OPA provides a number of services to work towards these goals, including the provision of advocacy, investigation and guardianship services to people with cognitive impairments and mental illness. Last financial year, OPA was involved in 1645 guardianship matters, 494 investigations and 61 new cases requiring advocacy.

Under the *Guardianship and Administration Act 1986* (Vic), OPA is required to arrange, coordinate and promote informed public awareness and understanding about substitute decision-making laws and any other legislation dealing with or affecting persons with disability.²

OPA has undertaken various systemic advocacy activities throughout the establishment of the NDIS and the development of a nationally consistent quality and safeguarding framework.³

OPA is currently guardian for 83 NDIS participants, advocate for six participants, and the office is undertaking six investigations in relation to prospective participants and participants where NDIS matters are relevant. OPA has previously acted as an advocate for 57 participants who currently reside, or have previously resided in Colanda Residential Services and Disability Accommodation Services in Colac and Geelong during the trial phase.

OPA provides an Advice Service, which responds to complex issues requiring a high level of expertise. Last financial year, it responded to 17,469 enquiries. Most calls (61 per cent) related to guardianship, administration or enduring powers of attorney. Ten per cent of all enquiries related to violence, abuse, exploitation or neglect.

OPA coordinates four volunteer programs: the Community Visitors Program, the Community Guardian Program, the Independent Third Person Program, and the Corrections Independent Support Officer Program. The office provides training and support to more than 800 volunteers.

As a key part of the quality and safeguards arrangements operating during transition, OPA Community Visitors continue to visit disability residential accommodations, supported residential

¹ *Guardianship and Administration Act 1986* (Vic) pt 3.

² *Guardianship and Administration Act 1986* (Vic) s 15(e).

³ See Office of the Public Advocate, *National Disability Insurance Scheme* <<http://www.publicadvocate.vic.gov.au/advocacy-research/ndis>>.

services and mental health facilities, residents and patients of which have various interactions with the NDIS.

About this submission

OPA's unique understanding of transitional issues arises from the interactions the Advocate Guardian and Community Visitors Programs have had with the NDIS to date. OPA's comments focus on those issues impacting people with cognitive impairment and mental illness, in particular.

This submission addresses term of reference (a) the boundaries and interface of NDIS service provision, makes comments in the context of other related matters identified in term of reference (d).

The matters on which this submission comments include the current quality and safeguarding arrangement in Victoria, both explicit and implicit by way of policies supporting those arrangements. The legislative arrangements include:

- the interface between guardians and nominees, and the NDIS process more broadly (Guardianship and Administration Act)
- residential safeguards, including crisis accommodation; provision and funding for clinical services when a person has committed an offence or is an ongoing risk (*Disability Act 2006* (Vic))
- the interface with the criminal justice system, including the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic).⁴

The submission addresses the gap created by the removal of the traditional case management function, and the replacement or 'modification' of that service through a mix of support coordination, local area coordination and activities undertaken by the National Disability Insurance Agency (NDIA) itself.

In the sections below, OPA expresses growing concerns of the negative impact of the transition to the NDIS on some people with disability, often those with the highest and most complex needs.

OPA does this in the context of the expectation that the existing Victorian quality and safeguarding framework would apply, subject to further development of, and transition to, a nationally consistent risk-based quality assurance approach that does not diminish Victoria's existing quality assurance system and safeguards.⁵

OPA is concerned about the gaps that are appearing which compromise the maintenance of Victoria's existing system.

This submission makes a number of recommendations to address those concerning gaps.

Principles to Determine the Responsibilities of the NDIS and other Service Systems

In this submission, OPA makes particular reference to the revised 'Principles to Determine the Responsibilities of the NDIS and other Service Systems' ('the Principles') as part of the Bilateral

⁴ See Office of the Public Advocate, *Submission to Joint Standing Committee on the NDIS inquiry into the provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition* <<http://www.publicadvocate.vic.gov.au/our-services/publications-forms/research-reports/mental-health/mental-health-legislation-research/389-opa-submission-to-jsc-ndis-and-mental-illness-16-feb-2017-1>>.

⁵ The existing Victorian quality and safeguarding framework includes Appendix C to Schedule B of the bilateral agreement includes references to the *Disability Act 2006*, the *Guardianship and Administration Act 1986*, the *Supported Residential Services (Private Proprietors) Act 2010*, the *Mental Health Act 2014* and the *Charter of Human Rights and Responsibilities Act 2005*, among other legislation.

Agreement between the Commonwealth and Victoria for the transition to the NDIS, Schedule I Management of Interfaces between the NDIS and mainstream services.

OPA understands that the Principles are used to determine the service funding and delivery responsibilities of the NDIS as compared to other service systems.

While the Principles were reviewed following trial to reflect lessons learnt, it is OPA's view that they need further review, now that the NDIS is in the second year of full roll out. There remains a lack of clarity around some interface principles. Inconsistent interpretation and application of the Principles compound this.

Principle 6 states that 'the interaction of people with disability with the NDIS and other service systems should be as seamless as possible, where integrated planning and coordinated supports, referrals and transitions are promoted, supported by a no wrong door approach'. OPA questions what this means in those instances where interpretation of the Principles may be guided by funding, and not by the broader needs of the person with disability, where these may cross a number of service systems. Who funds the gaps that are appearing? The submission speaks to this further below.

OPA's reflection on the NDIS four years into implementation suggests there is much opportunity for improvement. More than this, there is an opportunity to make a holistic improvement to the life of a person with disability where they may interact with a number of service systems.

The intention to build the capacity of the mainstream service system by way of implementation of the NDIS to respond to the needs of people with disability will not happen quickly, or easily. Setting clear boundaries—the intention of the NDIS (and the Productivity Commission in its recent report on Costs)—is a necessary intention. However, it does not recognise the complexity of the needs of some people with disability, nor does it recognise that a clear demarcation of such needs, serviced by different service systems, may not be possible, or desirable.

The *NDIA submission to the Productivity Commission Position Paper on Costs* commented that the delineation between services being provided by different services streams is neither clear nor efficient. One avenue to address interface issues is by way of the Joint Standing Committee and consideration of the submissions made to it. OPA's acknowledges the NDIA's engagement with issues raised with the Productivity Commission and as such we are encouraged by the reform that is possible. Reviewing the interface principles will assist this reform.

Recommendation 1

The *Principles to Determine the Responsibilities of the NDIS and other Service Systems* should be reviewed to ensure they address key interface problems that have arisen since full scheme roll out commenced.

Interface with guardianship

Victorian legislative framework

Under the Guardianship and Administration Act, a guardian may be appointed for a person with disability by the Victorian Civil and Administrative Tribunal (VCAT). VCAT must be satisfied that the person has a disability; is unable, by reason of that disability, to make reasonable judgments about their person or circumstance; and there is a decision that needs to be made. A guardian is a substitute decision maker.

