afi advocacy for inclusion

Submission in response to the NDIS Thin Markets Project Discussion Paper

About Advocacy for Inclusion

Advocacy for Inclusion acknowledges the Ngunnawal people as the traditional owners of the Australian land on which we work.

Advocacy for Inclusion provides national systemic advocacy and independent individual, self and advocacy for people with disabilities in the Australian Capital Territory. We are a Disabled Peoples Organisation which means most of our board, members and staff are people with disabilities. We represent all people with disabilities and recognise diversity.

We act with and on behalf of individuals to act on their own behalf, to obtain a fair and just outcome.

Advocacy for Inclusion works within a human rights framework and acknowledges the *United Nations Convention on the Rights of Persons with Disabilities* and is signed onto the *ACT Human Rights Act 2004*.

Contact details:
2.02 Griffin Centre
20 Genge Street
Canberra City ACT 2601

Phone: 6257 4005
Email: info@advocacyforinclusion.org
ABN: 90 670 934 099

Prepared and written by Bonnie Millen, Senior Human Rights Policy Advisor
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Recommendations

Recommendation 1: Immediate and robust service solutions to be developed following this Inquiry in NDIS Thin Markets, to be consistent with the current and emerging policy on an interim basis between Commonwealth Government and all States and Territories.

Recommendation 2: NDIA act and review via a formal mechanism between Commonwealth and State and Territory jurisdictions to delineate the roles and responsibilities of the NDIA and mainstream services regardless of progress level. This should be focused on the delivery of services, plugging gaps in the event of funding disputes and disagreements of responsibility. The participant is and should remain a priority.

Recommendation 3: Safety of individuals is essential, and thus should alternative accommodations, or care settings arise at short notice, the NDIS should make provisions to addressed urgent and critical situations without delay nor question.

Recommendations 4: NDIA further funds and supplies additional resources and funding to advocacy organisations if advocates are picking up the pieces when it comes to POLR situations.

Recommendation 5: NDIA to develop and operate a triage system to prioritise people who require urgent assistance. The individual should be supported by their provider, advocacy organisation or support networks without further barriers in place.

Recommendation 6: NDIA needs to place transparent Provider of Last Resort arrangements in place as the absence of such arrangements are putting people at risk of not accessing any supports, resulting in admission to hospital, aged care facilities or jail.

Recommendation 7: NDIA to reevaluate what 'last resort' means and how it has been problematic in the past. If there is no market, one needs to be created to provide basic crisis intervention and services and supports alongside advocacy organisations in each jurisdiction.

Recommendation 8: The NDIA to review the *Principles to determine the responsibilities of the NDIS and other service systems* between Commonwealth and State and Territory jurisdictions to determine responsibilities, roles and appropriate funding, budgeting and elimination of gap issues for participants caught in a complex systematic web that is not their fault.

Recommendation 9: The *Maintaining Critical Supports* policy needs to be evaluated and must commit to providing services in areas of crisis accommodation and emergency intervention.

Recommendation 10: The NDIA steps up to acknowledge the priority of addressing the Provider of Last Resort as a thin market. The NDIA needs to create a funding framework for continued provisions of disability services where the need for crisis accommodation and emergency intervention.

Recommendation 11: The need for the NDIS workforce to grow is paramount, and the number of NDIS providers will need to increase to create balance and support choice, control and individualisation of services. NDIA needs to create a national strategy between Commonwealth and State and Territory governments in addressing and improving the disability services workforce.

Recommendation 12: The NDIA to reconsider the staffing cap to have the capacity to address and implement changes to plugging thin market gaps for participants.

Recommendation 13: The NDIA ensure support coordination and its supply is now flexible with the increase of the Price Guide 2019-2020 and not for a fixed period due to the changing nature and circumstances of participants.

Recommendation 14: The NDIA track, monitor and evaluation the position of support coordination, particularly against the confusion of where advocacy can overlap.

Executive Summary

AFI believes the NDIS should be focused on increasing meaningful and tangible support for people with disabilities to exercise self-determination, tied with vigorous accountability, transparency and monitoring systems – with an unequal market distribution, the high risk of 'thin markets' is critical and requires to be addressed.

For some, to argue that there is danger in stating thin markets will always be present for the NDIA and that such an attitude is passive in making reform is unrealistic. There will always be a thin market within the NDIA and the limitations in which can be provided for individual participants and their needs that are reasonable and necessary. However, the thin/weak markets that are current now are too broad, and the gaps are too big – reforms to ensure those gaps are filled need to be paramount to ensuring that future thin markets are relevantly as small as possible.

