Market Readiness

Joint Standing Committee on the National Disability Insurance Scheme

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Written requests should be directed to Victoria Legal Aid, Research and Communications, Level 9, 570 Bourke Street, Melbourne Vic 3000.

Contents

[About Victoria Legal Aid 1](#_Toc508971399)

[Executive Summary 2](#_Toc508971400)

[Summary of recommendations 4](#_Toc508971401)

[Experiences of market and regulatory failure 6](#_Toc508971402)

[Francis’ story 6](#_Toc508971403)

[Ian’s story 8](#_Toc508971404)

[Samantha’s story 9](#_Toc508971405)

[Dan’s story 10](#_Toc508971406)

[James’ story 11](#_Toc508971407)

[Jamal’s story 11](#_Toc508971408)

[Sally’s story 13](#_Toc508971409)

[Participant readiness to navigate new markets 14](#_Toc508971410)

[Participant readiness where the participant has complex needs 14](#_Toc508971411)

[The impact of pricing on the development of the market 15](#_Toc508971412)

[The transition to a market based system for service providers and the development of the disability workforce to support the emerging market 17](#_Toc508971413)

[The provision of housing options for people with disability, with particular reference to the impact of Specialist Disability Accommodation (SDA) supports on the disability housing market 19](#_Toc508971414)

[Lack of awareness of Specialist Disability Accommodation under the NDIS 19](#_Toc508971415)

[Lack of disability housing stock leading to chronic delay 20](#_Toc508971416)

[The need for a regulatory response when a person leaves the remit of the Disability Act 2010 (Vic) 20](#_Toc508971417)

[Provider of last resort arrangements 21](#_Toc508971418)

[Urgent need for an enforceable and transparent provider of last resort mechanism 21](#_Toc508971419)

[“Maintaining critical supports” 22](#_Toc508971420)

[Essential elements of any mechanism 22](#_Toc508971421)

# About Victoria Legal Aid

Victoria Legal Aid (**VLA**) is a major provider of legal advocacy, advice and assistance to socially and economically disadvantaged Victorians. VLA is the leading provider of legal services to Victorians with disabilities and mental illness. In 2016-17, 22,849 clients – or 26 per cent – identified that they fell within this category.

Our Mental Health and Disability Law program provides expert legal advice and advocacy to people diagnosed with mental health issues, including cognitive neurological, intellectual and psychosocial disabilities. In addition, VLA conducts a large criminal practice regularly assisting clients who have complex disabilities where disability is directly implicated in their alleged offending. In 2016-17, 13,800 of the 51,500 clients who received criminal law assistance from VLA identified as having a disability.

VLA is also the leading provider of legal advice and advocacy to people seeking assistance with social security matters in Victoria. In 2016/17, our Commonwealth Entitlements program provided legal advice on 2,297 social security matters and funded 69 grants of aid. VLA is also funded by the Federal Government to provide legal services for NDIS cases that are complex or novel. To date VLA has assisted in over 50 NDIS appeals. We provide advice and representation to applicants who challenge decisions of the National Disability Insurance Agency (**NDIA**) at the Administrative Appeals Tribunal (**AAT**).

VLA’s legal practice is also supported by a non-legal advocacy service, Independent Mental Health Advocacy (**IHMA**). IHMA supports people who are receiving compulsory mental health treatment to make decisions and have as much say as possible about their assessment, treatment and recovery. This service is an integral component in realising the reforms and vision of the *Mental Health Act 2014* (Vic). This service is also, now, exposed to issues related to the National Disability Insurance Scheme (**NDIS**).

The work of IHMA and VLA’s Mental Health and Disability Law program is also informed by a consumer experience group: ‘Speaking from Experience’ (**SFE**). The group has 14 members and brings a breadth of experience and expertise to the group, including the experience of living with mental health challenges. We confirm that SFE have considered our contribution to this inquiry and endorsed it.

# Executive Summary

Victoria Legal Aid is grateful for the Committee’s commencement of this inquiry and its singular focus on the market and regulatory dynamics which currently exist under the NDIS. We welcome the opportunity to contribute.

This submission builds on our previous submissions and evidence to this Committee in response to its inquiries into:

* General Issues around the implementation of the NDIS.
* Transitional Arrangements for the NDIS.
* The provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition (**psychosocial inquiry**).

In our submission to the inquiries into Transitional Arrangements and General Issues, we explained that VLA criminal lawyers were beginning to witness clear and dramatic market failure affecting the provision of disability services to our clients with complex disabilities. We detailed the very significant consequences of this largely unmitigated market failure, including imprisonment for periods of several months. In our submission to the psychosocial inquiry we highlighted the potential for the NDIS to provide pathways back to the community for people with complex needs. VLA is concerned that this potential has not yet been realised.

Our submission to the Committee’s current inquiry is also based on our knowledge of the market as it is experienced by our clients. ***First,*** we describe the experiences which our lawyers and clients are repeatedly confronting when:

* a client with complex needs (whether that person’s complex needs give rise to difficult behaviours or demanding physical health issues) encounters the NDIS market;
* the NDIS market fails; and
* the existing regulatory framework does not:
	+ oblige and cannot be relied upon to guarantee that a person will receive their funded supports; or
	+ identify any government entity with clear responsibility for responding to market failure.

Since our last submission to the Committee in November 2017, we have seen an escalation and expansion of cases in which the unavailability of fully funded NDIS supports is directly affecting the liberty and safety of people with disability. The issue affects people with complex needs across Victoria, including, but not limited to, people living in regional areas. VLA lawyers across our criminal, mental health and disability law and NDIA appeals practices are now all engaged with clients experiencing this same issue. We set a sample of these cases out in detail below. Critically, when the NDIS market is ‘not ready’ or ‘fails’, our clients:

* remain in prolonged custody in prisons;
* are unable to be discharged from psychiatric hospitals, often after emergency admissions in the context of market failure;
* experience serious risks to their health and wellbeing; and
* become or remain homeless.

These serious consequences are fundamentally at odds with the intention of the NDIS to enable people with disability to exercise choice and control. Further, left unaddressed, this issue appears to be contributing to an increase in the situations and the length of time in which a person with disability is held, without choice, in an institutional setting. Such an outcome is directly opposed to the undertakings the Commonwealth and State parties made under the 2016 Victorian-Commonwealth Bilateral Agreement that in the roll out of the scheme ‘participants should not be put at risk’. It is the antithesis of the social and economic reform agenda which underwrites the NDIS.

