

**PARLIAMENT OF AUSTRALIA**

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

***TRANSITIONAL ARRANGEMENTS FOR THE NDIS***

**OCCUPATIONAL THERAPY AUSTRALIA (OTA)  
SUBMISSION**

**AUGUST 2017**

## Introduction

Occupational Therapy Australia (OTA) welcomes this opportunity to make a submission to the Joint Standing Committee's inquiry into transitional arrangements for the National Disability Insurance Scheme (NDIS).

Occupational Therapy Australia is the professional association and peak representative body for occupational therapists in Australia. As of March 2017 there were around 19,000 nationally registered occupational therapists working across the government, non-government, private and community sectors in Australia. Occupational therapists are allied health professionals whose role is to enable their clients to participate in meaningful and productive activities.

Occupational therapists provide services such as physical and mental health therapy, vocational rehabilitation, chronic disease management, assessments for assistive technology and home modifications, and key disability supports and services.

As such, they are a key provider of services to many NDIS participants.

OTA is a strong supporter of the NDIS and its focus on providing individualised support for participants with informed choice and control over their plans. Occupational therapists worked across all NDIS launch sites and contributed to the design and implementation of the scheme during its trial period. They are continuing to support participants as the scheme transitions to full rollout.

This transition has, however, revealed shortcomings in the scheme's design and its daily operation. In this submission OTA seeks to identify these shortcomings and suggest the most effective means of addressing them.

## Communication

The problem most frequently raised by those of our members working in the NDIS is the inadequate channels of communication between the scheme's key players. Participants and their carers should be able to reach the National Disability Insurance Agency (NDIA) within a reasonable period of time, and the Agency's undertakings to return telephone calls should be honoured. If the development of plans must be done over the telephone, which is by no means ideal, then new protocols and training should be implemented to ensure that Planners are well placed to produce evidence based plans that best reflect the support needs of the individual participant.

Our members have also reported that the provider section of the NDIS website can be difficult to navigate, as providers are required to sort through an abundance of information to find what they need (such as a particular set of guidelines). There is also a lack of user-friendly information for prospective providers who are interested in learning more about the scheme. OTA believes that the NDIA should adopt a co-design approach to developing operational guidelines. Providers often have no input into these or any opportunity to submit feedback on whether what has been proposed will work in practice.

Some occupational therapists have reported that the registration process can be quite lengthy, which may deter some people from signing up as providers. As noted above, another issue is the fact that providers quite often receive no response to phone calls and emails from NDIA staff. This could present a barrier to entry for new providers who may wish to speak to someone or ask questions about the scheme.

The NDIA's apparent inability to engage meaningfully with service providers, and the difficulties involved in navigating the NDIA website, act as disincentives to registration as an NDIS provider. At a time when there are doubts about whether the disability workforce will be sufficient to meet NDIS driven demand, the NDIA should not be allowing such disincentives to undermine recruitment.

## NDIS Planners

Following consultation with OTA members, it is apparent that planner inconsistency is a significant issue nationwide. The quality of NDIS plans varies considerably from person to person, and depends on the planner's level of experience and understanding of the different services available to participants. While OTA accepts that plans are purposely individualised, there can be no denying the fact that initial plans in the scheme's trial sites were often too ambitious and subsequent planning has become more modest. As a result, people with very similar disabilities often have very different plans. This is unfair and unsustainable.

Due to the fact that Planners are recruited from a variety of backgrounds, their understanding of appropriate options to support participants to achieve their goals, and the role of occupational therapists in this process, is often poor. It is clear that NDIS Planners frequently underestimate the hours of therapy required for a participant to achieve their goals, which subsequently affects the quality of their plan. It is also apparent that many Planners do not understand occupational therapists' key role in the prescription and review of assistive technology and home modifications.

OTA acknowledges that some Planners do have an allied health background and have developed plans that adequately reflect the complexities of a participant's needs. But many NDIS participants and their carers have been left frustrated by a lack of face-to-face contact with Planners. Moreover, Planners are often difficult to reach, resulting in providers having to advocate on behalf of participants.

OTA believes that occupational therapists should play a key role in working alongside NDIS Planners to assess and understand the functional needs of NDIS participants.

There are also inconsistencies with regards to Planners requesting reports from therapists in support of a participant's need for particular services. When reports are requested, therapists are often given insufficient time to provide these to Planners. Providers frequently request plan reviews if a participant's plan does not adequately reflect their needs, or if their circumstances change and they require additional supports. These reviews can take months to complete, resulting in added frustration for families and potentially affecting the relationship between participant and provider. In addition, the long wait associated with plan reviews frequently results in any progress that the

participant has made towards their goals being lost due to lack of continuity. This ultimately results in increased supports being required to re-establish progress.