Bluntly, the NDIS cannot provide fund plans for services that are non-existent and expect participants to source them with limited or no supports. In 2011, the promise that "improving access for participants in thin markets is a key objective of the NDIS" which requires "constant vigilance, monitoring and evaluation"[1] remains problematic as this has yet to be actioned.

In the beginning, the NDIA was defended in not actively being responsible for the thin/weak markets nor market failure the "thin markets were a feature of disability support arrangements previously, as well as in many other human services… thin markets will remain a feature of the provision of some disability supports under the NDIS".[2] [3]

Fast-forward since 2011, the rushed implementation the NDIS overall has increased the presence and danger of 'thin markets', rendering the scheme acute and overburdened by multiple markets. With markets leaving the scheme, no new providers entering due to high costs and risk and the market

[1] Productivity Commission (2011), *Disability Care and Support, Report No 54*, Canberra
[2] Productivity Commission (2011), *Disability Care and Support, Report No 54*, Canberra
[3] Provided this statement was provided when the scheme was new, it is fair to note that the timely and appropriate policies to minimise impact on participants and providers is yet to be mitigated and reconsidered as the issue of thin/weak markets have reach a threshold for some with high and complex support requirements.

threatens to fail epically where participants most need supports.[4] [5] As enablement of choice and control for people on the NDIS, the market currently renders those most vulnerable to unequal distribution. Where choice and control are dependent on the ability of people to choose from a variety, the emergence of 'thin markets' have caused an acute situation where choice is placed on demand and expertise. For people with complex needs, the need for expertise services is excellent, yet fewer when providers cannot provide appropriate supports or are scarce.

The NDIS and its success rely on market stewardship to ensure that services are delivered to every participant. It comes to no surprise that the largest gap in the NDIS is the emergence of 'thin/weak' markets, mainly where service delivery is not available for participants with complex disabilities and difficult behaviours. In our experience, even after people transition to the NDIS, the safety net disappears and can become more complicated under the current arrangements between the NDIS and State and Territory governments. At best, the NDIA's stewardship approach can be viewed by monitoring and assessing markets and taking actions to improve the functioning of the markets. In particular, we welcome the *NDIS Market Enablement Framework,* which will guide how the NDIA will monitor the market and determine strategies for growth, correction and closing of gaps.

The current arrangements in the ACT and the Commonwealth Government do not state which government entity is responsible for ensuring that people with disabilities with complex needs receive services. This is highly evident in the criminal justice system, housing and mental health sectors. In 2017, the NDIA reassured the Productivity Commission that they would act as the provider of last resort and this has by far been left behind, forgotten and turned to dust.

Recommendation 1: Immediate and robust service solutions to be developed following this Inquiry in NDIS Thin Markets, to be consistent with the current and emerging policy on an interim basis between Commonwealth Government and all States and Territories.

[4] Carey, G., Malbon, E., Reeders, D., Kavanagh, A. & Llewellyn, G. (2017) Redressing or entrenching social and health inequities through policy implementation? Examining personalised budgets through the Australian National Disability Insurance Scheme, *International Journal for Equity in Health*, vol. 16, p. 192

[5] Productivity Commission 2017, *National Disability Insurance Scheme (NDIS) Costs*, Position Paper, Canberra.

Provider of Last Resort

In a growing and unstable market, there remains confusion of what constitutes as a 'Provider of Last Resort' (POLR). As an advocacy organisation, we have faced confusion as to whether we are acting as a source of 'last resort' is urgently advocating on behalf of a consumer to be supplied adequate care and accommodation.

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.

The NDIA'S current 'market intervention framework'[6] highlights the presence of 'weak/thin markets' as well as describing the authorisation of a POLR by the NDIA where "provision of goods and services in order to ensure supply" is commissioned. The confusion lies in the line that "even in a mature NDIS marketplace, insufficient local demand, limited-service delivery, workforce shortages, and lack of infrastructure will produce "weak" or "thin" markets"[7] – providing no reassurance that even at a crisis intervention point, support and supply will be provided under the NDIA.

At best, providing advocacy where crisis support is required, is difficult when the NDIA is seen as a giant boulder in the path of progress for an individual in need. In our experience, we often have participants being denied services and care due to funding disputes between the NDIA and other government services, including:

- NDIS participants, with plans providing for intensive supports including 24/7 care to support their independent living;
- Trapped in a constant cycle of recidivism due to lack of supports to aid people with disability and mental health in the criminal justice system
- cannot get bail from the court because they cannot safely return home without residential care supports in place;
- cannot attract service providers to give them the necessary support or attract providers to coordinate their in-home supports as they are deemed too complex and challenging.