A guardian may be appointed if there are different views between family members about, for example, what is in the best interests of the person with disability which cannot be resolved. There needs to be 'no less restrictive option' available. An administrator can be appointed for the same general reasons, however, the decision must relate to legal or financial affairs.

Where there is no other suitable person to be appointed, the Public Advocate will be appointed as guardian. This is a last resort arrangement. The Guardianship and Administration Act contains provisions to ensure that a guardian's authority is limited to the specific area of decision-making needed, relating to a personal or lifestyle decision/s. Orders are made for the shortest time possible and subject to regular review.

Although guardians may have responsibility for one area of a person's life, for example accommodation, access to services or healthcare, guardianship decisions are not made independently of the person's personal and social wellbeing as a whole. Guardians need to have knowledge of the broader context for an individual by accessing relevant information about them.

In relation to the NDIS, a guardian must have decision-making powers in relation to access to services, and in some circumstances, accommodation powers. Usually, OPA is appointed guardian with other powers (i.e. accommodation or healthcare). A guardian may make NDIS-related decisions by virtue of a guardianship appointment, rather than NDIS-related decisions being the driver of the guardianship application. Notwithstanding this, OPA anticipates the numbers of guardianship applications will grow as the NDIS rolls out.

An attorney is appointed under the Powers of Attorney Act 2014 (Vic) by a person with decision-making capacity in relation to the making of that appointment. The decisions of an attorney will have the same legal force as if the person who appointed them had made them. Appointments can commence immediately, or when specified in the instrument of appointment. An attorney must have relevant decision-making authority to have legal standing in relation to lifestyle decisions.

National Disability Insurance Scheme Act 2013 (Cth)

The *National Disability Insurance Scheme Act 2013* (Cth) (NDIS Act) incorporates a variety of decision-making arrangements, containing elements of supported and substitute decision-making, as well as informal and formal decision-making.⁶ In practice, the arrangement may depend on the significance of the decision, whether there is conflict, and/or the suitability and availability of support.

Under the NDIS Act, a plan nominee is appointed at the request of the participant or on the initiative of the CEO to assist the participant or to do an act or thing in relation to:

⁶ Local Area Coordination is delivered by NDIA Partners in the Community. It is envisaged that Local Area Coordinators will help participants as they move from stage to stage through the NDIS process – including to support participants to understand the NDIS; access the NDIS; create a first plan; put the NDIS plan into action; and, review their plan. In practice, this role is being provided utilising a number of informal and formal decision-making arrangements.

- a) the preparation, review and replacement of a participant's plan; and
- b) the management of funding for supports under the participant's plan.⁷

A plan nominee may only do an act in relation to the above if they consider that the participant is not capable of doing, or being supported to do, the act. As such, a plan nominee can, in effect, be a substitute decision-maker. An appointment can be limited in scope and for an indefinite period. A plan nominee also has a duty "to apply their best endeavours to developing the capacity of the participant to make their own decisions, where possible to a point where a nominee is no longer necessary." There is no plan nominee of last resort.

Guardianship and the NDIS

It is unclear in the NDIS Act and the various NDIS Rules how a VCAT-appointed guardian (or administrator) is expected to operate within the NDIS, while also considering their own powers and duties under relevant state and territory laws.

OPA is of the view that the NDIS Act does not make adequate reference to state and territory appointed substitute decision-makers.

The Principles are silent on guardianship, other than in reference to it being funded by other parties (justice) as a support for people with disability, including victims and witnesses of crime, to access and navigate the justice system.⁸

This section includes reference to advocacy, community visitors and legal support. While OPA understands the rationale behind this, and that it relates to funding and service responsibility, the interface at which guardians are interacting with the scheme is broader than this.

Indeed, OPA is finding that it is playing an increasingly important independent safeguarding role in the NDIS, both because there is no Commonwealth-equivalent public advocates, and that the legislation does not adequately include recognition of state and territory-appointed guardians nor their role.

In the absence of an amendment to the NDIS Act (discussed further below), any review of the Principles should consider the interface between guardianship and the NDIS.

OPA spoke of the interface between appointment and scope of the roles of a guardian and plan nominee in the Guardianship and the NDIS: Discussion paper (2014):

It is clear that a plan nominee can fulfil a very important function for a participant in relation to the management of the participant's plan, in what is seemingly expected to be in an ongoing capacity. The role of a plan nominee as a supporter is likely to benefit an NDIS participant who has a cognitive impairment or mental ill health, where there is no one else to provide that support.

An issue that arises here is that there is no Commonwealth equivalent of state and territory offices of the Public Advocate, the Public Guardian, or the Adult Guardian, that can either fulfil the role of plan nominee (or play a role in training nominees). There is no nominee of last resort. In any case, it is not obligatory to appoint a nominee even in cases where the participant lacks capacity to do any act or thing in relation to their plan or the management of their funding. In this way, a participant may have their rights restricted because there is no one to promote or advance their views where they are unable to express those views, to have them heard and understood, and then put into effect.

⁷ *National Disability Insurance Scheme Act 2013* (Cth) s 78(1).

⁸ This includes identification of the justice system to fund and deliver support for people to access and navigate the justice system including guardianship, advocacy, community visitors and legal support, including where people with disability are: in contact with the criminal justice system currently living in the community (including people on bail, parole and non-custodial orders; subject to custodial sentences or other custodial orders (including people on remand); participants residing in youth training centres (also known as youth justice centres or youth detention centres: *Principles to Determine the Responsibilities of the NDIS and other Service Systems*, 23-25.

If the CEO were to decide that the appointment of a plan nominee is justified, and there is no suitable person able to accept appointment, then it is possible that a person who does not have any other person to support them will not have their wishes represented. It may be likely in this instance that an application for guardianship would be made and, if VCAT determine that there is a need to appoint a guardian, the CEO may decide that appointment of a nominee is no longer justified.

OPA firmly supports the legislative requirement that a guardian may only be appointed for a person with a disability who is unable by reason of the disability to make reasonable judgments, when there is a need for a guardian, and only when there is no less restrictive alternative available. Appointment must be for a time limited period, and it is ultimately VCAT's decision. The same safeguards do not apply for appointment of a plan nominee. The appointment itself is not reviewed (although it is a reviewable decision) and it can be for an indefinite period.⁹

While OPA supports the presumption of capacity under the NDIS Act, and the premise of choice and control at the heart of the NDIS, it does believe that there is a need for guardianship in limited circumstances. In OPA's view, the role of a guardian can be a crucial safeguard that can enhance the inclusion and legal personhood of the person for whom OPA is guardian. It can also enable protection from abuse, neglect and exploitation. OPA maintains that the safeguards provided under the NDIS Act in relation to the appointment of a plan nominee (while not compliant with the UN Convention on the Rights of Persons with Disability), can only apply when there is someone to accept appointment as plan nominee.¹⁰ OPA's practice reflection after more than four years of involvement in the NDIS is that the NDIA seems reluctant to appoint nominees.

