Dr Karen Hooper 13 July 2020
Principal Commissioner
Queensland Productivity Commission

Submission to the QPC Inquiry into the NDIS Transition and Market Development in Queensland

We welcome the Inquiry into NDIS Transition and Market Development in Queensland and look forward to your report. Delivering equitable access to a quality disability service under the auspices of the NDIS has required considerable planning, investment and regulation of the expanding market and workforce, as this significant reform expands across the country. The Australian Government's paper, *Growing the NDIS Market and Workforce* (2019), has indicated that the priorities for this phase of NDIS development are;

1. To improve the financial settings for service delivery
2. To deliver national consistency by regulation of the market
3. To address thin markets in regional and remote areas
4. For participants with "different needs", to develop provider and market capacity and capability and workforce capabilities, and
5. To establish systems for monitoring market effectiveness.

In this submission we address the following areas in relation to the NDIS transition and development, and highlight issues relating to gaps in services and thin markets.

1. Workforce issues
2. Gaps in services
    a. Psychosocial disability responses
    b. Restrictive practices and specialised behaviour support services
    c. Prisoners with disabilities

Several recommendations for consideration by the Queensland Government are included as part of the submission.

Yours sincerely

Dr Grazia Catalano PhD
Senior Research Fellow (Adjunct)
School of Nursing, Midwifery and Social Work
The University of Queensland
Brisbane Qld 4072 Australia
M: [redacted]

Dr Michelle Denton PhD
Senior Lecturer (Adjunct)
School of Nursing, Midwifery and Social Work
The University of Queensland
Brisbane Qld 4072 Australia

Workforce issues

Allied health practitioners in regional, rural and remote areas

Difficulty in accessing allied health services across regional, rural and remote areas is not a new issue. The 2017 State of the Disability Sector report indicated that 73% of service providers under NDIS reported increased demand for their services over the previous year (National Disability Services, 2017). Less than half (43%) expected to be able to satisfy future demand. In 2018, it was reported that allied health, and more specifically psychologists, were the most difficult staff to attract and retain to the sector and it was noted that these difficulties are exacerbated in regional and remote areas (National Disability Services, 2018). The market-driven solution hoped for by NDIS is posing significant challenges in this area in particular.

The most significant finding of the National Rural Health Commissioner' report in June 2020 (National Rural Health Commissioner, 2020) on allied health services in regional, rural and remote Australia is that funding models designed to be market-driven, specifically NDIS and My Aged Care, when applied to thin markets in rural and remote areas, result in market failure. In these areas the allied health services that are required for these programs are neither viable nor sustainable. This report reinforces that market driven solutions rely on the there being a viable market in which allied health practitioners can be attracted and retained. This is apparently not the case and it is clear that allied health staff cannot make a living in regional, rural and remote areas without attractive remuneration, professional development opportunities, and consistent work hours.

In addition to the challenges of maintaining a broad allied health workforce in regional and rural areas as detailed by the National Rural Health Commissioner, it has long been shown that it is particularly difficult to attract allied health practitioners who are trained and experienced in working with people with disability. It is also the case that the skill sets required by allied health practitioners in health services and education (the other two large employers of allied health practitioners in Queensland) differ from those required for some types of disability services.

The National Rural Health Commissioner has recommended the establishment of Service and Learning Consortia across regional and rural Australia as an alternative to a market-driven solution. This proposed Consortia would require a collaborative governance model which would integrate key Commonwealth programs in addition to those of relevant State and Territory governments, with the consortia pooling resources so as to attract and maintain a quality workforce for programs such as NDIS and My Aged Care.

Allied Health workforce planning and capability development

In general there appears to be an over-supply in some allied health disciplines and under-supply in others. Planning for allied health services in regional, rural and remote areas would be better progressed if there were a National Allied Health Minimum Data Set including workforce data.

An NDIS workforce strategy and NDIS allied health workforce capability strategy are urgently required to inform professional development programs.

