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JOINT STANDING COMMITTEE ON THE NATIONAL DISABILITY
INSURANCE SCHEME

(Public)

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MELBOURNE

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JOINT STANDING COMMITTEE ON THE NATIONAL DISABILITY INSURANCE SCHEME

Tuesday, 26 February 2019

Members in attendance: Senators Brockman, Carol Brown, Gallacher and Mr Andrews, Mrs Sudmalis.

Terms of Reference for the Inquiry:

To inquire into and report on:

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

WITNESSES

ANGLEY, Ms Philippa, Head of Policy, National Disability Services	30
BARRETT, Mr Michael, National Manager, Government and Stakeholder Relations, Occupational Therapy Australia	30
BRONTS, Ms Mary-Rose, Acting Business Development Manager, Multiple Sclerosis Ltd.....	46
CALLAWAY, Ms Libby, Senior Lecturer, Occupational Therapy, Monash University; and Vice-President, Australian Rehabilitation and Assistive Technology Association	46
CLELLAND, Mr Angus, Chief Executive Officer, Mental Health Victoria	1
CURLIS, Ms Tania, Private capacity; and NDIS Engagement Consultant, Tandem Inc.....	46
DEANE, Ms Kirsten, Executive Director, National Disability and Carer Alliance	30
DIMMOCK, Ms Karen, Chief Executive Officer, Association for Children with a Disability.....	46
DOUGLAS, Mrs Andrea, Professional Adviser, National Disability Insurance Scheme	30
FITZGERALD, Dr Jennifer, Chief Executive Officer, Scope (Aust.) Ltd.....	16
FORSTER, Mr John, Chief Executive Officer, Noah's Ark Inc.....	16
FRAGOMENI, Ms Sharon, Customer and Service Delivery Manager, Ovens, Murray and Goulburn, Scope (Aust.) Ltd	16
GOTLIB, Ms Stephanie, Chief Executive Officer, Children and Young People with Disability Australia... 	16
HANNA, Ms Trish, Chair, Early Childhood Intervention Australia.....	16
HUMPHRIS, Ms Shirley, Private capacity.....	46
HUNGERFORD, Dr Jim, Chief Executive Officer, The Shepherd Centre; and Deputy Chair, First Voice	16
HUNTER, Ms Robyn, Chief Executive Officer, Mind Australia.....	1
JOHNSON, Ms Helen, Parent Support Adviser, Association for Children with a Disability.....	46
JUSUFSPAHC, Mr Enis, National Manager of Sector Development, Early Childhood Intervention Australia.....	16
KEANE, Ms Yvonne, Executive Officer, Early Childhood Intervention Australia.....	16
KING, Ms Emma, Chief Executive Officer, Victorian Council of Social Service	30
MACQUEEN, Mr David, Strategic Business Analyst, Multiple Sclerosis Ltd.....	46
McGEE, Mr Patrick, National Manager, Policy Advocacy Research, Australian Federation of Disability Organisations.....	30
MOODY, Mr David, Acting Chief Executive Officer, National Disability Services	30
O'BRIEN, Mr James, President, Prader-Willi Syndrome Association of Australia.....	46
OLSSON, Ms Catherine, Senior Adviser Disability, Speech Pathology Australia	30
ORR, Mr Mark, AM, Chief Executive Officer, Flourish Australia Ltd	1
PETERS, Mr David, Private capacity.....	46
PETERSEN, Ms Sam, Private capacity	46
PIU, Ms Marie, Chief Executive Officer, Tandem Inc.	46
POLLOCK, Dr Sarah, Executive Director, Research and Advocacy, Mind Australia	1
QUINLAN, Mr Francis (Frank), Chief Executive Officer, Mental Health Australia.....	1
REYNDERS, Mr Llewellyn, Policy Manager, Victorian Council of Social Service	30
RUIDIAZ EL-KHOURY, Ms Stefania, NDIS Coordinator, Royal Institute for Deaf and Blind Children ..	16
SHARKIE, Ms Fiona, Chief Executive Officer, Amaze	16

WITNESSES—continuing

STORK-FINLAY, Ms Susan, Private capacity	46
SYMONDSON, Mr Tom, Chief Executive Officer, Victorian Healthcare Association	30
TEBBUTT, Ms Carmel Mary, Chief Executive Officer, Mental Health Coordinating Council.....	1
TOBIAS, Mr Glen, Acting Chief Executive Officer, Neami National	1
TURTON-LANE, Mr Neil, NDIS Manager, Victorian Mental Illness Awareness Council	1
WEST, Ms Lin, Private capacity	46

CLELLAND, Mr Angus, Chief Executive Officer, Mental Health Victoria

HUNTER, Ms Robyn, Chief Executive Officer, Mind Australia

ORR, Mr Mark, AM, Chief Executive Officer, Flourish Australia Ltd

POLLOCK, Dr Sarah, Executive Director, Research and Advocacy, Mind Australia

QUINLAN, Mr Francis (Frank), Chief Executive Officer, Mental Health Australia

TEBBUTT, Ms Carmel Mary, Chief Executive Officer, Mental Health Coordinating Council

TOBIAS, Mr Glen, Acting Chief Executive Officer, Neami National

TURTON-LANE, Mr Neil, NDIS Manager, Victorian Mental Illness Awareness Council

Committee met at 09:01

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

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

Before we begin, I will say that Mr Andrews is on his way. He may well have been delayed by the infamous Melbourne traffic.

Welcome. Thank you for appearing before the committee today. The purpose of this session is to gauge progress and development on issues identified during the course of the inquiry into the provision of services under the NDIS for people with psychosocial disabilities. In the interests of time, we would like you to forgo the usual opening statements, though feel free to forward any information to the secretariat.

We will start off with a question. At the time of the inquiry, there was a high rejection rate of applications from people with psychosocial disability in comparison with applications from people with other primary disabilities. Is this still the case?

Mr Turton-Lane: It certainly is the case. In my role as NDIS manager, one of the services we supply is NDIS appeals. It's federally funded support for people who are going through the appeals process of the NDIS. We hear from consumers daily who have been rejected by the NDIS. We are also supporting a number of people through the AAT process. My feeling is that the situation is probably yet to peak as far as the level of need out there from people trying to apply for the NDIS with psychosocial disability. Initially, the only people who were supported through the process were people who were aligned with mental health services, and there are a lot more people out there in the community who have been living in terrible conditions with no support for a long time who now seeking to apply.

Senator GALLACHER: Some of the evidence we heard previously was that people are actually ending up in jail, possibly as a result of that lack of support. Is that a view shared by the organisations?

Mr Turton-Lane: That's very much the case.

Ms Hunter: We're experiencing at Mind Australia a 50 per cent rejection rate of people who have been participating in the Partners in Recovery program. By their very definition, they have severe and enduring mental ill health. I have with me some examples of people with the same diagnosis and similar presenting functional impairment in similar contexts, but one gets in and the other doesn't. I've got one borderline personality, anxiety and depression approved NDIS and one declined NDIS. Similarly, there are some with schizophrenia, persistent and enduring, declined NDIS and approved NDIS. I can provide those examples too. But really it does point to the case that the planners do not have the capability, skills and experience supporting people with complex and

high-support needs. They need a constant definition to address this inconsistency with eligibility and the adoption of an assessment process that actually takes into account fluctuating functional impairment, not just a diagnosis.