***Second***, in answer to your terms of reference we set out the repeated elements within these stories of how a crisis occurred, and the successes of any interventions. Specifically, we highlight:

* Insufficient skill, expertise and assessment support held ‘in-house’ by many NDIS providers, including specialist support coordinators, that are interacting with clients with complex needs.
* The importance of understanding “NDIS participant readiness” in the context of a person with complex needs as a concept which necessarily requires a planned, reliable and continually engaged, framework of expert assistance.
* The fragility of boutique NDIS providers attempting to “move into” the niche provision of services to people with complex needs.
* The implication, among a complex of other factors, of the fixed NDIS pricing model in a number of cases.
* The repeated entanglement of insufficient disability housing stock, housing vulnerability, NDIS market failure, and diffused coordination of a person’s lived needs in crisis situations.
* Lack of awareness across the NDIA and service sector about the potential for NDIA funding to provide housing options for people with complex needs.
* The fragility of private accommodation obtained by a person with complex needs under ordinary tenancy agreements, and the consequential removal of regulatory oversight of these arrangements once a person leaves defined ‘disability accommodation’ and the remit of the *Disability Act 2006* (Vic).
* A fundamental absence of any enforceable obligation on any government body to ensure that an NDIS participant receives their funded supports.
* An apparent lack of awareness on the part of NDIA officers responding to contact from participants about the limits of the current market.
* The great time required and current absence of “spare personnel” available in Victoria (and presumably in other parts of Australia) to create a service for a person with complex needs in crisis “from scratch”, leading to a clear need for a standing and funded arrangement to respond when the market fails and to prevent crisis.

We do not set out this detail with an intention to indiscriminately criticise the scheme. Rather, our submission attempts to identify the market and corresponding regulatory dynamics which affect our clients under the NDIS, with a view to contributing to urgent, transparent and enforceable reforms to remedy this continuing and concerning issue.

While we appreciate the complexity which the roll-out of the NDIS continues to present for Commonwealth and State governments generally, the burden of the current market and regulatory shortcomings are most acutely carried by the NDIS participant. Market failure and the absence of responsible regulation to remedy it are issues which must be resolved now. Interim and permanent solutions can, and must, be identified and put in place by both the Victorian and Commonwealth governments.

# Summary of recommendations

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| **Recommendation 1:** The NDIA, in collaboration with State and Territory governments, should urgently assess whether individual supports provided to a person with complex needs should be funded at a different or variable rate. Such supports should not be automatically equated with ‘attendant care’. **Recommendation 2:** NDIA planning must take into account basic market realities, such as insurance policies, when determining what level of support is ‘reasonable and necessary’. **Recommendation 3:** The NDIA should provide a direct support service for specialist support coordinators struggling to navigate thin markets. This service should be staffed with expert case managers who are able to build the capacity of less experienced workers in the field.**Recommendation 4:** Clear direction should be available to NDIS participants and Specialist Support Coordinators about which State and Commonwealth entities can be contacted where they are experiencing difficulty obtaining supports or retaining consistent support. Staff at the entity should be trained and informed about what options are realistically available to the participant, and if no options are available they should be directed to the Provider of Last Resort framework. **Recommendation 5:** NDIS planners should proactively discussSDA funding with participants who may qualify. **Recommendation 6:** SSCs should explore funding for new builds for participants including where that person has previously not lived in SDA provided by the State.**Recommendation 7:** The NDIA should immediately publish the status of its current work on a provider of last resort. **Recommendation 8:** The Bilateral Agreement in Victoria should be amended to provide a clear framework for a reliable and swift provider of last resort mechanism during the transitional period. Consequent amendments should be made to the Operational Plan. A timeline for this action should be agreed and adhered to by Victorian and Commonwealth parties immediately.**Recommendation 9:** The amendments to the Bilateral Agreements and Operational Plan must include clear and specific allocation of responsibility for remedying market failure in an individual participant’s case. **Recommendation 10:** A PLR mechanism should be made practically available through the allocation of funding and planning resources so that whichever government entity is allocated responsibility, a solution to the market failure will not be delayed by the inevitable time required to locate, train and recruit the workers necessary to “stand up” a service in the context of an acute crisis within an already stretched market. **Recommendation 11:** If the NDIA recharacterises a PLR mechanism as a program to “Maintain Critical Supports”, this should not lead to a situation where a person is required to justify that a support is “critical” in order to access the mechanism. Their statutory entitlement to the support has already been established. It is already “reasonable and necessary” under the NDIS Act.**Recommendation 12:** At the conclusion of the NDIS roll-out, amend the NDIS Act so that:1. an NDIS participant can approach the NDIS Quality and Safeguarding Commission (Commission) to demonstrate reasonable efforts to obtain a funded NDIS support. If so satisfied, the Commission should be required to direct immediate intervention by the body responsible for the PLR to enable that support to be obtained.
2. Every direction made by the NDIS Q&S Commission must be tabled before Parliament.

If the NDIA intends to be the responsible entity for implementing the PLR framework during the transitional phase, these amendments should be made as soon as possible. |