Based on feedback from the sector, it appears that not all NDIS registered allied health providers have sound experience in working with people with disability. If this is the case, it may be that the NDIS registration process does not sufficiently draw out details of the allied health practitioners' experience and expertise in disability service provision. If these credentials are not confirmed by the registration process, it falls to the service provider and/or the NDIS recipient to search for an appropriately skilled allied heath practitioner.

Given the reported difficulties in recruiting allied health practitioners with disability expertise, including behaviour support expertise, consideration could be given to creating a network of senior disability practitioners (discipline-specific) to support allied health sole traders who lack sufficient relevant experience. This may require further funding via for example Commonwealth and State Governments, rather than relying on NDIS Recipient packages to include funding for more than one allied health practitioner.

Recent research on allied health services and workforce issues for NDIS

- In a study by Foley et al., (2020), views of research participants reflected that the pace of the NDIS transition was a potential barrier for participation and has precluded the development of a workforce skilled to meet the demands of NDIS across all allied health professions. This has resulted in longer than usual waiting times as service demand exceeds the existing workforce. Some research participants have highlighted that best practice, for example in interdisciplinary services, was made difficult under the new funding system and inhibited the delivery of best recipient outcomes. This issue was prominent among further cited examples of how funding arrangements ran counter to best practice in the delivery of therapy services. In addition, the provision of culturally appropriate services was not possible when interpreter and translation services and coordination of complex activities are not funded through NDIS. (Foley et al., 2020)
- A study by Dintino et al., (2019) highlighted the paucity of input into plans by therapists, especially in rural areas where availability of therapy services is insufficient. A gap was identified between what a Local Area Coordinator (LAC) included in a plan as desired

therapy and what and how that therapy might be provided in the actual service context. Therapists found that attempting to contribute to plan reviews based on what they saw as best for the client was too difficult, leading them to consider closing their books to NDIS referrals. The huge increase in demand for therapy services was overwhelming the already much in demand therapy services in these areas when they were already experiencing ongoing and unpredictable change as a result of the NDIS. The study presents an increasingly strong demand for better workforce planning that acknowledges the difficulties of recruitment and retention of therapists in the rural areas to support the implementation of NDIS. (Dintino et al., 2019)

- Personalised systems bring new market conditions to the care sector, providing a challenge to service provider adaptation. A study by Malbon et al., (2019) found that the NDIA website and the peak body (NDS) have been much relied upon by organisations seeking to adapt to the NDIS. Unlike a collaborative network, however, the NDIS network is stratified with the representatives from the peak body and government central to how information flows to providers. This supports the view that the introduction of a personalised competitive environment diminishes collaboration and collegiality in NDIS, and this remains a challenge for market growth and development (Malbon et al., 2019)
- A study by (Johnsson et al., (2019) aimed to identify the essential requirements, feasibility and some potential barriers in delivering therapy support to regional and remote participants on the autism spectrum. A multidisciplinary team (speech pathologist, occupational therapist, psychologist, and a special educator) delivered tele-therapy to participants on the autism spectrum with their families and local support staff. It was found that a significant number of hours were used in administration, training and collaboration time between tele-therapists and the project lead. This was of particular concern initially due to the lack of billable hours and potential threat to the sustainability of the program but this additional administration reduced as therapists became more confident with the technology. The tele-therapy pilot indicated that online services are filling a gap in regional and remote autism-specific provision, although larger scale research is needed to investigate a blended model of service delivery using online and in-person support (Johnsson et al., 2019)

The COVID-19 strategies which have enabled allied health telehealth MBS may also prove useful beyond COVID-19 with research urgently required to test its effectiveness as a viable service strategy for people with a disability.