OPA's submission to the 2015 review of the NDIS Act identified the need for reform to it and requisite state and territory guardianship laws to ensure state and federal appointments of substitute decision makers align. This would also address the gaps that exist for participants who need a plan nominee, but have no suitable person to accept appointment.¹¹

Recommendation 2

The *National Disability Insurance Scheme Act 2013* (Vic) should be amended to clarify and acknowledge the role of state and territory appointed substitute decision makers, particularly where there is no suitable person to appoint as plan nominee.

OPA guardians and plan nominees

OPA has made the decision not to accept appointment as plan nominee unless OPA is appointed as the person's guardian. OPA needs an appointment in order to have decision-making authority, and a guardian would only make a decision within the limits of the VCAT order.

OPA (and OPA SA) made the argument previously that clear and consistent interaction between plan nominees and state and territory substitute decision makers requires reconsideration of the functions and responsibilities of plan nominees. OPA maintains the view that current and any future NDIS nominee arrangements should better align with state and territory appointments.

Guardians could fulfil part of the plan nominee function in the preparation, review or replacement of the participant's plan, but cannot be expected to manage the funding for supports. It appears that the NDIA can particularise the role of nominee, however, an equivalent administrator

⁹ Office of the Public Advocate, *Guardianship and the NDIS: Discussion paper* (2014) <<http://www.publicadvocate.vic.gov.au/our-services/publications-forms/research-reports/ndis/decision-making/70-guardianship-and-the-ndis-discussion-paper-2014>>.

¹⁰ Office of the Public Advocate, *Submission to Independent Review of the Operation of the National Disability Insurance Scheme Act 2013 (Cth) Discussion Paper* (2015) <<http://www.publicadvocate.vic.gov.au/our-services/publications-forms/research-reports/ndis/law-reform/247-submission-to-ndis-act-review-2015>>

¹¹ Discussion on this point was in the context of the Australian Law Reform Commission's recommendations in relation to representatives and supporters in its Equality, Capacity and Disability in Commonwealth laws: Office of the Public Advocate, *Submission to the independent review of the National Disability Insurance Scheme Act 2013 (Cth)* <<http://www.publicadvocate.vic.gov.au/our-services/publications-forms/research-reports/ndis/law-reform/247-submission-to-ndis-act-review-2015>>.

nominee/representative function could be devised for situations where a public trustee would be best placed to perform this role.

To date, OPA has not accepted appointment as plan nominee, and it has only been requested of it twice. In one instance, a planner insisted that the OPA guardian either be a plan nominee or a correspondence nominee in order to receive a copy of the participant's plan. The guardian reported that the planner did not liaise with them, nor the participant's case manager when developing the plan. The guardian questioned how the planner was able to discern the needs of the participant without the presence of the guardian or the case manager at the planning meeting given the participant has a significant cognitive impairment.

NDIS decision-making journey

The three stages of the NDIS process require various access to informal and formal decision-making arrangements by, with and for people with cognitive impairment. These stages are:

1. Access: becoming a participant
2. Participate: plan development
3. Receive: choosing services.

OPA suggests that the NDIS journey be seen along a decision-making spectrum, and decision-specific, with complete autonomy on one end (being the presumption of capacity) and, at the other, substitute decision making. In between, advocacy and supported decision making can assist a person to participate in decision-making and implement their wishes.

Where an OPA guardian has been appointed for a prospective participant or participant, issues can arise at each stage.

Stage One: Accessing the NDIS

OPA's main comment relates to the uncertainty around the effect of some sections of the Access Request Form (ARF). OPA questions whether the real issue of who can sign an ARF—whether a guardian with relevant decision-making powers, or an OPA Advocate under powers provided in the Guardianship and Administration Act—is about access to, and authorisation to, disclose information.

Stage Two: Participating in the planning process

For persons with moderate to significant cognitive impairment, representation at a planning meeting is both important and significant. It does not seem to require decision-making authority. OPA's experience is that better outcomes are more likely to be achieved for a participant with significant cognitive impairment when the guardian is at the planning meeting to represent the wishes and rights of the participant. Indeed, the guardian has authority to be included in the planning meeting. At the very least OPA would support an advocate being present in planning meetings where there is no one else to represent the wishes and advocate on behalf of a participant with cognitive impairment.

However, it is OPA's experience that only guardians receive adequate feedback about the plan and outcomes of the planning meeting, thus challenging the effectiveness of an advocate (this relates both to independent advocates and where OPA is an advocate).

Following the planning meeting and approval of the participant's plan, guardians are usually able to access copies of plans but they cannot access the NDIS portal.

Stage Three: Receiving Services – choosing a support coordinator and signing service agreements

OPA understands that, at times, where a participant is unable to choose a support coordinator that, where appointed, a guardian makes the decision. Where there is no guardian, or plan nominee, OPA understands that, in practice, the NDIA chooses a participant's support coordinator.

An independent safeguard is removed from the process, and it is unclear who is representing the wishes of the person. Inconsistent practice challenges the 'control' at the heart of the scheme.

The matter of who can sign a service agreement (both for support coordination and for services and support that flow from that) on behalf of a person with cognitive impairment is unclear and, in some instances, is proving to be a barrier to service provision.

The NDIA's policy in relation to service agreements, contained in the Provider Toolkit Module 5: Service Agreements, states:

When a participant is developing a Service Agreement with a provider, they are advised to take a copy of their NDIS plan with them to help guide the discussion. Both participant and provider—or another person (such as a participant's family member or friend) and provider—will need to sign the Service Agreement once they have agreed on its contents.¹²

An issue arises in relation to a person with significant cognitive impairment who cannot sign a service agreement. OPA is of the view that the requirement contained in the Provider Toolkit should better align with the National Disability Insurance Scheme (Specialist Disability Accommodation) Rules 2016, which, for example, refer to a written service agreement, but do not specify that it must be signed.

Issues that arise for OPA guardians in relation to service agreements often relate to specific obligations the participant has to the service provider, to which the service provider expects the participant, or another party (perhaps without legal authority) to sign consent.

OPA is of the view that the relationship between a participant and a service provider is one of direct benefit. However, unless a participant is self-managing, the payer is the NDIA or a plan-management provider. As a result, the service agreement should be considered to be a statement of a contract's terms rather than a legal contract as such.

In current practice, service agreements have included matters outside the scope of the delivery of the NDIS-funded supports. OPA is of the view that service agreements relating to NDIS-funded supports should cover matters between participants and providers and should relate to the NDIS-funded supports only, and nothing beyond the scope of the NDIS Act.

Further, the only people who can enter into an agreement are the participant or a legally authorised person. Notwithstanding this, OPA guardians will not sign service agreements because often they include obligations that lie outside the scope of guardianship. For example, a guardian is unable to sign a service agreement where it:

- is beyond the powers the guardian has in relation to the participant (for example, the agreement contains provisions that affect the participant's finances)
- asks the guardian to take responsibility for matters that only the participant has control over (for example, require participant to treat the staff of the service provider with courtesy and respect).