OTA members have also stressed the extent to which many Planners are unfamiliar with the importance of integrated, multidisciplinary care. Planners and participants should be encouraged to view a package as an exercise in holistic wellbeing rather than merely the sum of unconnected goods and services. Such an approach facilitates the identification and treatment of comorbidities, which is often a constant consideration for people with disability. It also optimises preventative care.

Plans should also have a greater emphasis on goal setting. This not only gives the participant a greater sense of purpose, it provides benchmarks by which the success of a plan can be measured when it comes up for review. Again, NDIS Planners need to be made aware of the fact that goal setting is a core skill of occupational therapists.

While Planners develop and approve plans, they are sometimes unwilling or ill-equipped to play an ongoing role as case coordinator. This is particularly unfortunate if various service providers are working from different sites and communication between them is haphazard. It is often carers or a single service provider who must take on the unofficial and unremunerated role of case coordinator.

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

OTA recommends that consideration be given to how the skill level of Planners can be increased with respect to occupational therapy practice. We also call for the training of NDIS Local Area Coordinators (LACs) and Support Coordinators to be enhanced to allow for greater understanding of the roles of different health professionals. NDIS providers should be consulted throughout the process of developing or refining training material.

OTA is engaged in ongoing discussions with Allied Health Professions Australia (AHPA) around developing material to increase Planners' knowledge of the different allied health professions. OTA believes that the NDIA should develop a set of key performance indicators (KPIs) to monitor and assess the performance of Planners and the overall effectiveness of the NDIS planning process. There should also be clear timeframes for Planners to action requests for plan reviews and to respond to queries from participants and providers. The NDIA should consult more widely with participants and providers on the planning process to address specific concerns and ensure that the performance of Planners is in line with community expectations.

To facilitate the evolution of personalised plans, OTA believes minor amendments or adjustments to plans should be allowed without triggering a full plan review. This recognises that life circumstances can undergo degrees of change. It also enables some flexibility when the therapy supports required to work on goals are not initially planned for appropriately by less experienced Planners.

There is a widely held belief among participants, carers and providers that phone planning is an inadequate means of assessing a participant's needs. Phone planning should not be used in the development of a participant's initial plan and, if it is to be retained for plan reviews, new protocols should be introduced to improve its effectiveness.

## Travel

OTA members have also reported that NDIS Planners often do not appreciate how important it is for occupational therapists to perform assessments and provide services within the environment in which the client primarily functions on a daily basis (eg. home, school, workplace, residential aged care facility).<sup>1</sup> As a result, travel is not always included in a participant's plan.

This will subsequently affect the quality of care that a client receives, as home assessments are an integral part of occupational therapy. Assessments designed to determine a client's need for assistive technology and home modifications simply cannot be done in a clinic or over the phone, and private practices will be reluctant to offer these services to NDIS participants if the amount they can claim for travel does not reflect the costs incurred. This dilemma is particularly pronounced for people living with disability in regional and remote areas, participants who have already been identified as most at risk from any shortcomings in the scheme.

An occupational therapist working in a regional area noted that they can spend two to three hours driving to see a client. This provider's clients have complex support needs, and as such it is not practical for the client to travel in all cases. Furthermore, the complexity of the clients' needs means that a smaller pool of therapists with particular expertise are required to consult with these clients. It is becoming increasingly difficult to have travel included in NDIS plans, and this occupational therapist feels that clients' choice and control is being undermined as a result of therapists' travel being restricted in some newer packages.

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

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<sup>1</sup> There is considerable academic evidence to support the need for occupational therapists to observe how a client functions across a range of settings. Howe and Briggs (1982) state that it is the responsibility of the occupational therapist to consider the whole context when undertaking an assessment, including the home, school, workplace and community. Dunn et al. (1994) state that occupational therapy is most effective when it is embedded in real life – that is, when the occupational therapist can modify an occupation in the actual setting where it takes place. Ciampa et al. (2016), in a study looking at work integration, also support the need to undertake assessment in the setting where the occupation takes place.

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

Does this mean a participant has a maximum of \$1000 per annum to offset the travel costs of a team of different providers or \$1000 per annum per service provider? If the former, it is conceivable that one provider who sees the client multiple times within a short period may fully expend the funds available, leaving nothing for another provider who may need to consult with the client at a later date.

As indicated above, it is paramount, and also best practice, for functional assessments to be conducted in the participant's environment. The potential for an occupational therapist, in particular, to have restricted access to a participant's environment will restrict service provision and potentially compromise clinical outcomes.