Disability support workers in regional, rural and remote areas

A recent report by the Regional Social Development Coalition (Wallace, 2019) presented the key concerns and recommendations from a forum of NDIS and Aged Care providers in the Greater Whitsunday Region relating to workforce issues and costs of regional service delivery. Concerns included:

- Not enough allied health workers
- Not enough providers in the region
- Delays with workers obtaining Blue Cards
- High cost of new worker induction with the challenges posed by a transient workforce not being acknowledged
  - RTOs reluctance to deliver training in regional areas leading to higher costs and dependence on online training with unreliable connections and lack of face to face; required for building practical skills
  - No margin in NDIS fee scale for backfill when support workers travelled to attend training or to allow buddying and mentoring of staff (for example when they do not yet have their Blue cards)
- Sole traders needing access to training in values and ethics in disability service
- No recognition that when small organisations start up they require support for business planning and management to develop a sustainable practice

Recommendations in the Wallace (2019) report included:

- Provide a standardised worker induction package
- Undertake compliance audits in bulk to identify savings
- Change the NDIS fee structure to enable pay levels that attract and retain workers in regional areas, including travel costs
- Establish collaborative consortia through MOUs between regional providers, establishing a shared worker pool
- Provide incentives such as housing to attract workers to regions.

The Commonwealth Government in May 2020 announced the *Human Services Care Skills Organisation Pilot* to deliver a new skills set to support aged and disability sectors at entry level. (Details not yet available).

The Queensland Government has introduced the *Regional Skills Investment Strategy (2020)* targeting 17 areas across Queensland. 12 of those 17 areas have identified health care, social assistance and community services as priority areas for training. This is a further clear

indicator of need in the health and disability services sectors in regional Queensland. Issues already identified from the Regional Skills Investment Strategy include:

- The difficulties faced by smaller service providers in finding funds to pay the co-contribution for the subsidised courses
- The difficulties in engaging and being able to pay for an RTO to travel to small rural areas to deliver a course to very small numbers of participants
- In some areas internet connection is poor and providers prefer face to face training and some do require face to face for skills such as wound and oral care
- This training mainly relates to VET specifically when other professional skills sets may be required
- In small rural areas, collaborative training initiatives across service providers and sectors are valuable but who is funded to coordinates this?

Recommendations

That the Queensland Government support the recommendations of the June 2020 Report of the National Rural Health Commissioner to establish Service and Learning Consortia across regional and rural Australia to address market failures in relation to the provision of allied health services critical to NDIS.

That the Queensland Government examine the need for incentives for TAFE and other RTOs to provide affordable, subsidised training programs to support the growth and development of a disability workforce in regional, rural and remote areas of Queensland.

Gaps in services

Psychosocial disability responses

The QPC Issues Paper on the NDIS market in Queensland (June 2020) refers to the complex interface between the NDIS and other health and support services. Coordination across multiple interfaces is crucial in the provision of all health and disability care but has long been recognised as being core to the provision of mental health and psycho-social care in particular. Mental health and psycho-social support services need to be multidisciplinary, multiagency, cross-sectoral, and collaborative (Australian Health Ministers Advisory Council, 2013). The competitive market environment and the resultant fragmented and casualised workforce developing in the NDIS environment leaves an enormous challenge for the achievement of these ideals. While there were many deficits in community health and social

care for people with psycho-social disability prior to the introduction of NDIS, shifting funding from the mental health NGO sector into individual NDIS funding packages is undoing progress that was being incrementally achieved in the development of responsive, collaborative and integrated mental health and psycho-social care across the sector over the last 30 years since the release of the first National Mental Health Strategy (1992).

The recovery model is the driving framework for community mental health and psycho-social support. While recovery orientated mental health care is compatible with NDIS in terms of self-determination; important components of any intervention routinely include prevention and early intervention along with step up, step down approaches as key strategies for promoting recovery and preventing life-time disability. Research is emerging that the NDIS, with its emphasis on life-time care, is not necessarily well designed for people with mental health problems.