# Experiences of market and regulatory failure

## Francis’ story

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| *Part of Francis’ story was first provided to this Committee as part of VLA’s submission to its inquiries into Transitional Arrangements and General Issues. We also spoke to the Committee during its hearings in Melbourne in November 2017 about Francis’ case. Francis’ experiences of market and system failure continue to escalate and demonstrate the urgent need for a robust and standing provider of last resort mechanism. We provide the Committee with an update to his story below.* Francis is 20 years old. He has no prior criminal convictions and has never been in custody before. He likes everything Metro Trains, listening to music with big headphones and singing songs by Rihanna. Francis has a significant intellectual disability and autism. Before he transitioned to the NDIS, Francis lived in a Victorian Department of Health and Human Services (**DHHS**) house with DHHS funded workers who provided live-in care to him 24/7 as the complexities of his disabilities were such that he was not capable of living independently. In September 2018, Francis was remanded on charges relating to an assault. After Francis was remanded, the agency contracted to provide services to Francis in his home quit, stating that they were withdrawing services because Francis posed a ‘business risk’. In custody, Francis was initially detained in solitary confinement. He was clothed in a canvas smock and subject to handcuffing when outside his cell. He remains subject to handcuffing at all times outside his cell. He is very vulnerable in custody. When Francis’ lawyer discussed his custody with him Francis explained that he wanted to go home and that being in prison makes him sad. He finds the environment frightening and doesn’t feel comfortable engaging with other people in prison.After Francis was remanded into custody, no service provider was willing to take on his contract. DHHS initially said to Francis that they were only his landlord and that it was up to the NDIA to find a service provider. The NDIA have said to Francis that they are merely his insurer and ‘just a bank’. No-one came forward, claiming it was Francis’ responsibility to find a new service provider. Since Francis has been remanded, the NDIA increased the funding in his NDIS plan to over $1,000,000 from about $200,000 but despite this, no other service provider expressed any real interest in taking on this contract. His Specialist Support Coordinator stated that all his services were appropriately priced. Throughout this period two possible providers indicated they were “interested in entering the niche market” for people with complex needs, but ultimately did not enter into a contract with Francis. These providers had little background working with people with complex needs, and no staff cohort with relevant experience or training. One provider promised to “come on board” but was unable to recruit and train workers to fill a roster.**Update:**In November 2017, after Francis had been in custody for 2 and a half months, the Victorian State government intervened, and DHHS collaborated with key services providers in the State, with whom it had an existing relationship, to retain a service provider who would provide the 24/7 caring supports for Francis. In late November 2017, Francis’ lawyer applied for bail. The prosecution and the Judge agreed that Francis would not pose an unacceptable risk to the safety of the community if he was properly supported in his home. Given there was now a support agency contracted to provide these supports to Francis, the Judge granted him bail.The day Francis was granted bail, he allegedly assaulted two staff members in the context of arrival back to his former residence: the site of alleged sexual and physical abuse by his former carers. Initially, the police said that they were not planning on arresting Francis or taking him back to custody, as the alleged assaults were minor. Half an hour later, the service provider quit, meaning there was no-one else to provide the residential supports for Francis. In these circumstances, the police then charged Francis with a minor assault and he was taken back into custody, where he remains.Francis’s well-being has continued to deteriorate in custody. He remains very vulnerable and experiences the prison environment in an acutely harmful way because of his disabilities. For example, as a result of a prison transfer Francis has been subject to strip-searching. He was strip-searched before he was transferred and then strip-searched again when he arrived at the new prison. When Francis did not want to participate in the second strip search he was held down with force and prison guards cut off his clothes with scissors. Francis continues to spend over 20 hours a day alone in his cell. In late January 2018, DHHS located another service provider to work with Francis. However this provider stated that it would not be ready until February 2018 to start working with him. DHHS also decided that Francis’s original accommodation was no longer suitable for him and considered it was important to allocate him to an alternative residence. His lawyer understands that Specialist Disability Accommodation (**SDA**) funding was sought from the NDIA. However, because of the unavailability of disability housing stock, Francis had to wait for the residents of an existing DHHS house to be moved, and then certain renovations to be completed to that house.The new service provider said that in order for them to work with Francis, they have to be able to use restrictive interventions. In part, his lawyer was told, these restrictions are necessary as a result of the impact of the prison environment on Francis’ sense of safety. A wall has now been built that runs through the middle of Francis’ new accommodation which will separate Francis from his carers. There are three perspex windows in the wall and a door with a purpose-built perspex flap that can be lifted so that the carers can pass through Francis’ meals. There is no door in the property that allows Francis to go outside and all the doors on the property will be locked. When Francis is eventually released from custody, it is initially planned that he will have no contact with another person except through the perspex windows and flap.The new service provider who will provide day to day care for Francis applied to the Victorian Civil and Administrative Tribunal for an interim supervised treatment order (**STO**) to authorise the detention of Francis in the community and the use of seclusion in his home. However, recently, the service provider who had been engaged to provide clinical expertise in managing and downgrading the use of restrictive measures when Francis is in the community quit. This means that currently there is no NDIS provider who will oversee and guide the use of restrictive interventions. It is unclear when a replacement provider will be found.Francis’ lawyer has again applied for bail for Francis. DHHS said that everything would be “ready to go” by 6 March 2018 and the application was heard on that day. The magistrate who heard the bail application said that the issues before her were not criminal justice problems, but a health problem, and custody was not the right place for Francis. She said that when the STO is made, she will grant bail. On 15 March 2018 Francis was released on bail and the STO came into effect.Because of the complexities of Francis’ disabilities, he is not able to plead guilty to the charges. If he were able to plead guilty, a likely sentencing outcome would be a good behaviour bond or a fine. It is uncontroversial that he would not receive a custodial sentence, given his age, lack of prior criminal history and disabilities. When Francis was released he had been detained for six months. |

*Please note that the below case studies are also based on the experiences of real participants, but we have changed their names and omitted some minor details to protect their privacy.*

*We have also been unable to tell some client stories because, including as a result of market failure, we have been unable to obtain consent to their story being told.*

## Ian’s story

Ian is in his 40s and has one son. He enjoys chatting with friends, playing cards and sharing “a cheeky cigarette”. Ian has an intellectual disability.

Ian’s life has included repeated involvement in the criminal justice system. He has been detained in custodial or institutional settings for the last 12 years.

Last year, Ian was placed on a supervision order after further offending. The court heard evidence that there was a nexus between Ian’s intellectual disability and the offending as his disability meant that he had poor impulse control and difficulties with consequential thinking. The court heard that Ian needs to live in supported accommodation and also requires special supports to assist him with learning independent living skills, as a result of the extended periods in which he has been institutionalised. The court heard that it would be better for Ian to live in a supported house in the community rather than the current facility, which is a more restrictive environment.

As part of the supervision order Ian is subject to he is not presently permitted to leave the facility where he resides unless he is accompanied by staff. This facility is in regional Victoria, more than 250 kilometres from Melbourne.

In October 2017, Ian transitioned to the NDIS. He received a package that included funding for a specialist support coordinator as well as funding to help him learn independent living skills to assist him with achieving his goal of moving back to the community. Ian’s specialist support coordinator has been unable to organise any independent living programs for Ian to complete. Ian’s specialist support coordinator has explained that this is because there are no agencies that offer this support in the small town where Ian resides (and is required to remain under the supervision order). His NDIS package does not include funding for transport for agencies and so agencies from metropolitan areas have not been willing to cover the cost of travelling to Ian to provide him with these supports.

As a result, six months after the commencement of his plan, Ian has still not been able to use any of the funds in his NDIS package for these supports.

Ian’s specialist support coordinator is looking for supported accommodation in the community for Ian to move into. In his lawyer’s view, it is unlikely Ian will be able to transition to the community unless he is also able to complete the independent living programs he has been funded to complete under his NDIS package.

## Samantha’s story

Sam is six years old.  She loves Peppa Pig, going to Kindergarten when she can, playing with playdough, cars, baby dolls, bubbles and listening to stories. She communicates with a nod for yes and shakes her head for no. She coos when she sees babies. She lives at home in a large regional centre with her family.

Sam was born with multiple, complex disabilities, which can result in multiple seizures each day, low muscle tone and serious respiratory vulnerability.  Sam’s disabilities mean that she is unable to mobilise without assistance, it is necessary for someone to constantly watch her to determine whether she is having a seizure, and to assess the severity of that seizure to determine the appropriate medical response.  Sam’s treatment and the medical responses to her fluctuating condition have been determined by a major teaching hospital.