¹² National Disability Insurance Agency, *Provider Toolkit Module 5: Service Agreements* (1 July 2016).

In responding to a provider's service agreement, OPA does indicate that, where it has legal authority, it is prepared to consent to the provision of services. In order to acquit the formal responsibilities of guardianship, however, there needs to be a clear statement of what the service entails.

Where a person has a significant cognitive impairment, there should be a process of approval developed, in conformity with sections 4 and 5 of the NDIS Act, that would avoid the need for a signed service agreement.

Recommendation 3

In situations where a participant has a significant cognitive impairment, the NDIA should amend its policy requirement that service agreements need to be signed by, or on behalf of, participants.

OPA's experience in the NDIS – advocacy and guardianship

OPA's experience in advocacy is that recognition of the role of the advocate is crucial.

For advocacy to be effective, the advocate needs to be seen as a legitimate party to the various conversations that occur in the NDIS planning and implementation processes. Unless an advocate is able to be recognised, is kept informed of the processes and is able to access relevant information, they cannot meaningfully contribute.

OPA's experience in guardianship is that this role seems to be better understood and acknowledged by planners but this is not universally so. That guardians are usually able to access copies of plans but they cannot access the portal.

Not being able to access the NDIS portal is an impediment to decision-making and restricts the full operation of the safeguards and rights-enabling mechanism that guardianship provides. This is a significant administrative barrier that must be addressed. One option would be to enable an institutional login for state and territory public advocates/guardians, and administrators and financial managers, with privacy restrictions where necessary.

The authority to access information and to be seen to hold a legitimate role on behalf of, or in conjunction with, the participant ultimately facilitates successful engagement.

On occasion, guardians have only been able to access a copy of a plan by requesting it from the support coordinator. OPA made a recommendation made in a previous submission to this committee, and amends it in this context.

Recommendation 4

The National Disability Insurance Agency should enable an institutional login for state and territory appointed public advocates/guardians and administrators/financial managers, so they can access relevant participants' information

Residential safeguards

OPA recently made a detailed submission to the Victorian State Government's review of rights in Specialist Disability Accommodation (SDA).

In that submission, OPA made recommendations in relation to the important safeguarding role played by Community Visitors. It also identified a significant legislative gap in the area of crisis accommodation (which could equally be extended to broader crisis support services) post full scheme. Transitional arrangements and practices have also led to issues in these areas. Some of these will be detailed below.

Community Visitors

OPA's Community Visitors Program plays an important, independent safeguarding and advocacy role for people in disability services supported accommodation.

Traditionally these homes have been gazetted residential services, legislated for and regulated in accordance with the Disability Act. In an NDIS environment, these homes are known as Specialist Disability Accommodation (SDA), and new models of SDA will likely develop over time in response to the funding incentives being offered under the NDIS.

The Bilateral Agreement for Transition to the NDIS between the Commonwealth and Victorian Governments establishes that 'existing quality standards will be continued and strong safeguards will be maintained in Victoria during transition'.¹³ The independent oversight and advocacy provided by Community Visitors to residents in group homes (now being referred to as SDA) should therefore continue unaltered during transition.

However, since transition began, OPA has concerns that it is not being notified of new SDA. The Community Visitors Program is experiencing significant operational difficulties with ensuring they have an up-to-date list of residential services operating in Victoria (including new, NDIA-funded SDA). They recently received a list from the Department of Health and Human Services that purported to be a comprehensive, up-to-date list of gazetted residential services (including new SDA), after requesting such a list for more than a year without success. Based on its experience and field knowledge, the program has concerns about whether the list is, in fact, completely accurate.

As a result of this lack of knowledge about which SDA are in operation, it is very likely that the safeguarding function provided by Community Visitors has not been available to every SDA resident during transition.

This difficulty for the program suggests that there needs to be improved, clear communication and information-gathering processes around the identification of SDA in Victoria.

The other issue for Community Visitors in this transition environment is the lack of access to information about participants' NDIS plans. Community Visitors are finding it difficult to identify issues with service delivery and community engagement (for example, if residents have money in the NDIS plan that is not being spent, or spent inappropriately) and advocate effectively for SDA residents without access to their NDIS plans.

While OPA understands that there are privacy issues that need to be engaged with, OPA remains concerned about the effectiveness of Community Visitors being undermined by lack of information.

¹³ June 2016. *Victorian Quality and Safeguards Arrangements for Transition: Agreed between the Victorian Government, Commonwealth Government and the National Disability Insurance Agency*, p 5.

Recommendation 5

The National Disability Insurance Agency and the Victorian Department of Health and Human Services should ensure that Community Visitors can access relevant information about participants living in Victorian Specialist Disability Accommodation in order to enable them to fulfil their safeguarding role under the Disability Act.

Crisis accommodation

In a pre-NDIS world, the Victorian Department of Health and Human Services (DHHS) could be relied upon to ensure that especially vulnerable people with disability (and complex needs that threatened tenancy arrangements) did not become homeless.

DHHS provided a safety net in cases where their disability-related supported accommodation arrangements broke down.¹⁴ The safety net provided by the State Government was not specified by legislation but, in OPA's experience, it could be depended on. Anecdotally, in regions where the NDIS has not yet rolled out, DHHS continues to respond to accommodation crises experienced by people with complex needs and behaviours of concern.

OPA's view is that, since the introduction of the NDIS, DHHS can no longer be depended on to provide this safety net in regions where the NDIS has been rolled out. During the transition period, OPA has seen an increase in Notifications of Temporary Relocation and Notices to Vacate issued under the Disability Act (Vic)¹⁵. And, unlike pre-NDIS times, OPA has experienced increasing uncertainty around what will happen to the people being threatened with eviction from supported accommodation.

At this stage, none of the people who OPA is aware of whose behaviours threaten their tenancy have become homeless. However, as cases proceed through the VCAT processes under the Disability Act (with landlords seeking possession orders and warrants for repossession of properties), OPA is very concerned that very vulnerable people will face homelessness, and, potentially, prison.

The transitional arrangements are largely silent on who will provide and fund crisis accommodation for people whose behaviours threaten their tenancy. Neither the Victorian Bilateral Agreement¹⁶ nor the Operational Plan¹⁷ refer specifically to crisis or temporary accommodation or its provision to people with disability. The Operational Plan does have a section on 'Complex Cohorts and Service Delivery' where the parties agreed to "plan appropriate transition arrangements" for cohorts with complex needs, including "People with immediate needs requiring rapid provision of NDIS or non-NDIS supports".¹⁸

OPA has serious doubts that these arrangements adequately cover people who are facing eviction from disability residential services.