Senator GALLACHER: We were told that there are specialist planning groups who do take on complex cases. They are not working in this area?

Dr Pollock: We are yet to see them.

Mr Turton-Lane: That's yet to happen. That's on the way. It's been piloted in a few places across Australia.

Ms Hunter: I think what is being used as a proxy is having a psychiatrist or GP letter that is peppered with key words. That is influencing whether people are getting an approved plan. I would say a better proxy would be an OT or social work report that's developed over a suitable time frame, which would be something like three to six months to develop a reliable assessment of the needs and fluctuating needs over time so you can establish a reliable plan.

Senator CAROL BROWN: Are you able to give us any insight into how the pilot is working? Are you involved? Do you receive any information?

Mr Turton-Lane: It's underway in north-west Melbourne. I haven't had direct involvement with it. I have had direct involvement with people who would be ideal candidates for that pilot. But what I hear is that it is going to make a difference. But it is just one of many barriers to access in this space. It's access. It's planning. It's around the right supports. It's around the disability workforce being able to support people with mental health problems that are complex. Currently, a big issue that consumers have is finding a worker who can meet their needs. They're tearing their hair out trying to find people who've got even an inkling of how to talk to them and work with them. That's not there. There's been a huge exodus of skilled workers into other fields and other areas, so we're in this place now.

Mr Clelland: Can I add something in relation to the loss of skill? Across Victoria—and I'm talking from a Victorian perspective—a large number of existing suppliers of services have effectively pulled the pin in relation to providing services on the ground, because of the difficulties associated with operating under this scheme. Many are concerned about the transition from a well-qualified, skills based workforce to a less skills based workforce and, in particular, having to rely on staff who are not qualified and don't have mental health training. Many organisations have taken that on as a key risk to their organisation but also are philosophically against providing a service with a less-qualified workforce. Some others remaining and providing services are cross-subsidising, so charities are, effectively, subsidising some of the work of the scheme.

Mr Quinlan: I think part of the issue is that it's exacerbated by the fact that people are required to test their eligibility for the NDIS before they are allowed to gain access to the continuity of support services outside the NDIS, which means we're forcing a huge population of people who are unsuitable and should perhaps never be considered for the NDIS to nonetheless test their eligibility for the NDIS in order that they qualify for those continuity of support programs outside the NDIS. I don't want to say that there aren't people who are validly NDIS clients testing for the NDIS and being rejected; that is happening. But it's also the case that a very large population, because of the structural arrangements we've put in place, are being forced to test their eligibility when they never should be. I think it's bad for the system and it's bad for those individuals as well that they have to, essentially, go somewhere and say that they're permanently incapacitated, be rejected for doing so and then get access to ongoing state government programs or other programs.

Senator GALLACHER: Can you give us the detail in that?

Mr Quinlan: I'm afraid I don't know the numbers, but we know that there's a huge population. Some of my colleagues might correct me. Rough numbers of the national disability service planning framework suggested that there were in the order of 300,000 people with psychosocial disabilities who would benefit from some sort of individualised package of support, and there are 64,000 places in the NDIS. I'm not suggesting for a moment that all of those 300,000 should be in the NDIS—they should not be—but I think that gives you a sense of the scale of the population outside the NDIS.

To go to the workforce issue that Angus has raised: I just want to say that that exodus is continuing. We don't know what the arrangements are beyond 1 July, so there's a whole workforce out there dealing in this space today who don't know whether they've got a job on 1 July. We know that the need is there. It's self-evidence that the need is there, but as at today there's a huge skilled workforce who don't know whether they're going to be employed on 1 July. I think that just underscores the pressure that the system is under. That exodus, as Angus has said, has been occurring for some time.

Ms Tebbutt: To add to that with regard to some of the numbers of people who are making it through the NDIS pathway who are currently participants in the Commonwealth funded mental health programs: our national

peak body, CMHA, has been working with the University of Sydney on a project to track those numbers. They've released an interim report. The number of organisations participating at the moment is about 22, so it's small, but it's expected that that will grow as they continue this work. But that's showing that, for PIR, for example, overall 54 per cent of participants had applied for the NDIS and about 28 per cent had been rejected. For PHaMs, more than 50 per cent of participants receiving support under that scheme who had applied for the NDIS were rejected. I can certainly make available to the committee a copy of that report. As I said, it is an interim report—it's only the first phase—but it does have some useful, if small, numbers in it about what's happening with those Commonwealth mental health programs and participants under it who are applying for the NDIS.

In terms of the workforce issues, I would just say that in New South Wales we're experiencing a similar situation to what has been outlined by Victoria.

Mr Turton-Lane: It's quite extraordinary. Commonwealth funded programs like the PHaMs and PIR were set up because there was a need for those services—people were not getting the support in the community—and now they're gone. It makes very little sense to lose that workforce. It makes very little sense for people to now have to find their way through another system that's not even formed there, that's not even operating. In Victoria it's not operating. Many people in Victoria are really struggling.

Another area that is important to consider is the issues and barriers around access to the NDIS for people. If you are connected into the mental health system, you might have some reports that have been done by clinicians. That's fine. That's a fairly easy pathway. If you're in hospital or you have been in contact with clinical services, they can support you through the process. For other people who sit outside of that and may have something—engagement with community mental health services—it's a little bit more perilous because of the type of evidence that the NDIA requires around permanent and significant disability, psychosocial disability. It's very hard to access that material. Very few clinicians up to now have known how to write that material. So, there's a huge barrier there. I see a number of letters from psychiatrists who write about a person's diagnosis but don't write it in the way that the NDIA want to hear it. So, immediately that's a fail.

Another thing that's happening, which is even more concerning, is associated with the introduction of the NDIS Quality and Safeguards Commission. Psychiatrists and psychologists in the community who are supporting people to get the right information—often doing that work pro bono because they're doing a six-hour job in two hours—because of the standards under the NDIS, now have to pay an audit fee of \$6,000 to be able to work within the NDIS. If it's around access or planning, it's a disincentive. A lot of those people are saying that it's just not worth their while. If you're an individual psychologist, is it worth your while to pay an extra \$6,000 to be audited on top of the auditing that's already done to be a psychologist? It disadvantages the small providers who are probably the ones who are more likely to support people. So there are some real barriers in this space that need to be addressed.

Mr Tobias: I think perhaps the lesson that we've learned from Partners in Recovery and PHaMs is that those programs were able to discover, for want of a better word, a range of people who'd been completely disconnected from services. Those people find it very hard to go through the eligibility process, often having to self-fund the assessment process if they can't get funds through other programs. As of 30 June, those programs will go, and the question is: how does an NDIA arrangement find people like that, who have essentially fallen through the gap, into the future?

Mrs SUDMALIS: PHN has just been given a fairly sizeable chunk of money to give some permanency, because that was already identified as a problem, so it would be interesting to know if that is now being carried through. The other side of the equation is that there is no reason why PHaMs and Partners in Recovery can't be funded by PHN. Mind you, they'll whinge and grizzle and say they don't have enough money, but it's an important issue. You're saying that there's duplication of accreditation, effectively, for psychologists?