Sam has been a participant in the NDIS for over four years.  Her NDIS plans have included funding for individual support workers to fill a care roster in her home and when she travels into the community.  Among other things, these workers are funded to assist her to move, monitor her breathing, provide her with oxygen when relevant, and to administer rescue medication for her seizures while waiting for an ambulance. They also need to facilitate her communication and motor skills therapy so that she can, as her parents explain, “have the chance to live like a little girl”.

These supports are not funded in a way which allows Sam access to nursing staff under the NDIS’ fixed pricing rules.  Rather, the supports are funded at a lesser rate and intended by the NDIA to be provided by disability workers. Sam’s individualised safety care requires these workers to be continually trained and assessed by a hospital ‘trainer nurse’. Working with Sam is emotionally and physically demanding and relies on a high level of skilled training, acumen and experience for a non-nurse (RN) support worker.  The pool of carers is difficult to find and keep. Many refuse the job and others do not complete the training or soon leave.

In addition, if a support worker is sick with a common cold, they are not able to assist her because of the high risk of infection and its effect on her weakened respiratory system.

For the last four years Sam’s family have worked, without success, to try to find NDIS providers who are able and willing to provide her with the funded supports in her plan at the rate of funding, and to keep the roster running.  They have also tried repeatedly, without success, to retain a consistent specialist support coordinator (**SCC**), with sufficient skill to assist coordination of the supports funded to meet Sam’s complex and intense needs.

As the NDIS began to roll-out in their area, Sam’s family contacted each of the providers in the region.  Each of the major providers originally said yes to providing Sam’s care, but once her family explained what was involved, they said no.  All five providers gave the same reason for withdrawing their offers of support: that they were unable to take on the work because their insurer would not insure them to have disability workers provide the services which were funded in the plan, given Sam’s conditions.

Sam’s family also tried to retain a SCC to assist them.  One SCC tried for over three months to assemble a support team and, like Sam’s family, could not locate this support.  Ultimately the SCC withdrew services because the services were futile.  Her family have retained multiple SCCs of various capacities who have had, in all cases, limited ability to engage providers that can recruit workers to complete Sam’s care roster.

When the large provider market failed, Sam’s family moved to try to obtain the services from boutique private providers.  To date, the family have attempted to obtain the services from at least three smaller providers.  Each of these providers has taken on the work initially and then has been unable, both financially and practically, to provide the services. These services have cited the largely uncovered cost of training staff, the need for a large pool of specially trained workers to be available, and high staff turnover as critical to their decision to withdraw services.  Some providers have “left them high and dry”, withdrawing service without notice, or refusing to recruit further workers when they are unable to fill the roster.

Ultimately, the family now receive services from a not-for-profit disability agency who is working **at a loss** to provide services to people like Sam with complex needs.  They do not know how long this will last.  This provider cannot fill the roster either without a ‘nurse backup system’ (for which no funding is available) which results in a loss to this provider when it is called upon. The contract for Sam’s care presently only requires one month’s notice before all services end.

The market failure in Sam’s case has had dire effects on Sam and her family’s health.  When the market fails, the consequence for Sam is that she does not have disability workers in her home for much of the day.  In their place, Sam’s family attempt to fill the gaps.  On several days, her father has cared for her for 36 hours without sleep. When Sam’s family members get sick, the market failure and absence of any back-up mechanism means that they face a choice between attempting to care for her with the risk of infection, and failing to care for her.  There have been days when her family explains “we were just like, what are we going to do?”.  Further, last year, in the context of the repeated breakdowns in care for Sam, Sam’s mother suffered three mental health episodes, requiring hospitalisation.

Financially the impact of the market failure has been extreme.  For example, since early 2017, Sam’s father has worked only one day per fortnight so that he can try to provide care to Sam during the gaps in the roster and to respond to emergencies when existing staff quit or call in sick for shifts.  Sam’s family are now relying on another family member for financial support given their inability to take on full-time work.

Sam’s family have repeatedly raised the consistent market failure with the NDIA, drawing its attention to their multiple attempts and the efforts of her SSCs to fill the care roster.  Recently, the NDIA advised Sam’s family that, given their inability to fill the roster, the NDIA could see no justification for continuing to provide funding for the hours they had sought.

Further, when the family raised with the NDIA the effects that the market failure was having on Sam’s informal (family) supports, the NDIA advised them that the relevant response was for the family to contact Victorian child protection. Sam’s family evidently do not wish to relinquish their daughter. Rather, they wish for her to have access to the reasonable and necessary supports funded in her NDIS Plan.

## Dan’s story

Dan is a young man who has been diagnosed with Huntington’s disease. He writes poetry, and enjoys just getting out for a walk and singing. He is from a regional area in Victoria. He is a participant in the NDIS.

As part of the progression of Huntington’s disease, Dan has developed some mental health issues which have manifested in incidences of aggressive behaviour.

He is presently detained under an inpatient treatment order in a Secure Extended Care Unit at a psychiatric hospital (**SECU**). He is frightened at the SECU, and the nurses describe that he sleeps outside the nurse’s station at night in order to try to feel safe. Dan wishes to leave the SECU and live in the community closer to his family. He wants to be able to spend time with his family as the disease progresses, and to spend time with his brother who is also affected by the disease.

At a recent hearing before the Mental Health Tribunal, all parties agreed that if Dan had suitable accommodation and supports in place in the community, he should be discharged from the SECU.

Dan has a support coordinator funded under his NDIS to assist him under a ‘Housing Options Package’ to identify and access housing options. Since the commencement of the plan, the coordinator has identified no housing options for Dan because of his past aggressive behaviour. His coordinator has stated that, if she was able to identify housing for Dan, she would then attempt to instigate a Plan Review so that he could obtain some financial assistance with his housing. However, until she has located housing, she cannot do that.

As a result of this circularity, Dan is unable to create housing options for himself and is dependent on the identification of a home within existing disability stock (which is practically impossible) to leave the SECU and trigger any contemplation of whether he is eligible for Specialist Disability Accommodation funding under the NDIS.

As a result, Dan remains in the SECU indefinitely.

## James’ story

James is a participant in the NDIS and is funded to receive individual supports in his home. He has a disability that results in him having a range of behaviours of concern. Recently, he experienced a housing crisis.

As a result of the instability and disruption to James’ routine, his behaviours of concern escalated. His NDIS service provider quit. Soon after that a replacement NDIS provider was retained, but also quit. James was left without any disability supports and homeless. James ultimately presented to an emergency department and was admitted into a psychiatric ward.

At the Mental Health Tribunal hearing, which determined to involuntarily detain him in the psychiatric hospital for a further period, all parties and the Tribunal agreed that if James was able to obtain his funded supports and accommodation he would be able to be treated in the community.