For example:

a) Services to people with psychosocial disability are best delivered with a step up, step down approach in order to respond to periods of acuity and periods of recovery. The provision of intensive support for people leaving hospital after a mental health admission is crucial, with an easing off as increasing independence is achieved. Recognition of the need for intensive support post discharge is reflected in the National Performance Indicator requiring community follow-up within seven days of release after a mental health admission. See: (https://www.aihw.gov.au/getmedia/a563c9e5-e574-4734-ac5f-89025fed4de3/Key-performance-indicatos-for-Australian-public-mental-health-services-technical-specifications-summary-2008.pdf.aspx). Commonwealth funded programs such as PHaMs were enabling intensive follow-up for people leaving hospital for 4-6 weeks or longer as required. These funds have now been transferred to NDIS. The NDIS model of funding does not support this type of episodic funding and this has created a concerning gap in service provision (Rosenberg et al., 2019).

b) Assertive outreach models of care; for example reaching out to people with a history of isolating until they become so mentally unwell that they need to be admitted into hospital, is an important component of comprehensive contemporary psycho-social care. Individuals who have a tendency to isolate may be at a higher risk of harm to self or others, but will often choose not to have regular support when unwell. This group are at risk of missing out as NDIS models of funding are based on the recognition of the participant asking for support when they are unwell (Hayes et al., 2018). There can also be community risk consequences associated with this gap.

Minimally skilled support workers often do an excellent job of caring for people with complex mental health and psycho-social needs in the community for much of the time. However to successfully support people in the community, support workers need ongoing and/or rapid access to expert clinical supervision and collaborative care when a situation escalates, as is inevitable when caring for people with schizophrenia for example. Situations can rapidly become acute and unmanageable such as with suicidal behaviour or risk of harm to others. A highly skilled response needs to be available for advice and support to the worker; as well as the need for robust relationships with acute care services usually located in government mental health services in order to avoid frequent [or revolving door] expensive hospital admissions. The mental health sector has been struggling to establish supportive and collaborative relationships within and across non-government and government mental health services for the last 30 years with a view to reducing hospital admissions but with the fragmented and casualised workforce being created by the NDIS model of funding, the sector is at risk of losing ground in achieving these goals. This is because responsive rapid access to clinical expertise and cross sector collaboration requires robust organisational structures that are being dismantled as funding transfers from the mental health NGO sector across to individual funding packages in NDIS (Rosenberg et al., 2019, Furst et al., 2018). These issues are likely to be further exacerbated in rural and remote contexts.

Recommendations

That the Queensland Government:

- Increase capacity building component of NDIS (ILC) targeting psycho-social care
- Continue more block funding for mental health NGOs where gaps are identified
- Focus on evidence based interventions such as social skills training, supported employment and supported housing
- Develop Service and Learning Consortia ideas in terms of psycho-social care and consider other recommendations from the Improvement of Allied Health Services in Regional, Rural and Remote Australia Report
- Increase training opportunities for support workers specifically in mental health including support for new graduates.

Restrictive practices and specialised behaviour support services

The new 2-tiered system for development of behaviour support plans and authorisation of restrictive practices under the NDIS, regulated by the Disability Services Act, has required the creation of specialist behaviour support teams with registered NDIS providers designed

to replace the regionally based multi-disciplinary specialist behaviour support teams within Disability Services (Queensland Government). These teams act across the State providing positive behaviour support and associated planning and authorisation through the Queensland Civil and Administrative Tribunal (QCAT) for all forms of restrictive practices regulated under the Disability Services Act in Queensland. The changes have also meant that rather than requiring the authorisation by the external body, QCAT, for all forms of regulated restrictive practices, some forms of restrictive practices (such as chemical, mechanical and physical restraint) can be authorised by an appointed guardian for the person with disabilities (and in some cases by an informal decision-maker). As such there remains a centrally based multi-disciplinary team within the Queensland Government that provides short term approvals for each use of a restrictive practice, and provides authorisation and assistance to all plans which include the regulated practices of containment or seclusion.