The only mention of crisis accommodation is in the 'Principles', which state it is the role of "Other (non-NDIS) parties" to provide "homelessness specific services, including homelessness outreach and emergency accommodation". On the other hand, the "reasonable and necessary NDIS supports" include "supports to obtain and maintain accommodation and/or tenancies where these support needs are required due to the impact of a person's impairment/s on their functional capacity" and "reasonable and necessary home modifications...where the modifications are additional to reasonable adjustment and specific to the impact of a participant's impairment/s on

¹⁴ Bedson, L & Grano, P., 2017, *Submission to the Rights in Specialist Accommodation Review*, Office of the Public Advocate: Carlton.

¹⁵ FN Disability Act 2006 (Vic) ss 74, 76?

¹⁶ *Bilateral Agreement between the Commonwealth and Victoria: Transition to a National Disability Insurance Scheme* (16 September 2015). Accessed 11 August 2017 <http://webarchive.nla.gov.au/gov/20151020003310/https://www.coag.gov.au/node/526>

¹⁷ *Operational Plan Commitment between the National Disability Insurance Agency (NDIA), State Government of Victoria and Commonwealth Government for transition to the NDIS*, National Disability Insurance Agency and Victoria State Government.

¹⁸ *ibid.* (Operational Plan), Agreed Action 15.1, p. 18.

their functional capacity". In effect, the NDIA will support people to access and modify housing, but, crucially, will not directly control the provision of that housing. OPA is seeing this scenario for a number of its clients and are very concerned that it will result in them becoming homeless.

OPA asserts that for many participants eligible for SDA, but to whom no SDA is available, mainstream homelessness services are ill-equipped to provide an environment that meets their support needs. Indeed, eligibility for SDA requires a person to have disability related needs that are best met in disability specific accommodation settings.

OPA's submission to the Review of Rights in Specialist Disability Accommodation noted the safeguards and protections that would disappear for people with complex needs in relation to their SDA tenancies. In particular, a significant gap would appear (without additional legislative reform) for people whose behaviours of concern threaten their supported accommodation arrangements.

For example, under the Disability Act, provision of 'alternative accommodation' where behaviours of concern require a person to temporarily vacate their home is currently arranged by the person's disability support provider with assistance available from the DHHS.

Under the NDIS there are no provisions available for alternative accommodation – no additional 'crisis' funding from the NDIA and no one responsible for providing a bed. This situation was recognised and addressed in the recently released Productivity Commission Position paper on NDIS Costs, and NDIA's response to that paper. NDIA has stated that they are currently developing a 'Market Intervention Strategy' and are prepared to ensure market supply and act as provider of last resort in cases of 'thin markets' and market failure including in crisis care and accommodation situations and service gaps for participants with complex, specialised or high intensity needs, or very challenging behaviours.¹⁹

OPA's submission to that review proposed a state-based legislative framework to assist in filling this gap. The submission acknowledged that the proposed framework would not be workable without an agreement being reached between the NDIA and the State Government about funding for temporary accommodation in crisis situations. (Please see OPA's submission for further details on this topic.) This recent statement by the NDIA indicate that they may be open to filling this current 'transitional' gap in service responsiveness.

OPA looks forward to more detail on this recent statement in order to consider its likely impact and potential benefits for our clients. In particular, it is unclear whether NDIA's willingness to act as Provider of Last Resort will extend to the boundary issues and grey areas that have arisen during transition: for example, housing and crisis accommodation, services for people in close contact with the justice system, and participants with 'offending behaviours' (including issues identified in the section below on Clinical 'offence specific' services).

Two illustrative matters

In one matter, the Public Advocate raised the profile of the case of a woman who she was guardian for who had been forced to reside in gaol for more than 18 months due to lack of appropriate accommodation options.²⁰

After many months of negotiating, and thanks to the efforts of all parties, the NDIA was eventually responsive with a funding package, however, movement towards the woman's release was nevertheless contingent on the collaboration of a number of providers.

Ultimately, DHHS arranged accommodation; a public housing property that is being modified to meet the person's needs using Multiple and Complex Needs Initiative funding.

¹⁹ NDIA, July 2017, *NDIA Submission in response to the Productivity Commission Position Paper on NDIS Costs*, p. 39.

²⁰ Evidence given by the Public Advocate, Colleen Pearce, to the Joint Standing Committee's hearings on psychosocial disability and the NDIS.

In a second guardianship matter held by OPA, H is a young man, and an NDIS participant, residing in SDA. He has a diagnosis of anxiety, Autism Spectrum Disorder and Tourette's Syndrome. H's behaviours of concern began and have continued to escalate since November 2016.

These behaviours include property destruction (as a decluttering behaviour) and involve significant risk to his neighbours (as H frequently throws items into adjoining yards). The property damage resulted in a home that has only one working power point (for his television) and no heating. He has also physically assaulted staff and other residents, resulting in police charges and court attendance.

OPA was appointed as guardian in June 2017, after H was given a Notice of Temporary Relocation, to make decisions regarding his accommodation, access to services and healthcare.

H is clear about not wanting to live in his current unit anymore. His psychiatrist considers that the escalation in behaviours of concern are H's response to his present environment. His behavioural consultant is concerned about the quality of the supports being provided to him, including their overly restrictive and punitive nature.

The behavioural consultant wrote in an email to H's guardian and to the Senior Practitioner, that she held "grave concerns for [H's] wellbeing if he continues to reside in such an environment".

Indeed, H had lived in supported accommodation for more than eight years without demonstrating this level of problematic behaviour. For example, H had not previously engaged in this level of property destruction.

It is possible that a new residence, and appropriate levels of engaged staffing, could lead to much better outcomes for H.

The appointment of the guardian has resulted in greater access to psychiatric services, an agreement with H that enabled heating to be reinstalled to the unit, and positive engagement with the support provider.

The guardian has also obtained the support of the care team to change the request for alternative accommodation to allow H to access properties that are not 'robust', on the grounds that he had previously lived in such housing and that it will increase the chances of him finding a new home.

H's accommodation is at the centre of this situation. His current accommodation and support provider is following the processes specified in the Disability Act that will enable him to be evicted. The same support provider does not want to see H made homeless, and is continuing to house him. Yet all parties, including H, believe the current placement is untenable in the longer term – in part because of the damaged relationship that exists between H and the staff.

As an NDIS participant, H has (after a recent, timely plan review) been determined to be eligible for both 2:1 support, 24 hours a day, and to be eligible for 'robust build' SDA.

From OPA's perspective, therefore, the problem is not money. The problem is that eligibility for SDA does not necessarily make an SDA available to an individual participant. That SDA supply is insufficient to meet current demand is well-understood: H has money to pay for alternative accommodation (from the NDIA), but DHHS claims that no SDA exists that meets his requirements. This means that, if a public housing option is not found (that can be adapted to H's needs) before his support provider deems the support arrangement untenable and obtains a warrant for possession from VCAT, then H will almost certainly be made homeless.