## Jamal’s story

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| *Jamal’s story was first provided to this Committee as part of VLA’s submission to the inquiry into the ‘Provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition’.  We wrote about Jamal because he is a person with psychosocial disabilities related to his mental health who we considered may be provided a pathway back to the community by the NDIS.  This has not occurred, and has been delayed by a lack of available NDIS supports.* Jamal arrived in Australia at the age of 17 as a refugee. Soon after arriving he was imprisoned. While in prison he was diagnosed with a severe mental illness and transferred to a psychiatric institution. He was released after two years and then admitted to a civil psychiatric hospital. In 2014 Jamal damaged some property and assaulted a staff member at the hospital. He was arrested and charged. Jamal declined to seek bail as he did not want to return to the hospital. After some time in Melbourne Assessment Prison he was transferred to Thomas Embling Hospital, Victoria’s specialist high security forensic psychiatric facility. In January 2015 Jamal received a sentence of imprisonment for time already served, rendering him eligible for immediate release. He was immediately placed on a civil mental health order detaining him at Thomas Embling Hospital, where he remains. The treating team at Thomas Embling Hospital quickly determined that it was not a clinically appropriate environment for Jamal and attempted to have him transferred to a Secure Extended Care Unit (**SECU**) in a hospital in the community. However, the SECU at which Jamal had previously been treated refused to take him back, and other SECUs refused him because he was not in their geographical ‘catchment’ area. Other services to which Jamal might have been discharged, such as a community care units or supported residential services, also refused to take him. Jamal remains detained in an inappropriate forensic facility more than three years after his sentence finished, notwithstanding the clinical evidence that such an environment is neither necessary nor suitable to his needs. Due to Jamal’s institutionalisation, his guardian is only prepared to approve Jamal’s discharge if he receives significant mental health and disability support, and graduated leave to accommodation, from the hospital. **Update:**In 2017, Jamal was assisted by his guardian to make an application for NDIS funding.   Jamal’s NDIS planning process was fraught.  Initially, the NDIA told Jamal’s guardian that they could not process his application until Thomas Embling Hospital reported what supports he would need in the community.  However, the Hospital refused, explaining that those matters were outside its expertise which, it said, was limited to providing inpatient services.Frustrated, Jamal’s guardian then made an alternative application for a ‘transitional package’.  This was approved more than a year ago.  At the centre of this package was funding for a special support coordinator to in-reach to Thomas Embling Hospital, to help him find accommodation, gather information and co-ordinate assessments to determine the supports that he would eventually need in the community to inform a further application for a full package.  Through his guardian, Jamal contracted with an established NDIS provider, with expertise in working with people with psychosocial disability which included a specialised support coordination arm.  Within the market this was Jamal’s only viable option.  While this provider initially “signed Jamal up”, minimal action occurred on his case.  When his guardian persisted in inquiring why Jamal was not receiving any of the funded supports, the provider disclosed that they did not have the staff to be able to actually assign anyone to his case. While he had originally been assigned a worker, that worker had left the provider and no replacement was available. The provider wrote that: “The service sector has not caught up with the NDIS rollout and services are still employing support staff to work under the new fee structure. [Jamal] and MHT may need to understand this.”In response, Jamal’s guardian threatened to decommission the provider’s services.  Jamal’s lawyers, through informal means attempted to have Jamal allocated to a worker.  His case was ultimately escalated. Ten months after his package was approved, a replacement worker was eventually appointed to (re)commence his transitional planning.The provider also claimed that they would not in-reach into the Hospital.  Jamal’s lawyer was told that this is because the Hospital is a custodial environment (even though Jamal was not in custody there).  The provider has now reversed this position and some transitional planning has occurred, but it is not nearly complete.  In 2017, Jamal’s guardian located a public housing property for Jamal to reside in, if he was discharged.  The hospital is amenable to granting leave for Jamal to spend some time in the house as part of his reintegration to the community.  However, at present, the house has no furniture or appliances so Jamal cannot spend any extended period there.  At the most recent Mental Health Tribunal hearing, where Jamal’s further involuntary treatment at Thomas Embling Hospital was ordered, it became clear that none of the agencies engaged with Jamal including his specialist support coordinator had communicated about the importance of, or taken responsibility for, furnishing his house.  Jamal’s family were horrified and explained that they would immediately furnish it, but were told that it was not their responsibility.Given the critical importance of a gradual transition back to the community for Jamal, he will continue to be held at Thomas Embling Hospital until there is progress with his transitional steps.  |

## Sally’s story

Sally has a range of complex physical disabilities and has experienced homelessness.

When Sally’s first NDIS plan was set up, the NDIA determined that they would give Sally a short plan which provided **only** funding for a specialist support coordinator (**SSC**). Sally’s non-legal advocate was advised that the NDIA had allocated funding for the SSC to assess ‘what Sally needed’ given her complex health needs and housing and financial insecurity. It was intended that a new plan would be put in place with substantive supports after this assessment.

A month after taking the contract on, the service provider quit. The provider explained that they were no longer willing to work with Sally because her homelessness and lack of a reliable mobile phone made it “too difficult” to contact her. Sally has not been able to retain any further assistance. As a consequence, she is without supports.

# Participant readiness to navigate new markets

### Participant readiness where the participant has complex needs

VLA unequivocally supports the participant focus which is central to the design and intention of the NDIS. At the outset, however, we note that “participant readiness” is not necessarily a reliable or realistic prism for assessing the effective operation of the NDIS for many people with complex needs.

Rather, in our experience, a participant’s “readiness” for the NDIS, where they have multiple and complex needs, is in large part a reflection of:

* the level of planning around their transition to the NDIS by State disability services and the NDIA;
* the skills and NDIS system awareness of that person’s advocates and informal supports
* The ability of that person’s advocates, informal supports and specialist support coordinators to obtain help from the NDIA or the State when ‘things go wrong’;
* the extent to which the NDIS and State disability services remain engaged with that person, their advocates and informal supports as they transition; and
* the level of reliable, concrete, and enforceable regulatory safeguards in place within the system.

In our view, when an NDIS participant has complex needs, it is likely that their “readiness” for the market necessarily requires a planned, reliable and continually engaged, framework of expert assistance. As a result, in this submission, we focus on the ways in which these relevant elements of the current scheme interact with our clients with NDIS funding and complex needs.

# The impact of pricing on the development of the market

In our experience, the fixed pricing and the allocated prices for particular supports under the NDIS can be, but is not always, implicated in the current profile of providers who are able and willing to provide services to NDIS participants with complex needs.

***How*** pricing is implicated in our client’s experiences of market failure and ‘thin markets’ varies. Our experience demonstrates that currently pricing has little or no impact on immediate service provision when the reason for the service gap is that no suitable private service exists (although we appreciate that it may have some longer-term impacts). However, fixed pricing can negatively impact on service provision when it fails to factor in the client’s special circumstances, such as living in a remote location that may require services to travel, or having unique service needs that require specialist training and intensive support.