Mr Turton-Lane: Yes.

Mrs SUDMALIS: Would it be possible to get the Australian psychiatric association or some other peak body to go to the government and say: 'They already go through this process. Here's our accreditation. Why can't you make it: if you've got this one then you've got this one?'

Mr Turton-Lane: There are different standards, but that's a possibility. At the moment it's a disincentive.

Mrs SUDMALIS: Yes.

Mr Turton-Lane: Robyn mentioned OTs. OTs are great, but there are very few trained mental health OTs in this country. It's one thing to have OT knowledge about physical disability, but a mental health OT is quite different. For providers like that, who work for themselves—again, there are challenges there. It's for another set of people.

Mrs SUDMALIS: Something came up in one of my local disability forums. A physiotherapist/occupational therapist, who was having to travel a lot, said—and you pointed it out—that the language of acceptance by the system is different to the language of the therapist or the expert. She suggested that, within a reasonably short time, there be a co-developed document with a lexicon that says this means this in this system and this means this, and she was wondering whether there could be something developed not only for physical disability but also psychosocial disability. It would be a little bit more difficult to identify, I imagine, but because the NDIS and the NDIA are so quantified—it's all numbers—if you could get that parallel or scale of language it would mean that you wouldn't have that ridiculous situation where one person gets through and another person doesn't.

Ms Hunter: Can I address the point about the perceived conflict of interest. The person or trusted support worker, be it in an OT or a community mental health practitioner, who is best placed to inform the planning process, is barred from the discussion, and so what ends up happening is that around 80 per cent of the plans are inappropriate or inadequate. The quantum of funding is generous for people who do get a plan, but they're constructed with a very inflexible structure. Plans are frontloaded with 'core'—which, again, is some of this lexicon—which is doing four, which is exactly what a lot of these people don't need. They actually need to have flexible supports that are geared towards building their capacity and independence. But, because 70 per cent of funding is rigidly applied in this core, their needs aren't being met, so the burden is being transferred to unpaid carers, who have to pick up that additional burden when the support needs change. The inflexible plans can't flex. I suggest this happens when you treat people as algorithms. Also, plans are halved in year 2, with no basis.

Mr Quinlan: Can I just emphasise the point that Robyn just made. This also goes to the skills of the workforce, because the skills required to have a worker available to take someone shopping once a week are entirely different to the skills that are required to have someone teach someone to shop independently. I think that's part of what we're missing. What we're seeing is investment in the former, and were losing a lot of that investment in the latter.

Ms Hunter: If I could just finish here. I think a better way would be to reject the notion of these three categories around core, capacity building and assistive technology and allow flexibility so that funds can be used for capacity building in a flexible way, or the funds could be brought forward when the person is either side of being acutely unwell—becoming unwell or recovering post an exacerbation, a fluctuating need. I think that flexibility in the way that plans are structured is essential.

Mr Turton-Lane: There's a huge disparity between a good plan and a very average plan, and there is a difference for consumers.

For people who are getting a good plan, it's better than anything they've ever had before. It gives them a whole level of independence and self-agency that they've never experienced. It's absolutely meeting their needs and it's helping those people to grow as people, which is what I think the NDS is really about. It's about allowing disabled people to lead full lives in the community.

We need to work out why some people with mental health issues aren't getting good plans and why some are. We need to learn from that and make it not like potluck but something that's a standard that we have around how we work with people.

Mr Orr: I concur with that. I think that one of the things we experience is the vast variability in experience of people with planners. I think that plays into some of the comments that my colleagues have made. That relates to the skill of the workforce in the NDIA. Yes, some great things have started to happen and there are improvements, but they're very slow. Depending on where you are in the country you get a very different experience, a very different plan and a very different amount of support that's funded.

If I could just come back to the question, Ms Sudmalis, about standards: I think that is one of the challenges for organisations—for NGOs. We have a vast range of standards we need to comply with across government funding contracts. My compliance costs in terms of standards in the next 12 months will rise from \$40,000 to \$100,000 because, depending on where we are, we have to comply with the National Standards for Disability Services, the National Standards for Mental Health Services and the new NDIS Practice Standards, as well as work health and safety quality standards for other contracts.

All of those things are amazing standards, and they're great to be compliant with; they help us to deliver quality, safe services. But we do wonder sometimes if we can't get people together to say, 'What's the standard we need to apply and be accredited against so that there's an agreed standard across all of our services?' That would reduce the regulatory burden and our costs, but still maintain safe and positive services for people.

CHAIR (Mr Andrews): On that, is any work being done through the disability ministers' council to try to bring a lot of these standards together? It seems to me that there is duplication upon duplication.

Mr Orr: I'm not aware of any.

CHAIR: As a follow-up to that: which workers—if I can use that general description—in the NDIS field are not already registered under the AHPRA arrangements?

Dr Pollock: Community mental health practitioners. I think the registered professions would be the OTs, the social workers and the psychologists. All the others—and that's the bulk of our workforces—are not required to be registered.

CHAIR: Is there any reason, as a matter of public policy, why a person registered under AHPRA should need to be registered again? Or, to put it another way, why shouldn't their registration be accepted automatically as a default position in the absence of anything to the contrary?

Mr Turton-Lane: Not currently.

CHAIR: I know it's not so, but we're about trying to solve problems. This just seems to me to be one of the most simple and obvious examples of low-hanging fruit that could be dealt with quite simply.

Dr Pollock: I think that, as a matter of public policy, there isn't a barrier. I suspect that the barriers sit in the fact that there's different legislation covering different parts of disability systems.

CHAIR: Sure. But legislation can be changed.

Dr Pollock: Yes.

CHAIR: So my question is not about whether legislation causes this to happen at the moment or will cause it to happen in the future; my question is really about the public policy rationale for this. I can't see, personally—but you're more experienced than I am in the field—why, if you are already registered, for example, as an occupational therapist, or a speech therapist, or a psychologist or whatever, that registration shouldn't just be ticked as a registration for the purposes of the NDIS, unless there is some good reason in an individual case for why that's not the situation.

Mr Clelland: It makes a lot of sense. We need to note, though, that most of our staff who are OTs, social workers or psychologists are not registered; they haven't been required to be. It's just something that they'll have to do and pay for.

Dr Pollock: I think that's because, although they're qualified as OTs, psychiatrists and social workers, they're not working in a registered capacity; they're working as community managed mental health practitioners at a fairly senior level.

CHAIR: So in any event there should be no reason why the disability ministers' council or any other relevant ministerial council shouldn't actually be sitting down and sorting out how to simplify this, rather than adding another layer of registration and regulation on top of what's already a fairly highly-regulated area.

Mr Orr: And that's for individual practitioners. The standards I was talking about are for organisations. So it just adds a level of complexity that is not helpful.

CHAIR: But, again, with that process, I would have thought this should be a standing item on the agenda at the disability ministers' council, to actually look continually at how we can simplify the system, rather than just adding another layer of regulation on top of another one.