In the absence of an alternative SDA option, the guardian is supporting the pursuit of alternative accommodation to be secured through the Victorian Housing Register (public housing). The pragmatic benefits of this option include that the property would be H's forever, and that there are a far greater number of single occupancy properties potentially available when compared to existing

SDA stock. The future development of SDA stock depends on private investors willing to build. As yet, there are no public programs constructing new SDA stock to meet existing and future need.

Seeking public housing stock for people eligible for SDA brings up unresolved questions about who pays for disability specific property modifications. Again a mismatch between the 'Principles' document and current understandings and practices by decision-makers seems to be occurring. (In H's case, the OPA Guardian was told that the NDIA would not pay for building modifications to public housing stock. This contrasts with the 'Principles' document which is quoted below.)

This issue is addressed in the 'Principles' document, which states:

"Reasonable and necessary NDIS supports for eligible people include: reasonable and necessary home modifications to private dwellings and **on a case by case basis in social housing** where the modifications are additional to reasonable adjustment and specific to the impact of a participant's impairment/s on their functional capacity."

So, while the principles suggest that the NDIS should fund modifications to social housing (which is defined to include public and community housing), in practice, at least in the two cases described above, funding for modifications has not been forthcoming.

H's case speaks directly to the key points made in OPA's submission on the rights of SDA residents: there is no contingency plan for crisis situations including those where a person's behaviours are threatening their tenancy.

In addition, H's care team consider that he poses a risk to the community without appropriate housing or supports. H's guardian believes he will end up in prison if alternative accommodation and supports are not found before he becomes homeless.

If this occurs, H's guardian believes that transition back into community living would be much more difficult and expensive than it would be if he received appropriate supports and avoided prison, as occurred in the first case study.

As well as the likely cost saving, the negative impact of institutionalisation to H's wellbeing would be significant. Indeed, H's wellbeing has already suffered (as demonstrated by his escalating and continued behaviours of concern) through inadequate provision of support and, clearly, the alternative accommodation he desires.

OPA is very concerned about H and his wellbeing and is strongly advocating for DHHS and the NDIA to collaborate find H alternative accommodation.

As stated above, in a pre-NDIS environment, OPA and the community could rely on DHHS as a last resort. In the transition environment, there is significant uncertainty about who is responsible for ensuring a person, whose tenancy is threatened by their behaviours of concern (which are related to their disability), does not become homeless. OPA's experience, in the handful of relevant cases that it has been involved in, is that the NDIA has been forthcoming with SDA eligibility/funding and funding for high levels of support staff, but not necessarily with providing the accommodation itself.

The two cases above - both of which involve NDIS participants with significant and complex behaviours of concern - highlight the operative role the State Government has played in identifying and providing supported accommodation.

In the first matter, DHHS has found suitable supported accommodation for the person. In H's situation, DHHS has advised that it does not have an appropriate property available. If the NDIA funds – but does not build – SDA, participants will continue to be at risk of homelessness and imprisonment.

OPA acknowledges that the NDIA, in its response to the Productivity Commission's NDIS Costs study, has committed to be a provider of last resort in thin markets, including for participants with complex or very challenging behaviours, as well as for those who have an acute and immediate need for crisis care and/or accommodation. OPA hopes this implies that, operationally, the NDIA will be responsible for providing a suitable property, and not solely providing the funding, which would not solve the present issue.

OPA brings attention to the case examples provided in this submission to flag the early appearance of thin markets in the transition to full scheme. OPA's submission on the rights of SDA residents suggests that this matter needs to be urgently worked out between NDIA and the State Government, and not just to help H, but all the people whose behaviours of concern come to threaten their tenancy.

This is ever more pressing, as OPA notices that, in backing away from their role as disability support provider of last resort, State Government is creating a gap that will disproportionately impact (and risk increasing institutionalisation of) Victoria's most vulnerable citizens.

Recommendation 6

The National Disability Insurance Agency, in collaboration with State and Territory Governments, should address the 'thin market' problems already appearing in relation to accommodation and services available to people with complex needs.

Clinical ‘offence specific’ services

“NDIS do not fund offence specific supports as the ISP did.” DHHS response to an issue raised by Community Visitors Program.

With the recent expansion of the NDIS outside of the trial site, OPA has seen fall out for participants from NDIA’s unwillingness to fund ‘offence specific’ supports in at least two domains: participants on Supervised Treatment Orders under the Disability Act (Vic) and participants on orders specific to the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic).

These participants share a history of offending behaviours.

OPA is currently aware of at least two participants (A and W) who have experienced a substantial drop in funding because of the NDIA’s unwillingness to fund what they see as ‘offence specific’ supports.

While participants with offending behaviours represent a very small cohort of NDIS participants, these are unlikely to be isolated cases. In both of these matters, the provision of clinical treatment has been suspended or discontinued due to lack of funding on commencement of their NDIA plans. Details of these matters is provided below.

As in the section on crisis accommodation above, which looked at the negative impact on participants of practices and decisions made by both the State Government and the NDIA during transition, this section also presents the problems with current practices relating to people with offending behaviours and highlights that these practices are not in alignment with the ‘Principles’ document.

OPA’s experiences to date suggest that NDIA planners are taking too broad a view as to what is an ‘offence specific’ support. OPA argues that this broad view is not supported by the ‘Principles’ document.

What ‘the Principles’ say about people with intellectual disability in civil detention

In November 2015, the most recent edition of the Principles was published. This document was endorsed by State and Territory governments. The document guides, or should guide, NDIA planners in their decisions about what participant supports will be funded by the NDIA. As each service system and jurisdiction has historically operated differently, it is understandable that confusion over funding responsibilities might occur during transition.

Victoria’s approach to civil detention of people with intellectual disability is further advanced than those operating in other states and territories. For example, the treatment pathways available under Victoria’s Supervised Treatment Orders are not replicated in other jurisdictions. The details of the justice principles do not specifically cover civil detention, except at the broad level. However, OPA’s experience in transition demonstrate that NDIA planners seem to be interpreting the clinical psychology and psychiatry services provided to people who are at risk of offending behaviours as services that should be funded by ‘other parties’.

The Principles refer to “offence specific interventions which aim to reduce specific criminal behaviours, reasonably adjusted to the needs of people with a disability and which are not clearly a direct consequence of the person’s disability”²¹ as being the responsibility of ‘other (non-NDIS) parties’. This principle is likely the basis of the NDIA planners’ decisions not to fund.

²¹ *Principles to determine the responsibilities of the NDIS and other Service Systems*, edition released on 27 November 2015, p. 23

However, the Principles also refer to supports that address behaviours of concern and reduce the risk of offending and re-offending such as social, communication and self-regulation skills, where these are additional to the needs of the general population and are required due to the impact of the person's impairment/s on their functional capacity and are additional to reasonable adjustment" as being in the purview of the NDIS.