For example, in [Francis’ case](#_Francis’_story), his original SSC reported that in her view at least each of his supports was appropriately priced. Further, to the extent it is relevant, the increase of Francis’ NDIS plan from approximately $200,000 to $1,000,000 did not lead to any material change to his provider options. Instead, as we have detailed above, even where new providers sought to “move into the market” to access the high levels of funding with the plan overall (even if not a high price fixed to each individual support) they were ill-equipped to do so and simply could not recruit suitable or willing workers.

In contrast, however, when the specialist support coordinator to another client[[1]](#footnote-1) with behaviours of concern attempted to obtain individualised supports for him, pricing was a central focus of at least one provider’s refusal to work with him. Indeed, in one case, a provider appeared to offer to “take him on”, if he paid a premium price far in excess of the amount which had been allocated for these supports in his NDIS Plan. This situation is very concerning from the client’s perspective. It also reflects that:

* within thin markets the fixed pricing model may not be actually governing all private arrangements, leaving NDIS participants further vulnerable to the market’s weaknesses; and
* where a person requires intensive supports, it may be that pricing this support merely in terms of attendant care insufficiently reflects the intensity of work performed by a skilled support provider.

[Samantha’s story](#_Samantha’s_story) reveals a more complicated way in which pricing and NDIA decision-making impact immediately on the (under)development of the market. In Sam’s case, the NDIA’s decision to fund only disability support workers at the lower fixed rate to provide her with care created multiple barriers in the market and for commercial providers, including:

* large providers being unable take on the work because they could not obtain insurance for it; and
* multiple boutique providers commencing services, but deciding to withdraw because of:
	+ unfunded training;
	+ unsustainable recruitment overheads; and
	+ staff burnout (given the smaller pool of staff employed by the boutique provider).

Instead, the current solution for Sam is that a not-for-profit provider runs at a loss in an attempt to keep Sam’s services in place.

In [Ian’s case](#_Ian’s_story), his geographic isolation meant that even though his individual supports may have been appropriately priced, the lack of any inbuilt travel funding for a provider in his NDIS plan meant the overall ‘cost’ of providing the service rendered it commercially unattractive.

While VLA does not purport to have a clear solution to the pricing issues confronting the market, we do make the following recommendations to respond to the dynamics we describe above.

**Recommendation** The NDIA, in collaboration with State and Territory governments, should urgently assess whether individual supports provided to a person with complex needs should be funded at a different or variable rate. Such supports should not be automatically equated with ‘attendant care’.

**Recommendation** NDIA planning must take into account basic market realities, such as insurance policies, when determining what level of support is ‘reasonable and necessary’.

# The transition to a market based system for service providers and the development of the disability workforce to support the emerging market

The case studies set out above indicate strongly that the transition to a market based system for service providers has not been seamless, and raises significant risks for NDIS participants with complex needs.

In our experience, the disability workforce for people with complex needs (whether those needs arise from behaviours of concern or high risk health conditions) is insufficient to meet the current market demand, and will be further unable to meet the emerging demand. Pricing, as we set out above, is implicated in this issue. However, this concerning trend does not appear to be simply a matter of pricing. It also reflects a more complex shortage in:

* the mere number of staff available within providers; and
* the availability of trained staff with specialised skills willing to provide the relevant supports.

There does not appear to be a sufficient workforce to meet either the demand for specialist support coordinators, or for workers to provide substantive individual supports.

As we set out above, when [Jamal’s](#_Jamal’s_story) guardian persisted in following up on apparent inaction by a provider of specialist support coordinators leading to his continued detention at Thomas Embling Hospital under orders by the Mental Health Tribunal, he was told:

 “The service sector has not caught up with the NDIS rollout and services are still employing support staff to work under the new fee structure. [Jamal] and MHT may need to understand this.”

It cannot be overstated that in Jamal’s case, what he is being asked to “understand” is a lack of access to the threshold (but relatively basic) planning support to enable him to transition out of a high security forensic hospital, three years after his sentence is complete.

In [Francis](#_Francis’_story)’ and [James](#_James’_story_(Rhys))’ cases (as well as others which we have not been able to reproduce in detail in this submission) we witnessed (among other things) a lack of provider expertise, often expressly acknowledged by providers themselves. In one client’s case, when his SCCs expressed their lack of skill in navigating the thin market to the NDIA, they were left with a direction to “try harder”. In Francis’ case, when new providers sought to enter the “niche market” they acknowledged they did not possess any expertise “in-house” but intended to recruit it in; which they were ultimately unable to do when that expertise simply did not exist within the available, unemployed, pool of disability workers.

At the same time, in [Francis](#_Francis’_story)’, and [James’](#_James’_story) cases (in addition to others), we also observed the risks to NDIS participants of exposure to unskilled workers. These include: (a) abuse; and (b) an escalation of their behaviours of concern - requiring increased funding, leading to severe restrictions on their liberty, and a further narrowing of their options with this specialised market.

In [Samantha’s case](#_Samantha’s_story), the ‘training gap’ and pricing issues we described above, combined with the insufficient number of workers on staff, appear to have hampered the development of a skilled workforce capable of meeting Sam’s needs, once a provider willing to take the work on was located.

We make the following limited recommendations which we consider may assist in the development of these specific elements of the disability workforce:

**Recommendation** The NDIA should provide a direct support service for specialist support coordinators struggling to navigate thin markets. This service should be staffed with expert case managers who are able to build the capacity of less experienced workers in the field.

**Recommendation** Clear direction should be available to NDIS participants and Specialist Support Coordinators about which State and Commonwealth entities can be contacted where they are experiencing difficulty obtaining supports or retaining consistent support. Staff at the entity should be trained and informed about what options are realistically available to the participant, and if no options are available they should be immediately directed to the Provider of Last Resort framework.

# The provision of housing options for people with disability, with particular reference to the impact of Specialist Disability Accommodation (SDA) supports on the disability housing market

A serious shortage of durable housing options for people with disability is entangled in almost all of the stories we have set out above. For [Francis](#_Francis’_story), [Jamal](#_Jamal’s_story), [James](#_James’_story_(Rhys)) and [Sally](#_Sally’s_story_(DJA), homelessness or unsuitable and insecure housing have been the product and sometimes a factor leading to complex market failure and crisis. For these participants, a crisis of this kind is extremely significant, resulting in:

* indefinite detention in secure extended care units within psychiatric hospitals;
* indefinite detention in a forensic psychiatric hospital; and
* prolonged custody in prison in circumstances where a person without a disability would be in a position to obtain bail or plead guilty and receive a shorter sentence or no sentence of imprisonment at all.