This two-tiered system appears to be based on *assumptions* that:

a) *Physical restraint does not place the person with a disability at as great a risk of harm and does not encroach the human rights of that person to as great an extent as containment and seclusion*
    - Physical restraint can cause injury and even death, is a significant infringement of human rights, and can cause significant psychological trauma. Authorisation for the use physical restraint requires decision-makers to be very well informed of the impacts of its use and support staff must receive comprehensive training prior to its use (Luiselli et al., 2017). In Ireland, for example, a doctor must examine the individual subjected to physical restraint within 3 hours of the incident, and following a physical restraint incident it is compulsory for a psychiatrist to be informed immediately (Hughes and Lane, 2016).

b) *Registered NDIS providers can recruit and maintain multi-disciplinary specialist behaviour support teams in relation to the authorisation and use of restrictive practices and collectively provide statewide coverage*
    - Given the reported difficulties of recruiting expert clinicians for a multi-disciplinary team (especially psychologists) in disability and behaviour support; and given that NDIS funding arrangements are unlikely to enable the employment of <u>multidisciplinary</u> teams by NDIS registered providers, specialised behaviour support teams under these current circumstances may be difficult to sustain in urban and regional centres and are very unlikely to be recruited and sustained in rural and remote areas of Queensland. When

the Queensland Government recruited specialist positive behaviour support teams for all regional centres across the State, it had the capacity to utilise 457 visas as part of an international recruitment strategy.

It is unclear how many NDIS registered specialised behaviour support teams are operating across Queensland and the extent to which these can meet demand. This would require a detailed study to specifically examine capacity and capability of NDIS specialised behaviour support teams in Queensland.

Until these issues are understood, the continuation of a specialist behaviour support team based within the Queensland Government appears to be critical and best placed to ensure a ready, expert and multidisciplinary team to:

- provide short term approvals for restrictive practices
- develop all positive behaviour support plans that include containment/seclusion
- seek approval through QCAT for those plans, and
- provide advice on the implementation of those plans including containment/seclusion and any accompanying restrictive practices within those plans.

Recommendations

That the Queensland Government undertake research to examine the capacity and capability of NDIS providers registered for specialised behaviour support to assess the extent that they can provide an adequate response to demand for behaviour support across Queensland and thereby ensure the rights, safety and dignity of Queenslander with a disability subject to restrictive practices.

That the specialist behaviour support team based in the Queensland Government continue in its role in relation to short term approvals, planning and authorisation processes for seclusion and containment under the Disability Services Act.

That the Queensland Government review current legislation that allows for physical restraint to be approved by guardians and family members with a view to more rigorous approval processes.

Prisoners with disabilities

The *Queensland Corrective Services Annual Report 2018-19* states that more than 1000 prisoners have been identified as potentially eligible for the NDIS with more than 170 granted access to NDIS. Updated information indicates that those figures have since risen to

1700 and 300 respectively. These numbers were identified not through screening and assessment but through questions posed upon reception to prison and staff observations and interactions with prisoners. The total prisoner population in Queensland is 8771 (Australian Bureau of Statistics, 2019). Based on the figures provided by Queensland Corrective Services, 11% to 19% of prisoners in Queensland are likely to have a disability and 1.9% to 3.4% are likely to be eligible for the NDIS.

However, if QCS were to administer routine screening and assessment for disability, the proportion of prisoners with disabilities is likely to be much higher than the estimated 11%-19% in Queensland. The figure would likely be 30% to 50% of prisoners in Queensland with disabilities (based on research from other jurisdictions) and a proportion of those would be eligible for the NDIS.

For many persons with disabilities who are involved in the criminal justice system, particularly those with mild intellectual impairment, borderline intellectual functioning or mental health conditions, their entry to prison may be the only opportunity to be assessed for disability and become eligible for the NDIS. The NDIS' collaborative work with QCS to date needs to be positively acknowledged. However, it is important that QCS continue to accelerate its efforts to identify persons with disabilities amongst prisoners and clients of community corrections in a methodical manner using proven instruments for screening, assessment and diagnosis.

The reported lack of appropriate rehabilitation programs targeting offenders with disabilities in particular the reported lack of NDIS services available to people in prison has been described as a "market failure" in the Law Council of Australia's *The Justice Project Report (2018).* The NDIA states that it funds a range of supports for NDIS recipients, (that is for those prisoners who already have an NDIS funding package when they enter prison), but there is no definite information available as to the extent to which this may occur in Queensland prisons, especially in regionally and rurally located prisons. There were submissions along these lines made to the *NDIS Thin Markets Project*, but the report from that Project is not yet available.