OPA strongly suggests that much, if not all, of the content of the clinical services provided to people under a civil detention regime would clearly fall into the category of reasonable and necessary NDIS supports (as they are described in the paragraph above).

For example, the treatment of one participant subject to civil detention specifies the goals of his clinical treatment were much broader than 'offence specific supports'. The supports provided by the clinical psychologist were intended to help the person "manage the challenges of living with others", develop "healthy and adaptive relationship skills" and increase the person's ability to self-manage behaviours – all of which speak to reduced risk of reoffending. OPA argues that in this case the practice has not reflected the funding principles.

What is happening for participants with a history of offending behaviours?

In practice, at least some clinical services are not being funded under the NDIS, seemingly on the grounds that they are 'offence specific supports'. OPA knows of at least two cases that appear to fit this scenario, concerning people who have experienced significant cuts to their clinical support services on transition to the NDIS.

OPA has a long history of engagement with and advocacy support for this client group. In a significant number of these matters, the person concerned has experienced serious disadvantage and mistreatment during childhood. And their behaviours of concern, which have included offending behaviours, can very often be understood to stem from their functional capacity in the context of a lack of opportunity to develop prosocial behaviours.

As such, OPA sees the clinical supports being provided to people who present the risk of offending behaviour as clearly supporting the development of prosocial, communication and self-regulation skills – all of which would help reduce their risk of offending and should (in accord with the 'Principles') be funded by the NDIA.

OPA acknowledges that this area is one where it is not always straightforward to draw hard lines between clinical supports that aim to 'reduce specific offending behaviours' and clinical supports that aim to reduce behaviours of concern more broadly and build prosocial life skills. However, the potential outcomes of reducing clinical supports to people with 'offending behaviours' are very serious and possibly very costly (if it results in increased interaction with the justice system).

Recommendation 7

The NDIA, in collaboration with State and Territory Governments, should urgently address gaps in clinical service provision for participants with a history of offending behaviours. In doing so, the NDIA and State and Territory Governments should work to ensure the long-term sustainability of highly skilled and specialised disability support services which work with participants with complex needs.

Supervised Treatment Orders

Supervised Treatment Orders (STOs) constitute a civil detention regime for people with an intellectual disability in Victoria who pose a significant risk of significant harm to others. The regime allows people to be civilly detained in order to provide treatment to reduce the risk of harm to

others. When an STO is made by VCAT, the person is required to have a treatment plan that has been approved by the Senior Practitioner.²²

In at least one case that OPA is aware of, a participant subject to an STO had their funding for clinical services significantly reduced on transition from his Individual Support Plan (ISP) to his NDIS plan. This resulted in A (the participant) experiencing reduced services and supports from his psychologist and concern from A's disability support provider that they may not be able to adequately manage his risk to others or deliver on the goals specified in A's STO treatment plan. His psychologist wrote about the reduced services:

"The changes have considerable impact on the clinical governance and holistic approach in the care, management and supervision of A, and subsequently, on risk manageability."

In A's case, the Office of Professional Practice, which includes the Senior Practitioner, became involved and are seeking to resolve the problems presented by the NDIA funding decision. They are liaising with A's support coordinator to pursue a plan review to obtain a higher level of clinical funding for A. They are seeking additional assessments that, it appears, might be used to reframe the support provided by the clinician – to more clearly identify A's deficits in the domain of Daily Living Skills and his need for support in this area.

It is unclear what will happen to A if his request for more funding is denied. In this case, DHHS staff estimated A's plan review will likely take 6 to 8 weeks from time of submission. And the submission is waiting on assessments. It is also unclear who is responsible for paying for those assessments, but it appears they will be carried out by A's current service providers.

In addition, A is currently involved in what appears to be a very exploitative situation with some 'friends'. A's care team is very concerned about A's susceptibility to financial exploitation, and they are seeking an Administration Order to protect his assets. They are aware that A will be unhappy about this intervention and will soon have an increased need of support from his psychologist.

OPA welcomes that the NDIA is currently working to improve participant pathways, including 'a streamlined approach to making minor changes to a participant's plan'.²³ It remains unclear whether the NDIA has prepared some form of contingency funding that will be accessible on short notice when situations like these arise.

More generally in relation to STOs, *Victoria's Quality and Safeguards Working Arrangements for Transition* states that the NDIA must facilitate the Senior Practitioner to exercise his functions under the Disability Act. These functions include oversight of treatment plans and being able to direct a service to 'carry out.... a treatment', practice or procedure (s. 4.2.5). It is unclear how the Senior Practitioner can direct that treatments are carried out if they are not being funded by the NDIA, and DHHS has not stepped in to meet the shortfall in A's case.

People managed under non-custodial supervision orders

Community Visitors who visit Plenty Residential Services (PRS), which has historically been used to accommodate people transitioning out of the secure Disability Forensic Assessment and Treatment Service (DFATS), have identified at least one resident (W) whose funding package substantially decreased on his transition from a state funded Individual Support Package (ISP) to an NDIS plan. W is subject to a non-custodial supervision order under the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (Vic). W lost all funding for clinical services, one of the consequences of this reduced funding was that W ceased visits to his long-standing clinical psychologist.

²² Under the Disability Act 2006 (Vic) the Senior Practitioner has the authority to give clinical direction, supervision and oversight, and to monitor the use of restrictive interventions and compulsory treatment (under STO's) (ss 23-24). The Senior Practitioner is generally responsible for ensuring that the rights of persons who are subject to restrictive interventions and compulsory treatment are protected and that appropriate standards in relation to restrictive interventions and compulsory treatment are complied with: s 23(2)(a).

²³ NDIA Submission in response to Productivity Commission Position Paper on NDIS Costs, pg.25

DHHS advised the Community Visitor Program that funding for long running “psychological treatment” for W was discontinued due to “clinical advice regarding their lack of efficacy”. OPA questions whether the Senior Practitioner supported this assessment and whether they were approached to provide advice about alternative treatment programs. OPA is currently enquiring into W’s situation, holding concerns that if treatment is abandoned for W, he would lead a life of continued restriction and containment without hope for future rehabilitation and reintegration into community. DHHS stated that it is seeking funding for counselling services through a GP mental health treatment plan—OPA questions whether this will be sufficient.

In response to concerns raised by Community Visitors, DHHS noted that the NDIS does not fund offence specific supports as the ISP did. The department did state that it is assisting W to request a review of his plan and that it was “committed to topping up [W’s] funding to ensure he is not disadvantaged, pending the review of his NDIS plan”. Whether DHHS will continue to subsidise his support package if the plan review fails to obtain more funding is unclear.

Prior to W’s plan review, DHHS stated that “clinical input will continue to be provided to the care team by psychologist X (DHHS)...[who] will continue to conduct risk assessment reviews and consult to the care team...regarding supervision needs”. OPA understands that Risk Assessments are not being funded by the NDIA (but were under ISPs). The DHHS response quoted above suggests that perhaps DHHS is picking up this expense. It is unclear if DHHS has taken a general position in relation to the funding of risk assessments or if they will decide whether or not to fund them on a case by case basis.