For example, as we detail above:

* ***As James*** was transferred through a series of unsuitable houses, his behaviours of concern escalated and multiple service providers refused to work with him and withdrew services. Ultimately, left without housing or supports, he self-reported to an emergency department and was detained in a psychiatric unit. He cannot be discharged until suitable housing and supports are secured.
* ***For Sally***, her NDIS Planning has been undermined by her inability to secure a SSC to help her identify housing options, because her SSC withdrew services when it was “too hard” to work with her as a result of her homelessness.
* ***For Francis***, abuse by former carers in his former residence made it unsuitable for him. However, the only alternative residence within the already sparse disability housing stock was already occupied. His access to this house then relied on these residents being slowly moved before any renovation could occur to adjust the house for his needs. Francis remained detained in prison throughout this period.

In addition, for another client,[[2]](#footnote-2)when her NDIS providers withdrew services, and she was unable to secure even a SSC to assist her to retain new supports, the Director of Housing terminated her tenancy as a result of her inability to fulfil a term of that tenancy that she have supports in place in her house. She, too, was unable to obtain bail without housing or supports in place.

### Lack of awareness of Specialist Disability Accommodation under the NDIS

Further, there appears to be a profound lack of awareness within the service sector, as well as in a range of government agencies, of the availability or nature of SDA funding under the NDIS. While we appreciate that SDA funding is exceptional within the NDIS generally, it is a form of funding which is specifically intended to be granted where, among other things, a participant has “very high support needs”.[[3]](#footnote-3) However, with one exception, we are not aware of any situation where a client with high support needs was proactively considered for SDA funding, or where this funding was discussed by a person’s specialist support coordinator in the context of a housing crisis.

Exceptionally, through the likely intervention of DHHS, it appears that SDA funding has been granted to Francis. However, as we detailed above, for [Jamal](#_Stephanie’s_story) and [Sally](#_Sally’s_story) (as well as other clients in very similar situations), SDA funding does not appear to have been canvassed or considered by their SSCs or the NDIA, or is largely illusory because of their inability to secure a SSC to assist them to identify their needs.

### Lack of disability housing stock leading to chronic delay

VLA strongly supports the NDIS’ intention that by providing specific funding for SDA, it will encourage investment in and actual growth of suitable accommodation for people with very high needs.[[4]](#footnote-4) However, for our clients, including [Dan](file:///C%3A%5CUsers%5Cholliekerwin%5CDesktop%5CJSC%20Market%20Readiness%20submission%20.docx#Dan’s story (Sam M)), it appears that a circular process may be occurring, in which:

* a SSC funded to explore housing options for a person with complex needs does not contemplate SDA funding **until accommodation has been found**;
* the SSC then applies on the person’s behalf for traditional State owned ‘disability accommodation’;
* because of a person’s high needs, they are not considered eligible for the traditional ‘disability accommodation’ or suitable accommodation is simply not available; and
* the process of obtaining support services grinds to a halt because there is no identified accommodation and the SSC does not, then, consider or instigate a plan review process to obtain SDA funding.

While we do not anticipate that, in every case, a person would be granted SDA funding, the pattern we describe above has two important, but concerning, effects. First, it appears that the rarity of existing disability stock for people with complex needs may be ultimately operating as a cap on the funding of SDA by the NDIS. Second, it is likely that, most people granted SDA funding will have previously been granted disability housing under the State regimes. Together, these two effects appear to us likely to **limit the** **growth** of suitable accommodation for people with very high needs.

### The need for a regulatory response when a person leaves the remit of the Disability Act 2010 (Vic)

As the Office of the Public Advocate has detailed in its submission to this inquiry (at p 18), the establishment of non-government “disability housing” requires careful consideration and planning to enable the existing safety and oversight measures which apply under the *Disability Act 2010* (Vic) (**Disability Act**) and through the “community visitors program” to effectively “carry over” to participants using NDIS SDA. We support the submissions and recommendations of the OPA in this regard.

**Recommendation** NDIS planners should proactively discussSDA funding with participants who may qualify.

**Recommendation** SSCs should explore funding for new builds for participants including where that person has previously not lived in SDA provided by the State.

# Provider of last resort arrangements

### Urgent need for an enforceable and transparent provider of last resort mechanism

In our previous submission to the Committee’s inquiry into Transitional Arrangements and General Issues, we detailed that, in Victoria, provider of last resort measures or any real solution to address the very serious effects of market failure remain opaque, unclear and incomplete.

At present, the Victorian Bilateral Agreement is silent as to what will occur in the event of market failure. Instead, it states:

The Parties agree that these arrangements will be used to continually review market, sector, participant, workforce and system readiness to transition to the NDIS and that if this monitoring indicates significant concerns that put agreed transition arrangements at risk, then a strategy for addressing the issues will be developed.

The Parties agree that participants should not be put at risk and that the agreed strategy could include changes to the phasing schedule.[[5]](#footnote-5)

The Bilateral Agreement also defers detail regarding implementation arrangements including arrangements to support readiness of the disability services market, including providers, the broader sector, workforce and participants to an ‘Operational Plan’ agreed between the Parties and the NDIA. However, this Operational Plan provides no practical framework for acting to remedy the unpreparedness of private providers to be engaged to provide services to certain cohorts of participants. Instead, among other things, it states that:

The NDIA, Commonwealth and Victorian Government will continue to work together in regard to progressing effort and contingencies related to Victorian sector and system readiness.[[6]](#footnote-6)

and that:

…the NDIA will lead on identifying and developing approaches to ensure that a provider of last resort is available, as well as support for participants in crisis.[[7]](#footnote-7)

In submissions made to the Productivity Commission in 2017, the NDIA stated that:

[It] is prepared to act to reinforce thin markets where intervention is necessary to ensure market supply, and to act as a Provider of Last Resort where the market fails to provide this supply.

Despite this, since our last submission to this Committee, there has been no material change to the situation despite further recommendations by multiple, established inquiries, that urgent action is necessary. For example:

* In 2017, this Committee recommended that: … the NDIA provides details of how it is ensuring a provider of last resort is available for all NDIS participants unable to find a suitable service provider, regardless of their location, circumstances and types of approved supports.
* In 2018, this Committee recommended that:
	+ **the Australian, state and territory governments and the NDIA work together urgently to include crisis accommodation and Provider of Last Resort arrangements for housing in their respective bilateral agreements and operational plans.**
	+ **the NDIA develop and publicly release a strategy to address thin markets.**
	+ **the NDIA publicly release its Provider of Last Resort policy as a matter of urgency.**

These remarks have also been echoed by the Productivity Commission,[[8]](#footnote-8) the Australian National Audit Office[[9]](#footnote-9) and in the McKinsey & Company Independent Pricing Review.[[10]](#footnote-10)

The NDIA is not acting as a PLR and we are not aware of any document which establishes a clear responsibility on either the NDIA or State and Territory governments for responding when the market fails, or details what that response may include.