The Law Council of Australia which was submitted to the NDIS Thin Markets Project Consultation stated that "a market-driven model – for instance falling within the "market facilitation" and "market deepening" categories described by the Consultation Discussion Paper-may have serious limitations in its ability to address thin market situations" and emphasised that "timely access, or lack thereof, to appropriate disability-related services may affect a person's life outcomes, including possible incarceration by the criminal justice system and their prospects of subsequent rehabilitation." (Law Council of Australia, 2019).

Recommendations

That the Queensland Government accelerates the program within Queensland Corrective Services to identify persons with disabilities and their access to the NDIS.

References

AUSTRALIAN BUREAU OF STATISTICS 2019. Prisoners in Australia 2019. Canberra: Austalian Government.

AUSTRALIAN HEALTH MINISTERS ADVISORY COUNCIL 2013. A national framework for recovery-oriented mental health services. Canberra.

DINTINO, R., WAKELY, L., WOLFGANG, R., WAKELY, K. M. & LITTLE, A. 2019. Powerless facing the wave of change: the lived experience of providing services in rural areas under the National Disability Insurance Scheme. *Rural and Remote Health,* 19.

FOLEY, K., ATTRILL, S., MCALLISTER, S. & BREBNER, C. 2020. Impact of transition to an individualised funding model on allied health support of participation opportunities. *Disability and Rehabilitation* [Online].

FURST, M. A., SALINAS-PEREZ, J. A. & SALVADOR-CARULLA, L. 2018. Organisational impact of the National Disability Insurance Scheme transition on mental health care providers: the experience in the Australian Capital Territory. *Australasian Psychiatry,* 26**,** 590-594.

HAYES, L., BROPHY, L., HARVEY, C., TELLEZ, J. J., HERRMAN, H. & KILLACKEY, E. 2018. Enabling choice, recovery and participation: evidence-based early intervention suppport for psychosocial disability in the National Disability Insurance Scheme *Australasian Psychiatry,* 26**,** 578-585.

HUGHES, L. & LANE, P. 2016. Use of physical restraint: ethical, legal and political issues. *Learning Disability Practice (2014+),* 19**,** 23.

JOHNSSON, G., KERSLAKE, R. & CROOK, S. 2019. Delivering allied health services to regional and remote particpants on the autism spectrum via video-conferencing technology: lessons learned. *Rral and Remote Health,* 19.

LAW COUNCIL OF AUSTRALIA 2019. Submission to the NDIS Thin Markets Project Consultation.

LUISELLI, J. K., SPERRY, J. M., DRAPER, C. & RICHARDS, C. 2017. Parent-Guardian Evaluation of Physical Restraint Among Adults with Intellectual Disability: a Social Validity Assessment. *Advances in Neurodevelopmental Disorders,* 1**,** 73-78.

MALBON, E., ALEXANDER, D., CAREY, G., REEDERS, D., GREEN, C., DICKINSON, H. & KAVANAGH, A. 2019. Adapting to a marketised system: Network analysis of a personalisation scheme in early implementation. *Health and Social Care in the community,* 27**,** 191-198.

NATIONAL DISABILITY SERVICES 2017. State of the Disability Sector Report 2017.

NATIONAL DISABILITY SERVICES 2018. State of the Disability Sector Report 2018.

NATIONAL RURAL HEALTH COMMISSIONER 2020. Report for the Minister for Regional Health, Rgional Communications and Local Government on the Improvement of Access, Quality and Distribution of Allied Health Services in Regional Rural and Remote Australia. Australian Capital Territory.

ROSENBERG, S., REDMOND, C., BOYER, P., GLEESON, P. & RUSSELL, P. 2019. Culture clash? Recovery in mental health under the National Disability Insurance Scheme-a case study. *Public Health Research and Practice,* 29.

WALLACE, D. 2019. Greater Whitsunday Regional Report-NDIS and Aged Care Providers Forum-December 2019. Whitsunday Region: Regional Social Development Coalition