Mr Quinlan: I note, just as an interesting aside, that the workers employed by the NDIA, who have deep and intimate contact with a whole raft of the people who we're talking about, are not captured by the national quality and safety standards. So there's no requirement that they meet the standards of the people sitting at this table.

CHAIR: Yes.

Senator BROCKMAN: Just going back to your opening remarks, Ms Hunter: you talked about like-for-like not being treated equally, and Mr Orr touched on it as well. Is there any pattern to the inconsistency?

Ms Hunter: No.

Senator BROCKMAN: Is it a jurisdictional question? Is it merely who you apply with on the day? Is it a question of the planner? Is there any consistency to the inconsistency?

Ms Hunter: I think that it's a lottery. It's who you actually get sitting across from you and in having those conversations. The agency is set up to be a funding body and, in actual fact, there is no evidence that the agency can do effective planning for these people. There are examples of planning out there. An example is the TAC approach, or even SIL quotes. Now, the language is abhorrent—to actually quote around a person and their life—however, that does offer an example of how you could actually undertake it differently, and in a way that's proven to be more effective than the way it's currently being done.

Mr Quinlan: I'll just add to the point you made. We conducted some work, and I'll provide you with a summary of it, that suggested there is a phase 0 required in relation to the NDIA. Let me explain that: I think it would be fair to say that, as a general rule, people who have excellent support ahead of the application process and who have advocates sitting alongside them do much, much better in the planning process and what they end up with. But those arrangements are largely ad hoc and are largely subsidised, effectively, by agencies on the ground which have those connections.

The piece of work that we've done, amongst other things, recommends that we invest significantly in what we coined as 'phase 0', which is to say, 'Let's get people ready for the planning process so that they understand some of the options, so they build their confidence and so they have something to bring to the table when they get to the planning table.' We think that would make a huge difference in terms of the outcomes.

Mr Tobias: I think it stems from a basic misunderstanding of psychosocial disability. One of the side effects of psychosocial disability is social isolation. There are two prongs to that: it means it's very difficult to get the information to those people and that when you do find them, their needs are hidden because of their social isolation. So it takes a while to peel the onion.

Senator BROCKMAN: Okay. Just back to you briefly, Mr Quinlan: from your national peak body position, have you seen differences across state jurisdictions? Or are the rates of acceptance of mental health applications approximately the same?

Mr Quinlan: I think I would say they're approximately the same, but I would also want to say that it's very difficult. It just seems to be a very ad hoc lottery type of thing. On a state level, there is variation across regions within a state.

Senator BROCKMAN: Based on how many services existed previously?

Mr Clelland: There's a whole manner of factors, but I think part of this gets down to the training and competency of the workforce within the agency itself. We're quite heartened with commitments that were made last year around building a psychosocial disability competency framework within the agency and commitments to train planners in psychosocial disability. We're really keen to see that fast-tracked because we suspect that some of the challenges that we're encountering will be overcome with that capability development within the agency.

Ms Tebbutt: If I could just add to that because one of the things we have seen in New South Wales where the scheme was rolled out earlier—so, in the Hunter, for example—is the rates of people making it through to getting a plan are higher. So, there is an issue around the scheme maturing and people being able to understand it and work more effectively within the scheme, but it's still not at the level that it was predicted it should be at in the Productivity Commission report in terms of numbers of people with a psychosocial disability getting a plan. But, definitely as the scheme matures, I think we are seeing better outcomes.

The other point I would make is that we have been doing some training with NDIA staff around using a website that we established—reimagine.today—which helps people understand the psychosocial disability and how to navigate the NDIS. So, the NDIA have embraced that and the training is going ahead, but it is difficult for people to find the time to attend the training because there are so many demands on NDIA staff's time.

Mr Quinlan: It's also important to note that the assessment process reflects acceptance but also reflects in the size of the plans. So, I've certainly had national providers say to me that demographic groups that look very similar in two different parts of the country can have variants of plan size of up to 100 per cent—so, \$15,000 averages in one region and \$30,000 averages in another region—for population groups that for their intents and purposes look exactly the same.

Mr Turton-Lane: There are a whole lot of factors that go into planning, and some of them are around the supports that you have. It's not a simple equation, unfortunately; I think it's complex but we need to embrace that and work with it.

Senator CAROL BROWN: Ms Sudmalis mentioned PHNs and PHaMS. Do you have a comment on her suggestion around PHNs taking over—

Mrs SUDMALIS: No, not taking over; being a funding source.

Senator CAROL BROWN: That's what I was going to say: taking over—

Mrs SUDMALIS: Heaven forbid!

Senator CAROL BROWN: I hadn't finished what I was going to say; I was saying taking over the funding of.

Mr Tobias: So, the issue is: those people's jobs finish on 30 June—they're jumping now. It's almost too late, isn't it, to stem that flow. From what we can see so far, the funding that replaces that is just a very small

proportion and we've got no information yet on the continuity of support funding—it's a bit late in the day not to know what the extent of that funding will be.

Mr Quinlan: I had communication from an agency just this morning who are talking about 300 clients and something like 50 or 60 per cent of them haven't yet tested eligibility in relation to the NDIS. As I said, there is no certainty about what's happening on 1 July, which is not very far down the track. This is a non-government organisation that carries the risk of all of that employment burden, carries the investment that they've made in all of that staff but also carries a really deep commitment to 300 people in their community that they've been serving for some time. They're unable, as at today, to have any discussion with those people—neither their employees nor those clients—about what comes next.

Senator GALLACHER: Can we get on the public record the critical risk you see emerging at 30 June from each of your respective organisations: are we going to have a workforce or not; is there going to be continuity or not—that sort of thing?

Mr Quinlan: On our current trajectory, it's just really hard to say what's going to happen. As I said, we've been losing that workforce already and that will only continue, that will only exacerbate, as we get closer and closer to the date.

Mr Clelland: It's causing high levels of distress amongst the participants as well, of course, because they don't know what's going to happen at the end of the financial year.

Mr Tobias: Western Australia, it seems, once again, is a special case. The roll out of the NDIS is delayed in some areas, so people won't even have the opportunity to attest to their eligibility before 1 July, yet that's when the services disappear.

Mr Quinlan: I want to go back and emphasise the points my colleagues made about how long it takes organisations sometimes to build trust and relationships with the population that we're talking about. It's not like we can just pick people up and start again from scratch. These are often people who've been deeply connected with organisations and who've invested a lot of time and effort. Organisations have often subsidised a lot of effort to build trust with those people. That's just not something that can be picked up quickly. Quite potentially, I think the fear is that these people will be lost to the system again, frankly, until they turn up at a very expensive accident, emergency or ED with very florid issues and problems.

Senator GALLACHER: What should we be advising to happen?

Mr Turton-Lane: On what Frank was saying, we need more intensive support for people to get into the NDIS and around the planning process. To give you an example, I advocated for a person who was given a \$1 NDIS plan. He had \$1 in his plan and that's because he walked into the planning meeting and didn't know much about the NDIS and was asked these questions. Because of his history of trauma and mental illness he just shut up and said, 'Oh, no, I'm fine with this; I'm fine with that,' when he was very not fine. This person was homeless for a number of years. He's in a precarious living situation now, but he's got a place to live. I had to work with him for a number of hours to get him to feel like he could tell his story at the next planning session.