Our members have also reported that it is difficult for providers to keep track of the amount that has been spent and what remaining funds are available. While therapists can try to see multiple clients in the same geographical area on a particular day, this is not always possible and does not give participants choice and control over their supports – in this case, choosing where they would like to see a provider. One therapist reported that they work predominantly with children and sometimes provide services in schools. They try to schedule appointments at times that are most suitable for the school, however this may not be possible if travel costs are capped at \$1000 per year. The same therapist noted that they currently charge a flat rate based on overall kilometres travelled (beyond 10 km from their place of work), as they are currently working across funding streams and charging for provider travel at the hourly rate is out of scope for other government-funded programmes. In effect, this provider is not being paid anywhere near the amount that is stipulated in the Price Guide. They also work in a rural area that does not seem to be classified as such in the Price Guide, and are regularly required to travel up to one hour each way to consult with clients.

Finally, members have noted that there is a lack of clarity around the circumstances in which the travel limit applies (eg. when participants are self-managing part of their NDIS funding or if their plan is being managed by someone else). All OTA seeks for the profession is that travel, which is an essential tool of trade, be fairly reimbursed. It is not about assisting practitioners to make a profit – it is about fairly covering costs.

The cost of travel is such that NDIS work is becoming unviable for some of our members, particularly those working in rural and remote areas.

## Written reporting

Just as occupational therapists must travel to consult with clients, they are also obliged to complete more written documentation than other allied health professionals. Traditionally this has involved significant report writing around initial and subsequent client assessments, and the considerable paperwork around the design of home modifications and the prescription of assistive technology.

Under the NDIS, the assessment role is effectively shifted to the NDIS Planner, and is based largely on goals and issues identified by the client or carer. It is then that the occupational therapist is approached with these identified issues. This has significant implications for the occupational therapist's documentation process. The occupational therapist may have to evaluate the assessment of a new referral in order to address the goals as identified by the Planner, but this time may not be funded. When occupational therapists receive new referrals under the NDIS they need to incorporate any report writing into the session time, unless funding is provided for written reporting. Unless report writing occurs during session time or is funded, it represents a threat to a practice's ongoing viability. Medico-legal considerations and the requirements of the Australian Health Practitioner Regulation Agency (AHPRA) also dictate that thorough client records be maintained by our members at all times. So the paperwork burden is constant but, under the NDIS, sometimes uncompensated.

Any price review of the NDIS needs to address this reality and develop a means of incorporating this professional necessity into funded services. And again, Planners need to understand the extent to which report writing is a core element of the occupational therapist's service provision, and of the importance of factoring funded report writing into a participant's service agreement.

OTA would be happy to assist in the development of training modules that promote and support this understanding on the part of Planners.

Similarly, participants need to be made fully aware of the fact that the prices set for therapeutic supports take into account preparation time and report writing.

## **Funding arrangements**

OTA is concerned that existing escalation parameters are unlikely to reflect the full increase in NDIS costs over time and this will result in the Australian Government bearing a higher share of the scheme's costs over time. It is also true that, as arrangements currently stand, the Australian Government bears all the risk of any cost overruns, but not all the control.

This is the result of the scheme's hurried and flawed design and, unless addressed, threatens the scheme's long-term viability. All Australian governments should accept this reality and come together in a spirit of cooperation to design a funding arrangement that more closely ties authority to manage risk with funding liability.

## **Boundaries and interfaces with the NDIS**

OTA considers that the NDIA should not only report on, but address, known boundary issues relevant to mainstream and disability service interface as they are playing out on the ground. A significant example is reported by occupational therapists working with school-aged students with disabilities, resulting in vast differences in access to therapy services for children living in different jurisdictions across Australia.

It is anticipated that at least 30,000 students with additional needs will be NDIS participants. Currently, the provision of therapy services is determined by a state or territory education department's policy regarding access to its schools or by a given private school's willingness to allow access. It is important to note also that therapy can involve facilitating a student's work in the classroom and/or participation in extra-curricular activities. This is a very complex field, with levels of access varying widely between jurisdictions and schools. It is currently unclear how these complexities will be managed under the NDIS, given that state and territory governments, and their education departments, will ultimately decide which, if any, clinicians will have access to classrooms and playgrounds.

However, discretionary access to NDIS-funded therapy services in the school environment, based upon principal and school jurisdiction preference, means that the education/disability interface is seamless for some, and acts as a significant barrier to both funding sources for therapy for others. For example, children with a disability living in Queensland have vastly improved access to school-based occupational therapy services compared with those living in Victoria. Such inequity needs to be addressed via a national disability scheme.