OPA suggests that this loss of funding for what are being incorrectly labelled as ‘offence specific supports’, including psychological treatment relating to offending behaviours, will occur for many participants currently residing at PRS and unknown others across the state as they transition to the NDIS. It is unclear who will fill this funding gap if NDIA fail to pull their practices in line with their ‘Principles’ document.

Support coordination versus case management

OPA has concerns around the availability, quality, and comprehensiveness of support coordination as currently funded under the NDIS. OPA staff observe a direct relationship between adequate funding and timely provision of paid supports and the effectiveness of NDIS plans for people with cognitive impairments. Support coordination is one of the key determinants of the successful implementation of an NDIS plan.

In terms of availability, OPA is beginning to see a shortage of support coordinators. In some areas, Community Visitors report considerable delays in the implementation of plans because there is an insufficient supply of support coordinators. Some agencies now operate waiting lists rather than referring participants to other agencies that have the capacity to provide this support. This is worrisome as support coordinators enable participants to put their plan in motion, 'to utilise their support budgets to achieve their goals'.²⁴ In other words, some participants need a support coordinator to be appointed before they can access the other supports in their plan.

OPA has advocated for high quality staff to be employed at all stages of the NDIS participant pathway. We repeat the argument for employing support coordinators who are qualified and skilled in working with people with disability, and who are remunerated accordingly. Notwithstanding this, the issue of quality care sometimes transcends qualifications; OPA has worked with highly knowledgeable and capable support coordinators who find themselves unable to deliver the level of supports required by some participants within the maximum allocation of 2 hours of support coordination per week. The issue of quality is thus twofold: the quality of support coordination relies on the employment of qualified, skilled workers, but this needs to occur in conjunction with increased funding for this role.

Finally, OPA argues that for some participants the role of support coordinator needs to be more comprehensive and should be broadened into one with more responsibilities. In OPA's experience, people with cognitive impairment require much more than the sole coordination of their supports. Some individuals will, as a result of their disability, require coordination of multiple aspects of their life. In a pre-NDIS environment, this type of far reaching 'coordination' is provided by case managers from government or non-government agencies, and has been invaluable in ensuring that a person's life runs as seamlessly as possible.

In the pre-NDIS environment, in some instances, where a person with disability attend a court hearing, the case manager could help their client gather the necessary paperwork, choose an appropriate outfit on the day, and accompany them to the hearing to provide in person support. With transition to the NDIS, a support coordinator would instead arrange transport for a participant to attend a court hearing and not provide any of the additional supports the person requires prior, during or following the hearing. Case managers play a more comprehensive role in overseeing and coordinating multiple aspects of a person's life. They provide direct and holistic support to ensure that service provision achieves its expected outcomes for the participant. OPA is concerned about the loss of such a comprehensive support for people with complex needs in the transition to the NDIS. Further, it is not the legislative role of a guardian to fulfil a case management function in the event that gaps appear in the transition to NDIS.

In the NDIS model, the support coordination role is one of capacity building. It is a support that helps participants implement their plans to achieve their goals, which is more broadly in line with general principle 1 of the NDIS Act to support the right of people with disability to 'realise their potential for physical, social, emotional and intellectual development'. However, OPA argues that the current format of support coordination is too limited to fully enable this outcome or promote this right.

²⁴ NDIA (March 2017). *Support Coordination: Information for participants and providers*

OPA also identifies inefficiencies in the way support coordination currently operates. The support coordinator role is one that creates linkages between a participant and each of the services they receive. This model overlooks a crucial component of high quality care, that is communication *between services*, and OPA foresees this as becoming increasingly problematic. Community Visitors note examples where NDIS funded service providers arrive at a participant's house, without the house supervisor having been made aware of the participants access to external supports. The current position description of a support coordinator does not list a responsibility to facilitate communication between providers, which OPA sees as a significant loss of wraparound care. Especially for clients with complex needs, effective service provision is highly dependent on the cooperation and communication between all services.

Finally, one last aspect missing from the support coordination care model relates to crisis situations. The NDIA would identify support coordinators as a participant's contact person in the event of an NDIS-related crisis. For example this could be a crisis related to a participant's eviction from an SDA, as in the case studies presented above, or related to a participant's admission to hospital. In practice, OPA is aware that in these cases support coordinators do not have access to 'fast track' changes to a participant's plan or supports, thus rendering the crisis response ineffectual. A further operational complexity is that crises often occur outside of business hours and may likely be that neither the NDIA or support coordinators are accessible. OPA sees this as an important inconsistency between the responsibilities and powers accorded to support coordinators by the NDIA. In restructuring the role of support coordinator, this will be important to reconsider, especially for participants with psychosocial disability for whom crises could require rapid, punctual readjustments to their plans.

Recommendation 8

The National Disability Insurance Agency should introduce “intensive support coordination” as a funded service based on the traditional comprehensive case management model, to ensure that the NDIS has the capacity to respond to emergencies

As the transition to the NDIS continues, it is becoming apparent that there needs to be access to contingency funding to enable providers to respond in times of crisis. This would relate to, for example, access to funding for SDA where a participant does not have it in their plan, for support coordination where funding has been exhausted or where urgent respite is needed.

Recommendation 9

The National Disability Insurance Agency should provide access to contingency funding to enable support services to respond to participant crises.

One way to make to enable emergency and urgent responses would be to ensure plans have flexibility built. There is a need for the NDIA to address the long wait time for plan reviews.

OPA recognises recommendation 10 in the committee's recent inquiry, and builds on this here:

Recommendation 10

The National Disability Insurance Agency should develop an approach to build flexibility in plans to respond to the fluctuating needs of participants with cognitive impairment, including allowing for minor adjustments to be made without the need for a full plan review.

Continuity of supports

OPA understands that a disability client's transition to Continuity of Supports Programme (CoS) will be based on where they live and when the NDIS rolls out in their area. The phased approach is intended to support minimal disruption to care and services for both older people with disability and their service providers (clients will continue to access the current state and territory-managed/funded disability system).

OPA's primary concern rests on the implementation of CoS, and the state's commitment to continued funding of current disability services for a person over the age of 65 who is not NDIS eligible, and where CoS might not be implemented yet (given also that the Victorian roll out schedule is unclear). OPA would want to be sure that the funding provided by the state government is consistent, and that it has not decreased in the transition to NDIS.

A further issue that relates to this is one of equity. Where a person over the age of 65 living in a group home, they will only receive the same level of service funded by CoS as is consistent with what they currently receive through state disability services. Whereas, a NDIS participant living in the same group home, for example, will likely receive additional services through the NDIS, creating an inequity. The nature of the funding structure and the age requirements create this inequity, and Community Visitors have seen early instances of this in their visits to disability group homes in the North East Metro Area.