Mr Clelland: In terms of specific recommendations, a couple spring immediately to mind. One is the urgency of establishing a comprehensive outreach program within the NDIA with the skills and capacities to pick people up. But I also think that some of the recommendations are outside the NDIA, which is to say: invest in that population of people who are outside the NDIS and always going to be outside the NDIS. I'd say a PIR-like or PhAMs-like program outside the NDIS could provide that support.

Ms Tebbutt: I was going to say that with continuity of support there are two issues. One is the lack of certainty about what is going to happen come 30 June when the current programs cease. We know that the continuity of support commitments have been made by the government but it is unclear how that is going to play out in practice. Even the primary health networks don't yet know what sort of funding they're going to get or how they'll manage that funding. So I think there's that lack of clarity around a deadline that is fast looming. I think the second issue is the issue that Frank went to, which is: even with the continuity of support funding, it's not going to be enough to support all of the people who need support who are not going to get a plan through the NDIS, particularly people who are currently not in any sort of Commonwealth supported program or going to get an NDIS plan. It is unclear about what source of support there is for that group of people, because the continuity of support money will not be enough and will not cover that group. It's that gap.

Mr Quinlan: Not even close.

Ms Tebbutt: Those two issues are critical.

Mr Turton-Lane: I just want to challenge Frank on the assertion that people will never get into the NDIS. Just because a person might appear not to require the NDIS at one point in their life doesn't mean that—and I think you'd agree with this. I know what you were saying. There are people out there who have needs at one time, but it doesn't mean that person may not need the NDIS. If their health deteriorates to a point—that's life. What happens to a person that makes them go down hill rapidly? If there are no supports there, that's one of the things that's going to entrench disability in that person, so it becomes significant.

Senator GALLACHER: So we really need to get some suggestions about how we can recommend improvement.

Ms Hunter: I would like to suggest that the workforce we were speaking about before, that does have skills and experience, could be useful in developing that establishment phase that Frank was referring to. You build up a knowledge with someone, a trusted relationship. That could inform a plan that is a warm referral through to the NDIA—so that person doesn't experience rejection; they're only referred to the NDIA if they're appropriate to be referred to the NDIA—and, if they're not appropriate for the NDIA then it's a warm referral through to the continuity of support.

Mind Australia has completed a piece of research around choice in the NDIS. One of the key findings of that was how stressful and difficult the planning and review process is. People ask for things and they don't end up on plans. They experience rejection. They retreat. They're hard to engage with again when that happens. A particular area of concern around that is employment. Again, what Neil was referring to—the NDIS can afford great opportunities for people and, if we put the appropriate and realistic goals in people's plans and give them the appropriate support, employment goals could be possible for them. So the NDIA has the possibility, the potential, to be quite transformative. I see that the workforce we have—it's a slow death for them, at the moment. Mind Australia is mapping, as we speak, what to do with 90 FTE, come 30 June, of people we've invested years with, in terms of their training and supervision, to make them excellent staff. Up until now, Mind Australia has been very committed to retaining staff, but when that funding ends we don't have options.

CHAIR: This is the last hearing of this parliamentary committee in this parliament. Our last report will be tabled in four weeks time. Then there will be a gap, I presume, of six months, at least, before there's another parliamentary committee, if there is one, overseeing this area. So I would ask you to concentrate on the next few weeks, because this is our last chance to say something about what needs to be done in the meantime. So can any or all of you identify the No. 1 or two priorities that need to be addressed immediately, as in the next couple of months or so? That's probably the most useful thing we can do, apart from looking at the longer-term issues.

I suspect the most useful thing we can do is make some recommendations about what needs to be done immediately to try to avert some of the problems or challenges or, potentially, disasters that you're all alluding to. Can we bring it down to real, practical things that, if we agree, we can suggest need to be done immediately?—otherwise, there are going to be problems in the not too distant future.

Mr Quinlan: I take Carmel's point, as we understand it, that the money's in the forward estimates, in relation to the sorts of support programs outside of the NDIS that just need to be implemented earlier. I think there was a suggestion at Senate estimates, last week, that some of that investment might be about to happen. So anything we can do to press the urgency of making that investment would be very welcome. I think, also, lifting the requirement that people need to test their eligibility, in relation to the NDIS, in order to gain continuity of supports is terribly important.

It always seems to me, when you think how many people are outside the NDIS and are always going to be outside the NDIS compared to how many are inside, it's a bit like sending people off to the cardiologist to have their blood pressure tested. It just seems to make no sense whatsoever. We know the people. They're already in contact with agencies. Let's provide them with support. They're the couple of things I'd suggest.

Mr Turton-Lane: I would say: the appeals and reviews process of the NDIS.

For people who are either rejected or have a plan that doesn't meet their needs, the process of that appeals process is quite torturous for people. People are waiting—you've probably heard this—six months, eight months for an outcome. Then, the people apply, they get rejected and they appeal the decision. They end up in the AAT. Then what they have is two or three years of grilling without any supports—no support from the NDIS. They go through people's medical records. They sift through everything. They look for something, because then it's at a point where it becomes a legal argument rather than people's lives. I don't know of anyone who'd go through that process who didn't really have a need, because your whole life is there for the public. I've worked with people in that space and had to write statements for them and their carers. It's very distressing. Then they put their statement in and it's, like, 'Well, we need more information.'

Is it permanent? The notion that we need to test permanency is really loaded, because no-one can tell if someone's mental illness or impairment is going to be permanent. There's no science there. They keep on asking for more and more evidence about impairment. In the AAT space you have consultant psychiatrists—35 years; former heads of mental health services. They write a report. What happens to that? 'Oh, it's too high level.' The decision-makers around who's listening to people who actually know about mental health and about disability impairment—it's just not happening in that space. People are waiting for so long. It's very cruel and demeaning for people to have to go through that process.

Mr Quinlan: Chair, we've made 27 recommendations on the basis of that work I mentioned earlier, about the psychosocial pathway, and have taken the liberty of mapping those against recommendations that your committee has previously made. I'd be very happy to table that as part of the proceedings.

CHAIR: Thank you.

Mr Clelland: In terms of immediate priorities, Neil mentioned the dollar plans or low-value plans. We need to target those in very short order. There is a practical problem here in that if someone has a plan or has been accepted into the NDIS—they have a plan—they become ineligible for state services, and then they're left with nothing. We need to act on that very quickly.

Senator GALLACHER: Forgive my ignorance, but what is a dollar plan? What practical effect does that have?

Mr Turton-Lane: Because that person was eligible in Victoria—if you were already in mental health community support services, you got automatic access into the NDIS. This person did, but he met a planner who had no idea about how to work with him. To hear his story, he had no supports out there, because the service had fragmented around him. He didn't have the support leading into the plan.

Senator GALLACHER: I understand that, but what is the practical effect of having a plan with one-dollar value?

Mr Tobias: Essentially, they're saying you're eligible but at this point in time your needs are low.

Senator GALLACHER: And it can be lifted?