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

OTA addressed this issue in detail in our submission to the 2015 Senate Inquiry into Students with Disability. In the Senate Committee's report, released in January 2016, recommendation 9, made to government, states: "The committee recommends the government work with states, territories, experts, stakeholders, school systems, parents and students to establish a national strategy to improve the education of students with disability". The full report can be accessed at:

[http://www.aph.gov.au/Parliamentary\\_Business/Committees/Senate/Education\\_and\\_Employment/students\\_with\\_disability/Report](http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Education_and_Employment/students_with_disability/Report)

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

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

Members also report the existence of a grey area between the NDIS and the state and territory health systems. For example when a person with disability is discharged from hospital after a



medical incident and prescribed an item of assistive technology, is that equipment disability related and funded under the NDIS, or is it medical and funded by the health system?

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

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

## **Assistive technology**

Members from across the country have expressed concern about the uncertainty surrounding the delivery of assistive technology as part of NDIS packages. Before the introduction of the NDIS some jurisdictions allowed one AT provider to have a monopoly on the provision of goods to people with disability who were receiving government support. Under new arrangements it appears that in some jurisdictions these same providers will have, if not a monopoly, a preferred provider status.

It is imperative that, consistent with the overriding principle of consumer choice, NDIS Planners and participants be thoroughly acquainted with the breadth of AT providers available to deliver goods in a genuinely free and fair marketplace. This awareness, and the competitiveness it breeds, will ensure lower AT prices and, it follows, NDIS packages that make the participant's dollar go further.

## **The withdrawal of traditional services**

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

OTA notes that any disabled person aged over 65 years is, ipso facto, ineligible for the scheme. And confusion over eligibility for the NDIS is perhaps most pronounced for those experiencing mental health problems. Given the lack of clarity around the access criteria for the NDIS for people with mental illness, it is clear that a significant number of people will be deemed ineligible. It was recently reported that more than 100,000 people with severe mental illness who are currently receiving

services will not be eligible for the NDIS.<sup>2</sup> There will only be 64,000 NDIS places allocated for people with psychosocial disabilities once full rollout of the scheme is complete, meaning that many people could miss out.

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

Although OTA is supportive of the NDIS, it is critical that funding for the scheme does not come at the expense of existing programmes and services for people with mental health conditions. The growing focus on the NDIS has meant that other federally funded initiatives have become something of an afterthought, despite the fact that people with mental health conditions who are not eligible for the scheme are likely to significantly outnumber those who are. Following the release of the NDIS Quality and Safeguarding Framework in early February, industry stakeholders immediately raised concerns that the rights of people with disability who are not NDIS participants would not be protected.<sup>3</sup>

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

In New South Wales, for example, Ageing, Disability and Home Care (ADHC) services have had funding withdrawn by the NSW Government before users of the service have transitioned to the NDIS. This means those who relied on ADHC and are eligible for the NDIS are temporarily without any support, while those with chronic health conditions but who are ineligible for the NDIS are without support indefinitely.

## Conclusion

It is deeply troubling that so many of the problems associated with the rollout of the NDIS to date are fundamental in nature. These are not teething troubles but issues as basic as the imbalance between funding liability and the authority to manage risk. Unless addressed in a spirit of cooperation by Australian governments, this anomaly threatens the very viability of the scheme.

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<sup>2</sup> <http://www.theaustralian.com.au/national-affairs/health/100000-mentally-ill-lose-ndis-cover/news-story/3f2363653fc5e86044f4ae2116395273>

<sup>3</sup> <https://probonoaustralia.com.au/news/2017/02/concerns-ndis-quality-safety-framework-forgets-majority-people-disability/>

Other fundamental problems include matters as crucial to the success of the scheme as the limited knowledge and experience of many NDIS Planners. This is giving rise to imperfect and undeniably inconsistent plans.

This problem also involves the extent to which Planners fail to appreciate the role that allied health professionals can and should play in an integrated care plan. The NDIS is supposed to enhance the capacity of 460,000 Australians to function. Yet too many NDIS Planners do not understand the key role occupational therapists play in the assessment and development of functionality.

These problems will not be effectively addressed until the overarching problem of poor communications is addressed. The NDIA must acknowledge and address the fact that the scheme's rollout is being gravely impeded by poor lines of communication between Planners, providers and participants and their carers. Only when this problem is solved can many of the other issues raised in this submission be effectively addressed.

And OTA remains very concerned that at a time of such uncertainty state and territory governments are dismantling services on which people with disability have relied for decades, many of whom may ultimately be deemed ineligible for the NDIS.

Occupational Therapy Australia thanks the Joint Standing Committee on the National Disability Insurance Scheme for the opportunity to make this submission and would be happy to elaborate on the concerns we have raised.

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