###  “Maintaining critical supports”

In March 2018, the CEO of the NDIA stated that:[[11]](#footnote-11)

We are..putting in place arrangements to better support participants with complex needs involved in the justice system, including working with state and territory colleagues to ensure we have the right arrangements in place to Maintain Critical Supports (historically referred to as "Provider of Last Resort").

VLA welcomes the recognition by the NDIA that action is necessary now to support participants with complex needs involved in the justice system. We share the view that this action cannot be delayed.

However, without further detail about this development, we express our preliminary concerns that:

* These “arrangements” appear to be in train without an intention that they will be made public so that participants, their advocates, informal supports or SSCs can actively take advantage of them.
* Any substitute mechanism for a PLR framework should not lead to the need for a person to justify that a support is “critical” in order to access the mechanism. If only “critical” supports are intended to be covered by the mechanism this will, wrongly, lead to a situation where a person with complex needs who has already established that each of the funded supports in their NDIS plan is “reasonable and necessary” is additionally required to demonstrate that the support is “critical” in order to actually receive it when the market fails.

### Essential elements of any mechanism

A mechanism to respond to market failure and ensure that participants can access their funded supports should be enforceable, clear, pre-planned and funded so that, when necessary, the response can be as ready as possible.

***Clear pathways for participants and providers in crisis***

Market failure is distressing for participants, their advocates and informal supports. It may also be distressing and confronting for inexperienced providers of support coordination. This much is clear from [Francis’](#_Francis’_story) and [Sam’s](#_Samantha’s_story) stories set out above. In our view, the pathway in to any PLR framework should be clearly set out and publicised so that any of the diverse parties who may, at the time of crisis, be responsible for escalating it know how to get help.

***A ready response***

In our experience, especially in the context of [Francis’](#_Francis’_story) case, the task of “standing up a service” for a person with complex needs in crisis “from scratch” is a fraught one, which is likely to be replete with significant delay in recruiting staff from an already thin market. In our view, a PLR framework should, at a minimum, require that the government body responsible for it:

* Forms standing arrangements with multiple, robust providers with existing skill in working with people with complex needs (including both behaviours of concern and high risk physical disabilities) which permit the responsible body to immediately contract their workers in the context of market failure.
* Provide sufficient funding to those particular providers to enable them to respond in the context of market failure, including by operating at a small surplus so that emergency recruitment of their workers does not undermine their own service delivery.

***Transparency, enforceability and accountability***

Any PLR mechanism should be clear, enforceable and include fixed timelines for the delivery of a person’s funded supports. The framework should be embedded in the Bilateral Agreement in Victoria and the Operational plan.

While we do not express a clear view whether an ultimate provider of last resort may be best sourced from within State disability services, we highlight that the State presently (and unlike the NDIS marketplace) retains a pool of highly trained staff with long-running experience providing disability services to clients with complex disabilities.

In our view, confined legislative reform is necessary to ensure that this mechanism is reliable and enforceable.

Specifically, we consider that at the conclusion of the NDIS roll-out in Victoria simple amendments should be made to the NDIS Act so that an NDIS participant can approach the NDIS Quality and Safeguarding Commission (**Commission**) to demonstrate reasonable efforts to obtain a funded NDIS support. If so satisfied, the Commission should be required to direct immediate intervention by the responsible government body (whether it is the State or the NDIA) to enable that support to be obtained. Every direction made by the NDIS Q&S Commission should be tabled before Parliament so that the operation of this mechanism is transparent. If the NDIA intends to be the responsibile entity for implementing the PLR framework during the transitional phase, these amendments should be made as soon as possible.

**Recommendation**  The NDIA should immediately publish the status of its current work on a provider of last resort.

**Recommendation** The Bilateral Agreement in Victoria should be amended to provide a clear framework for a reliable and swift provider of last resort mechanism during the transitional period. Consequent amendments should be made to the Operational Plan. A timeline for this action should be agreed and adhered to by Victorian and Commonwealth parties immediately.

**Recommendation** The amendments to the Bilateral Agreements and Operational Plan must include clear and specific allocation of responsibility for remedying market failure in an individual participant’s case.

**Recommendation** A PLR mechanism should be made practically available through the allocation of funding and planning resources so that whichever government entity is allocated responsibility, a solution to the market failure will not be delayed by the inevitable time required to locate, train and recruit the workers necessary to “stand up” a service in the context of an acute crisis within an already stretched market.

**Recommendation** If the NDIA recharacterises a PLR mechanism as a program to “Maintain Critical Supports”, this should not lead to a situation where a person is required to justify that a support is “critical” in order to access the mechanism. Their statutory entitlement to the support has already been established. It is already “reasonable and necessary” under the NDIS Act.

**Recommendation**  At the conclusion of the NDIS roll-out, amend the NDIS Act so that:

1. an NDIS participant can approach the NDIS Quality and Safeguarding Commission (Commission) to demonstrate reasonable efforts to obtain a funded NDIS support. If so satisfied, the Commission should be required to direct immediate intervention by the body responsible for the PLR to enable that support to be obtained.
2. Every direction made by the NDIS Q&S Commission must be tabled before Parliament.

If the NDIA intends to be the responsible entity for implementing the PLR framework during the transitional phase, these amendments should be made as soon as possible.

1. This client’s story has been unable to be reproduced in full in this submission because he does not presently have capacity to consent to it being shared. [↑](#footnote-ref-1)
2. This client’s story has been unable to be reproduced in full in this submission because she is not able to be consent to its disclosure at present. [↑](#footnote-ref-2)
3. See, Operational Guideline, ‘Specialist Disability Accommodation’, especially Part 5: ‘Deciding to include SDA in a participant’s plan’. [↑](#footnote-ref-3)
4. See, ‘Specialist Disability Accommodation: Decision paper on pricing and payments’, 1 June 2016. [↑](#footnote-ref-4)
5. See, Schedule E to the National Disability Insurance Scheme (NDIS) - Bilateral Agreement between Commonwealth and Victoria - 16 September 2015 at 2. [↑](#footnote-ref-5)
6. Paragraph 6.1 of the Victorian Operational Plan. [↑](#footnote-ref-6)
7. Paragraph 6.5 of the Victorian Operational Plan. [↑](#footnote-ref-7)
8. Productivity Commission, *National Disability Insurance Scheme – Costs* (2017) at 36. [↑](#footnote-ref-8)
9. Australian National Audit Office, *National Disability Insurance Scheme—Management of the Transition of the Disability Services Market* (2016-2017) at 27. [↑](#footnote-ref-9)
10. McKinsey & Company, *Independent Pricing Review, Final Report* (2018). See especially 59 onwards. [↑](#footnote-ref-10)
11. NDIA, *From the CEO – March 2018* (March 2018). [↑](#footnote-ref-11)