[6] NDIA (National Disability Insurance Agency) (2016), *NDIS Market Approach: Statement of Opportunity and Intent*, Geelong.
[7] NDIA (2016) *NDIS Market Approach: Statement of Opportunity and Intent*, p.15

The issue of the interface between the NDIS and mainstream services have become more complex and the roles of each need to become well-defined in a policy framework to differ to avoid conflict of interest.

Recommendation 2: NDIA act and review via a formal mechanism between Commonwealth and State and Territory jurisdictions to delineate the roles and responsibilities of the NDIA and mainstream services regardless of progress level. This should be focused on the delivery of services, plugging gaps in the event of funding disputes and disagreements of responsibility. The participant is and should remain a priority.

The confusion of whether last-resort issues and if such issues equate as a thin market is confusing and needs to be addressed. People with a disability with complex needs or unpredicted circumstances, ending up in public aged care facilities, hospitals or institutional care such a prison, mental health wards and group homes is concerning. The lack of resolution surrounding how jurisdictions, including the ACT, can settle for a framework that identifies key service providers or settings of last resort to maintain critical supports that are ongoing.

In our experience, when people with high and complex needs rely on support to eat and drink are admitted to hospital are often left unsupported as it becomes a health vs NDIS interface issue. Arguments seem to arise from Supported Independence Living (SIL) providers that this support is not covered in their SIL quote if the participant is not present in the home and when the quote covers daily living matters. Instead, such support seems to then appear from their social support funding. It then becomes left for an advocacy organisation to organise such independent living support as it is overlooked in by the SIL provider.

We also see alarming cases of people being admitted to hospital, healthcare or aged care facilities and not being released (or placed under guardianship arrangements) due to lack of support staff available to assist daily. Within these practices, AFI can attest to handover processes lacking or unprovided, compromising the care and support of the individual. Despite participants being eligible and have access to NDIS, the question of what happens when sudden care changes occur, and they cannot be cared for in their own homes. Without the NDIS and limited care options available in the community for family or providers, there has been no choice but to admit them to a hospital or an institutional setting arrangement.

The NDIS as a boulder analogy can well be applied to barriers faced by advocates trying to find a solution to crisis intervention and access to accommodation but note the friction between the NDIA and State and Territory health systems. If the NDIA do not have the capacity nor the willingness to actively respond to crises in jurisdictions, including the ACT, that actively requires the health system to intervene and a thin market, how can they actively develop a 'service response' in time and with a limited capacity of staff?

It is unfair to assume the individual should have funding to cover any critical incidents that may occur outside of that the NDIS would traditionally fund. The confusion of how last-resort support will be addressed, who provides support and how quickly falls to the NDIS and should not fall to the person with adequate support measures put in place. This is not the role of an advocate and nor should it be if the NDIA claims to be a PORL provider. It places extra strain on advocacy organisations to pick up the pieces for individuals in PORL situations.

Recommendation 3: Safety of individuals is essential, and thus should alternative accommodations or care settings arise at short notice, the NDIS should make provisions to addressed urgent and critical situations without delay nor question.

Recommendations 4: NDIA further funds and supplies additional resources and funding to advocacy organisations if advocates are picking up the pieces when it comes to POLR situations.

The prioritisation of urgent and critical needs requires the NDIA to act faster to address gaps when they arise in a crisis. If services are not already in place, have ended or changed for the individual, the real consequences are that situations will worsen for people and advocacy organisations will continue to be safety net. People with disability and psychosocial disability have been provided wrong supports as an option by staff whom are ill-trained or equipped to support them, be retained in a custodial environment, hospitals or institutional settings as there is nowhere for them to go and forced to remain in their homes without additional support for their families or carers. If there are no complex services to support individuals 'to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life'[8], then it enters a thin market domain. This is evident where there is no market and no accessibility to alternative options.

[8] UN CRPD *Article 26 – Rehabilitation and habilitation*, s.18(a)

Recommendation 5: NDIA to develop and operate a triage system to prioritise people who require urgent assistance. The individual themselves should be supported by their provider, advocacy organisation or support networks without further barriers in place.

Recommendation 6: NDIA needs to place transparent Provider of Last Resort arrangements in place as the absence of such arrangements are putting people at risk of not accessing any supports, resulting in admission to hospital, aged care facilities or jail.

Recommendation 7: NDIA to reevaluate what 'last resort' means and how it has been problematic in the past. If there is no market, one needs to be created to provide basic crisis intervention and basic services and supports alongside advocacy organisations in each jurisdiction.