Mr Tobias: Correct.

Dr Pollock: I'd like to add to what Neil was saying previously about the AAT process in particular. The CHOICE research that we did revealed how really stressful the whole process of engagement with the NDIA is, right from thinking about whether you're going to apply through to plan review—multiple plans, multiple years into the scheme. We had a look at the cases that went to the AAT last year, and there were 34 cases. Four of those were people with psychosocial disability. The 30 people who didn't have psychosocial disability all had legal representation—not just advocacy; actual legal representation. The people with psychosocial disability did not. I think this is a significant disadvantage. I think there are two parts to supporting people, particularly through the AAT process. One is to ensure that there's funded advocacy available for them. I would question whether the funded advocacy services that currently exist are actually sufficient enough to reach everyone who needs—

Mr Turton-Lane: Workers burning out is a real challenge.

Dr Pollock: On top of that, I think people need funded legal representation. We do a fair bit of work with community legal centres, and we are aware through that that there isn't specialisation. It's relatively new legislation, but we're aware that there aren't lawyers who can both work with the community that we're talking about—not every lawyer can really work with people with psychosocial disability. It's a combination of having the right personality, attributes and ability to build relationships, but also the legal knowledge around the NDIS Act to support people through the process. Funding for that would be great.

Senator BROCKMAN: Jumping back to these minimal plans, one-dollar plans, do we know how many there are with people who were accessing state based services?

Mr Clelland: We've got no clarity around that. That draws us to an issue around the data and statistics that are available. There's great state-level and national data that's produced by the agency on the websites and so on, but we can't drill down to any great degree into the psychosocial disability participant group. We don't know. We hear reports and stories, and what Neil has just related to you is relatively common, but we can't put a number on it.

Senator BROCKMAN: What would we be thinking? Is it in the realm of thousands, tens of thousands?

Mr Turton-Lane: I doubt it's that many. You take it up a level, there are \$4,000 plans, there are \$2,000 plans, there are \$8,000 plans. Are any of them really going to meet people's needs? Do the plans have support coordination? No, because there's a trend not to provide support coordination. How do people then access services and exercise choice and control if they don't have a support coordinator working with them? Support

coordinators—again, now we're in a market economy, you can get good support coordinators or you can get absolutely terrible support coordinators. What impact does that have on a person?

Again, the quality and safety framework. There is nothing there to support people in the moment apart from—what then? Then what people really need is some advocacy or some contact with services to let people know that things aren't travelling well for them, that things are going really bad. I've seen people with \$50,000 to \$60,000 in their support coordination funds, and it has just disappeared. That person didn't have the ability to work with someone with complexity. Six months later they've got no support coordination, they've got no plan, they've got no services. Then, for some of those people with complexity, they might be at risk of having someone putting out a VCAT order on them or a guardianship when, with the right supports and the right kind of staff, that wouldn't happen. But that's not the situation we have. This is an extreme case, but this is happening with people.

Mrs SUDMALIS: In light of the fact that we are trying to get some expedient solutions now, would it be worthwhile for this group right here and now to nominate the dollar minimum—which is not the dollar—that, if they're in front of the review panel right now, they should be taken straight to the top of the pack to be reviewed within a very short time? Is there a number that you could choose now—admittedly, that's going to cause problems one way or the other. But say there are 100 cases that are around that. Is that something that would help those people immediately rather than waiting the months and months and months there are for review?

The other one is: can you recommend a step-wise one for those people who are unsupported in total and nominate a mechanism that would assist them? I'm not sure legal counsel is the way to go, because, as you say, there are not many who have the parallel skills of legal and empathy with somebody with a disability. For starters, to have immediate alleviation for the people who have been identified as having a disability and are not able to speak for themselves, having a planner not knowing the right questions to ask and not being able to read the body language of the person on the other side of the table, is there a rough dollar estimate regarding the number of people who have been thrown into a severe lack of funding level?

Dr Pollock: Mental Health Australia, along with a consortium of providers, who are sitting at the table, undertook a piece of work to look at existing data that we have on the client cohort that we believe are NDIS eligible. We took existing data of the support we'd given to those people in previously funded programs and through that we came up with not a dollar figure but a tiered arrangement of hours of support. Those are all people who, certainly at tiers 2, 3 and 4, are NDIS eligible. Tier 2 has 50 hours a month, tier 3 has 80 hours a month and tier 4 has 120 hours a month. You can use that as the basis and convert that to a dollar figure—potentially anyway.

Mr Quinlan: We'd be very happy to provide the additional information on the basis of that report. As we said, we conducted a piece of work with the support of members—many of them are at the table—that looked essentially at what psychosocial support packages looked like prior to the NDIS, within the constraints of the various programs and so forth that limited some of those arrangements. We think that would make an important contribution now as the NDIA are gaining their own information about what the current psychosocial support packages look like. We think there could be a useful marriage of some of that information. As recently as last week, we've been discussing that with the chair of the NDIA, Helen Nugent, who's expressed an interest in pursuing that work. I'll provide the information subsequently, if that's okay.

CHAIR: It seems immoral that somebody can get a dollar package, which is nothing, and yet be virtually excluded from all other services that they would otherwise have got. That's just—

Mrs SUDMALIS: Cruel.

CHAIR: immoral.

Mr Orr: Chair, if I could come back to your practicality question, people have touched on this issue repeatedly: the way in which the NDIA engages with the community managed NGO sector. We've done a lot of work in the last 18 months with Mental Health Australia around the Optimising Psychosocial Support Project, which is trying to use our vast experience and deep experience in supporting people with psychosocial disability to inform the NDIA's developments. I think that's a really important practical thing that the agency can step up to more. It's been doing some better work with the sector. Getting a bit of a hurry-on in relation to that would be very useful. As Frank said, he met with the chair of the NDIA board last week, and that's a positive development, but I think that really needs to be a focus in the next couple of months. The second thing, and Ms Tebbutt talked about this, is the training of NDIA staff around psychosocial disability. It's a bit of a concern—maybe an understandable one because people are busy—but, if it's a priority for the agency to get this right, then training of staff around psychosocial disability which has been developed by people with lived experience of psychosocial disability must be a fundamental priority.

Ms Tebbutt: On that, we are pleased with the engagement that we've had with the NDIA around the reimagine training. We're very glad that they've embraced it, and it's now being rolled out, but it is the case that staff are very busy and are trying to do a lot of things. To add to what Mr Orr said around the engagement of the NDIA, particularly regarding the psychosocial disability stream that the government announced at the end of last year, which was a very welcome announcement, there would be a desire for a greater amount of information about how those trials are running and how they're going to be evaluated to take advantage of the great wisdom and knowledge that sits with service providers and consumers in contributing to the trials, because there isn't a lot of information yet as to how that is all actually rolling out.

Mr Quinlan: Including how the successful parts of those trials could then be taken to scale, because I think nobody anticipated that that investment was ever likely to meet the entire needs. So I think how that might progress to a scaled investment that will meet the sorts of needs we talked about earlier is important.

