Office of the Public Advocate

Productivity Commission
Canberra ACT

24 March 2017

Mr Harris, Chairman of the Productivity Commission,

RE: National Disability Insurance Scheme Costs

As Victoria's Public Advocate, I welcome the opportunity to respond to the Productivity Commission's Issues Paper on National Disability Insurance Scheme (NDIS) costs.

The Office of the Public Advocate (OPA) is an independent statutory body that works to protect and promote the rights, interests, and dignity of people with disability. In order to achieve this, my Office provides advocacy, investigation, and guardianship services to people with cognitive impairment and mental ill health and undertakes research and policy work that aims to improve the lives of people with disability.

OPA is the coordinating body of the Community Visitors Program in Victoria, in addition to three other volunteer programs, and provides support to over 800 volunteers. Community Visitors are empowered by law to visit Victorian accommodation facilities for people with a disability or mental illness at any time, unannounced. They monitor and report on the adequacy of services provided, in the interests of residents and patients. Community Visitors perform a crucial role in protecting and promoting the rights of people within the new disability service environment.

As a result of these functions, my Office has extensive expertise in understanding and negotiating the new disability service environment created following roll out of the NDIS. I take this opportunity to highlight some concerns being raised through my Office's involvement in NDIS roll out areas in Victoria, which I consider relevant to this review.

Market boundaries and the intersection with mainstream services

There are important service gaps resulting from the boundaries established in the Council of Australian Government principles (COAG principles) between the NDIS and mainstream service systems, particularly the mental health and justice sectors.

To my understanding, the Victorian Government has reallocated the majority of the Community Mental Health Support Services (CMHSS) funding to the NDIS. This is cause for concern, as I question whether the NDIS can, or should, effectively replace the service components that are currently delivered by CMHSS. The COAG principles clearly illustrate that the NDIS will complement mainstream mental health services, which remain responsible for the treatment of mental health, the operation of mental health facilities, early intervention services, and intensive case coordination when it is "related to mental illness". The risk created by withdrawing funding from CMHSS is fragmentation of one of Australia's most robust and effective community mental health sectors and the ensuing redirection of consumers into clinical services that may not have the capacity to support them.

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On the intersection with the justice system, the COAG principles outline that the NDIS "will continue to fund the reasonable and necessary supports"; a statement that is vague and subject to differing interpretations. Moreover, some of the responsibilities accorded to the justice system in the COAG principles have seldom been available in the pre-NDIS environment; for example, 'specific interventions to reduce criminal behaviours' and intensive case coordination – both of which are attributed to mainstream services – are not currently provided by the justice system and it is unlikely that they will be under the NDIS.

Close monitoring of service trajectories and outcomes for individuals who interact with - either or both - the NDIS and other mainstream services is required to ensure and confirm that they do not 'fall through the cracks' and that they receive a level of care that is in line with their support needs.

Planning Process and Market readiness

The discussion paper for this inquiry suggests that "extending existing part-time and casual carer hours" could reinforce the disability workforce in preparation for the NDIS. Contrary to this, I suggest that a casualisation of the workforce will be detrimental to the quality and safeguarding of services provided under the NDIS.

Adequately qualified staff will continue to be required at every stage of the NDIS process. This begins with high quality planning and support coordination to assist eligible individuals in understanding how to interact with the scheme, negotiate plans, and find supports that are aligned with their needs.

NDIS planners and support coordinators should be required to hold professional certifications. If assisting a participant with a primary psychosocial disability, for example, planners and coordinators should be trained mental health professionals. For numerous years, the Community Visitors Disability Services Board has repeated its recommendation for a minimum requirement of a certificate Level IV for all staff in the disability sector. This safeguard works towards reducing the risk of abuse and promoting higher quality care. I believe workers supporting NDIS participants with complex needs should benefit from higher wages, as this cohort requires workers to acquire an additional layer of knowledge and skills.

Governance and administration of the NDIS

As a participant driven scheme, the NDIS creates difficulties for people with complex needs, cognitive impairment, or limited supports in their lives that should not be underestimated. Having to research, locate, and evaluate the value and quality of services can be a challenging task, and for those with high or particularly complex needs or in regional areas, the required services are not yet on offer within the market.

As the sector transitions to a choice market model, providers have a choice as to which services they will provide and which participants they will support. Few mechanisms exist to construct or require the market to provide or meet the demand for specific services for complex individuals. My concern is that providers will refrain from providing services and supports for challenging cohorts. In thin markets, the most vulnerable individuals will find themselves with little or no choice in accessing the care they need. For instance, the obligation to develop services in rural areas will disappear, regardless of the need for such services.

Through advocacy and guardianship, OPA has observed several occasions in which people with disability would benefit from a 'provider of last resort'. One situation that illustrates this is the phasing out of the Disability Support Register, which has been challenging for some OPA clients in trying to find accommodation that matches their required level of care. In the past, the Department of Health and Human Services had centralised vacancy management processes, a function it has now abandoned. The consequence is that the burden is now placed onto individuals who may not be capable of undertaking the task of finding appropriate accommodation. I strongly advocate for a 'provider of last resort' and recommend that this be the Department of Health and Human Services rather than the National Disability Insurance Agency. This will be particularly relevant where the market is thin, and in the case of market failure.

I would welcome the opportunity to discuss the contents of this letter with you further.

Thanks you for the opportunity to contribute to the review of NDIS costs.

Kind regards,

Colleen Pearce
Public Advocate