Mr Tobias: The priority from our perspective is the looming funding cliff where all Commonwealth funding to Day to Day Living, PHaMs and PIR ends on 30 June. It's such a hard cut-off point. There's no way in the world, given the pace that the NDIA is working at the moment, that those people remaining will be able to go through the eligibility process and have it tested. From our perspective, it needs to be extended and rolled over so that we give ourselves the best chance (a) of not losing the workforce, (b) of filling the gap until the psychosocial stream is up and going properly and (c) to get those people and support those people to test their eligibility while we work out what we're doing.

Senator CAROL BROWN: What information have you received from government, other than the date where all the money will be rolled over, which is 30 June? Have you received any other information?

Mr Tobias: Only that it stops.

Senator CAROL BROWN: That's it.

Mr Tobias: At the moment, the PHNs are commissioning the psychosocial measure, which is a small extension of the funding. But they're commissioning that, so we don't know where or who is going to be in receipt of that money, so it's not going to provide, necessarily, continuity of that workforce and therefore continuity of the relationship with the clients.

Mr Clelland: And, of course, it's commissioned 31 different ways across the country.

Mr Quinlan: I just want to emphasise something, if I may. We talked about the funding cliff at the end of June, but as an employer now who's been in similar circumstances with funded programs, it could well be employees on longer-term arrangements who are entitled to three months notice at the end of their employment, which means that, actually, if the funding ends at the end of 30 June, I might be required as an employer to give that person notice at the end of March. I say that really just to emphasise the urgency of the problem. It's not like it's four or five months down the track. The boards and the employers sitting at the table will be making active decisions now about when we are required to give notice, what that notice has to look like, and whether we have to give notice and say, 'We want to give you three months notice but we're hopeful that the funding's going to be renewed, so please don't leave.' They're terrible, terrible circumstances.

Senator CAROL BROWN: What are we talking about in terms of an extension and time?

Mr Turton-Lane: I would say at least a couple of years.

Dr Pollock: I would too. Realistically, it will be three years.

Mr Turton-Lane: I think that's realistic thinking.

Dr Pollock: I think three years is really steep, because the broader system and policy landscape hasn't landed yet, and I think it's going to take a while. It will probably take another three years, possibly longer, before we actually understand what the implications of having an NDIS are for what sits between acute and clinical services and supports. I think having some sort of guarantee of continuity and stability over that minimum, probably realistically, three-year period is reasonable.

Mr Clelland: Of course, we have the Productivity Commission inquiry underway and a royal commission here in Victoria that will take the next couple of years to do, so having that stability, I think, is very much needed.

Ms Hunter: Can I also just make a point around the burden of compliance to contracting through the PHNs, because you've actually got a myriad of different contracts that you're actually then having to report again. So in addition to the accreditation and compliance requirements, you've actually got this commissioning and contracting burden as well, which is not insignificant. One of the things that I'd really like to do in the immediate sense is come back to your question before.

If the MHA recommendation on support purpose types and the two phases of support, that would go a long way towards helping people get decent plans and, if they are not eligible for the NDIA, a warm referral through to other funding types. So if there was one thing we had to land on that could be done tomorrow, that would be it.

Mr Turton-Lane: Mental Health Australia's *Optimising psychosocial support* report made a lot of recommendations around pricing. We need appropriate pricing to work with complexity and with people who, for a whole lot of reasons, are difficult to engage and work with. Alongside that, we have the issue around reasonable and necessary psychological supports. For people with mental health issues, the current stance of the NDIA is: 'We don't fund therapy. We don't fund psychological supports.' That means a person has 10 visits to the psychologist a year under Medicare. For anyone who has a high level need, that is nowhere near enough. You would need at least 15 or 20 visits and ongoing work for that person. When that person has that opportunity, their life can change. They can get out the front door. They can have relationships. They can look at work. They can get a job. So it is going to be cost-effective to the scheme to be able to support people to move on. We don't want people disabled because of the lack of supports for people. We want people to have that. But the current situation is that people aren't getting the supports they need in their plan around what is going on in their heads and what they need to sort out.

Mr Quinlan: I want to tie that point to the point we made earlier. The discussion about pricing, inevitably and rightly, invites questions about scheme sustainability. To extend the example I gave earlier about shopping: if we invest in a low-paid worker to take someone shopping for a lifetime, that's an enormous burden to the scheme; if we invest in a higher paid worker to build someone's capacity and teach them over two or three years to get out and about and shop themselves, it is a higher investment upfront but we've reduced the long-term burden on the scheme. I think we need to be thinking much more about that investment in capacity early in order to avoid the ongoing costs. So I would reject arguments that say the investment in a higher paid and higher qualified workforce earlier necessarily places at risk the sustainability of the scheme.

Dr Pollock: The Optimising Psychosocial Support Project made a series of recommendations on redefining or using different language for price items. That was generated by a lived experience expert group. The redefinition of the price items focused the support much more on recovery and capacity-building. They are written in language that is palatable to people who might be using the scheme as participants or as a support person, family member or carer. It is not just that they are more palatable; people then understand what they mean, and can start to ask for those in their plans with their planners. Consequently, they may end up with a plan that makes sense to them, the goals they are trying to achieve and the skills they need to do that.

Senator CAROL BROWN: Carers can access continuity of support—considering that there is some carer funding being rolled into the NDIS?

Mr Quinlan: Largely no, and that's a separate issue, but some of what once we might have called entitlements that carers receive—a recognition that carers are doing important work for and on behalf of the community—now are at the whim of the plan, essentially. For instance, respite is only provided to a carer if the participant decides that that's part of the plan. So there are some terrible challenges for carers in that space.

Senator CAROL BROWN: We talked a little bit about outreach and Mr Quinlan talked about needing a comprehensive outreach program. Can you give me an idea as to what is occurring now in outreach—reaching those people who may never have received any supports or who have had very little contact?

Mr Quinlan: I think it's fair to say that it's almost exclusively happened because the organisations sitting at the table invested and connected to people with often very challenging circumstances. Really, one of the fears is that that's part of a capacity for the system that is teetering on the brink and about to be lost because that workforce exists already. So I'm not aware of terribly much at all that's happening beyond that.

Mr Turton-Lane: In Victoria, the state government committed some ILC funding to support to support Neami and ACSA to outreach to people who were sitting outside the mental health system and weren't in contact with mental health services but obviously were severely impacted by mental health difficulties—people in the homeless sector and in a range of different areas, including AOD and the justice system. Unfortunately, because ILC funding is going to finish in July, that's a project that will cease. They're skilled workers and intake workers, so they've got a high level of skill, have the ability to work with people and are able to fund assessments. They've got a little bit of money there to fund assessments—the very necessary thing that you need to get into the NDIA. If you're a homeless person, you were assessed 20 years ago, you had some contact with the clinical sector and you've been homeless since or you became homeless at some point in time, there may be no evidence around your level of disability or what your needs are. There are people who are in contact with a service, but there's whole other community and I would hasten to say that that would extend into people who are termed by the NDIA as

'hard to reach', people who are living in SRSs or private congregate care facilities—I think they're called hostels in other states.

Mr Quinlan: To state the obvious, these are not people who are going to self-present at an NDIA office with the requisite paperwork available to them without very considerable support from the sorts of workers who are employed by the agencies at the table.

Mr Clelland: The state government is starting, I guess, a stopgap program over the next couple of years that has significant funding going into supporting people applying or attempting to apply to the scheme and, of course, providing some support to those that are rejected as well.

Dr Pollock: In Western Australia, they had a centralised process for people who were living in psych hostels. The NDIA in Western Australia managed a process to engage the couple of hundred people or whatever it was living in psych hostels—people who were very, very disabled with really quite significant support needs. They got a very high level of engagement in the scheme, but my understanding is that the majority of those people ended up with very small packages—\$7,000 to have a support worker take you out over the road to the park maybe once or twice a week.

It's good engagement, but, again, they are packages that mean for those people their only option, really, is to stay living in the psych hostel but with a little bit of disability support.

Mr Turton-Lane: You're talking about 6,000 people across Australia who live in private congregate care. That's a big population of people who are not being reached. I also think in our Aboriginal communities, obviously there are going to be some challenges around how much contact they have with the mental health system.

Senator CAROL BROWN: You said earlier that there was a 50 per cent rejection rate. I'm not sure if you actually did say how many go on to appeal, but I was wondering what the success rate is. I understand the difficulty that you've already outlined in terms of the people and appealing and that support is needed, but do you have any information around those that do appeal and how successful they are?

Ms Hunter: We don't do funded advocacy at Mind Australia. The information that I was providing were people who have received services from Mind and we've actively supported in trying to get them into the NDIS and when they've been rejected. We're currently going back through over a thousand records to test their eligibility and support them to retest their eligibility for that, because we believe that by their very nature they do have the complex needs that should be being met by the NDIA. Again, we are trying to work in a very constructive way with the agency to try and get as many of these people supported by the agency, but we don't do funded advocacy through the appeals process.

Senator CAROL BROWN: You don't have any information for those ones?

Dr Pollock: We could take it on notice and see whether we can provide that information, certainly.

Mr Tobias: We would love to see that data from the NDIA, on how many people are re-presenting and re-presenting.

Senator CAROL BROWN: Chair, we could probably request that information.

Dr Pollock: I think the three or four AAT cases that were psychosocial disability last year were all rejected, overturned, but I would want to check that.

Mr Turton-Lane: There are many more psychosocial. We've got seven with our service at AAT level. As I said, some of them are now into their third year.

Mr Clelland: We absolutely need more data on this cohort of participants, so granular data would be very useful across the country.

Senator CAROL BROWN: We'll see if we can assist. The committee previously recommended that clients receiving mental health services, including services under the Commonwealth program, transitioning to the NDIS should not have to apply for the NDIS to have a guaranteed continuity of support and access to services. That wasn't supported. Have you had a look at the government's response as to why that was not supported? Essentially, they consider it's in the best interests of existing clients to have the opportunity to test their eligibility.

Mr Quinlan: I'm afraid I don't understand the rationale for that. As I said earlier, it seems we're asking a huge population of people to test their eligibility knowing that a very large proportion of those people are not going to be found eligible for the NDIS and nor should they be, as there are a whole raft of support arrangements outside the NDIA and NDIS that are much more suited, or should be much more suited, to those people. So I don't understand that rationale, apart from the possible administrative neatness of keeping lists of people tracked appropriately.

Senator CAROL BROWN: I'm sure you would have had a look at the response to that recommendation. I was wondering whether you could have another look at it and perhaps give us a suggestion as to how the committee, looking to recommend something along those lines, could alleviate the concerns.

Mr Quinlan: I would be very happy to coordinate a response from the group.

Senator CAROL BROWN: I'm interested in the availability of services. Are people who are getting reasonable plans or good plans able to access the supports and services they need?

Mr Turton-Lane: Often, no. Often in regional and remote areas there's very much a lack of support. If you wanted someone with experience in working with someone with mental health issues, you would be very challenged, even getting a support coordinator who's got a background in mental health. There are huge waiting lists for services. So what do people do? They take pot luck with some company they don't know anything about. The whole process is very challenging for consumers to know who they're working with.

Mr Clelland: It's not just regional areas, of course. There is a thin market in metropolitan Melbourne due to the issues I raised earlier about providers withdrawing.

Dr Pollock: I think it's probably exacerbated when people have huge amounts of core in their packages. You are correct: there simply aren't enough providers, including in metro Melbourne, to provide that level of core.

Senator CAROL BROWN: What's the situation in terms of provider of last resort arrangements?

Mr Tobias: What we see is complex, perceived as difficult, clients getting shunted around providers because one provider says, 'I can no longer do this.' It gets to the point where several providers have rejected a participant. Then what seems to happen is the state government comes in and tries to put some money on the table to encourage a provider to come forward to provide services to these complex people. The provider of last resort is actually the emergency department, I think, in reality.

Mr Turton-Lane: I don't know whether that's going to continue. I don't know the COAG details about what's going to happen in future around that relationship. Come end of June this year, the state government in Victoria is effectively out of disability. So the provider of last resort—what happens there? I'm not really sure, but if you'd like I could find out a little bit more for you.

Senator CAROL BROWN: Yes, that would be good. Thank you.

Mr Orr: Senator, if I might make a comment. These are very important questions and I just reflect on my colleagues talking about people having to present to different providers and being rejected and testing their eligibility repeatedly. From my point of view, it's an important systems issue, but it's also the personal impact on people. The people we support who go through those processes find this really difficult, some may even say traumatic, as they try and access the supports they need to live their lives. I think we have to continually remind ourselves that this is about people and people's lives, and we shouldn't be doing things that complicate them more than they need to be.

Senator CAROL BROWN: Mr Tobias, in terms of the Victorian government putting money on the table to try and attract a provider, how does it come to the attention of the Victorian government that a participant is without a service or cannot get a service?

Mr Tobias: It's a good question, and I'm not sure. I guess services or perhaps the lack, or the NDIA talking to them and saying, 'There's a looming problem here because we can see that providers are wanting to withdraw from providing a high-needs person with a service.'

Dr Pollock: It may also be that the individual has a guardian.

Senator CAROL BROWN: It's not satisfactory though.

Dr Pollock: No, not at all.

Mr Turton-Lane: And I'm seeing the situation where people are getting guardianship applications placed on them because the system hasn't supported them. These are people who have been supported in the past who now have a guardianship application. It's probably not what we want to see in this space.

CHAIR: I think we have exhausted the time available to us. Thank you all very much for your submissions and the discussion this morning. I also want to thank you for your ongoing efforts and work with this committee over the duration of this parliament. As I said, this will be the last occasion in this parliament when we have the opportunity of examining these issues. So I thank you very much for all your work over that period of time. If there is any further information that you can provide, could we have it by 12 March, please, so that we can report in time. But, again, thank you very much.

Mr Quinlan: Thank you. On behalf of my colleagues I would just recognise the work of the committee. We have been here a few times and the committee has always been responsive to the evidence that we have provided and has always provided, I think, very useful and important recommendations and has been an important vehicle for change. Though none of us have yet landed where we want to be, I really appreciate the endeavours of the committee and the work that you have done.

CHAIR: Thank you.

Proceedings suspended from 10:31 to 10:48