The NDIS is currently dedicated to a particular funding model, with limited flexibility. There is also conflict where the NDIA is not only the funder but also holds a view of the appropriate funding model that it expects from its jurisdictions. Moving to a fee-for-service and paid from individual packages raises the question of whether it is appropriate to use the individual plan model that may work for some participants but may worsen for others who have limited funding or are ineligible for NDIS funding.

Currently a partnership approach between the ACT Government providing the service and the NDIA funding, which is being implemented to support areas of the service delivery system under health that the ACT system any otherwise struggle to fund. From 1st July 2019, the NDIA will fund public rehabilitation, aged and community services in the ACT under Canberra Health. From here, consumers will need funds allocated in their NDIS plans to pay for these services as the funding model switches from 'in-kind' to a 'fee for service' model. Consumers are being told through a promotion that supports can be still supplied; however, without funds pre-allocated or approved in their NDIS plans. As a government entity under ACT Health, Canberra Health Services is now an NDIS Service Provider. Is this interface a conflict of interest with a jurisdictional government entity becoming an NDIS service provider and will it plug gaps?

Existing state and territory government processes that arise in crisis and emergencies that will cease despite the absence of formal arrangements under the NDIS is a concern.[9] Without key services that can respond to emergency crises and have expertise in linking people with complex needs to providers and services, there will be consequences where people continue to be placed in environments in which they will be stuck. The NDIA has not placed triaging systems in place to address urgent cases.

The NDIA, which has fundamentally changed previous state and territory previous funding and service structures, should be revisiting the way state and territory services used to operate in emergencies to ensure that the individual is well placed and not left in limbo. From an advocacy perspective, there appears to have been no process to ensure the provision of adequate, equipped services that manage crisis intervention and emergency service as there is no direct market and the system ultimately relies on state and territory governments.

The COAG document *Principles to determine the responsibilities of the NDIS and other service systems* lacks clarity and are open to misinterpretation. The lack of funding, roles and responsibility between the NDIA and mainstream services has created an emerging gap of its own where the fault is not of the participant. The impact on access to services for both eligible and non-eligible people with disabilities is great, particularly in the areas of justice, health, transport and crisis accommodation.

The focus should largely be on addressing boundary issues with mainstream services, the health interface and supported living accommodation settings. The slow delivery and promise of the *Maintaining Critical Supports* pilot framework remain unignored by the advocacy sector – as advocacy organisations are often called to address and hopefully plug the gaps involving participants with short-term solutions. We recognise and welcome the introduction of the *NDIS Complex Needs Pathway*. However, crisis intervention is a priority. The lack of information and approach by the NDIA is troubling – particularly when it is blatantly obvious that the issue is ignored and hidden behind a bureaucratic response.

Recommendation 8: The NDIA to review the *Principles to determine the responsibilities of the NDIS and other service systems* between Commonwealth and State and Territory jurisdictions to determine responsibilities, roles and appropriate funding, budgeting and elimination of gap issues for participants caught in a complex systematic web that is not their fault.

[9] Transitional arrangements for the NDIS and the Market readiness for provision of services under the NDIS reports

Recommendation 9: The *Maintaining Critical Supports* policy needs to be evaluated and must commit to providing services in areas of crisis accommodation and emergency intervention.

The NDIA remains responsible for the PLOR arrangements, and it remains frustrating from an advocacy point of view as a policy, and operational plan remains unreleased and unrecognised as a core priority. As far as thin markets are concerned, this is an area of critical need.[10] The absence of crisis and emergency services remain critical where there is a market failure in this area, and the workforce is ill-equipped.

Recommendation 10: The NDIA steps up to acknowledge the priority of addressing Provider of Last Resort as a thin market. The NDIA needs to create a funding framework for continued provisions of disability services where the need for crisis accommodation and emergency intervention.

Thinning NDIS Workforce

In our experience working with clients of high and complex needs, the lack of progress to address gaps where scarce services are available or exist has been highlighted continuously. We also note NDIA's reluctance to consider any service delivery model that is not based on the individualised and broadly-rolling-out of fee-for-service models. It is also a gap when continuity of supports lessens, and the participants lose their chosen provider and are required to redevelop a rapport or support system with a new provider or support staff who may be less experienced in working with high complex needs. This is apparent where allied health workforce is thin within the NDIS: OTs, psychologists, speech and language therapy and behavioural therapists are all in demand.

Case studies highlight a significant gap where disability support workers are low in numbers and reliant on casual contracts due to low support staff available. We regularly receive requests for advocacy for people being put to bed at 8 pm and not provided choice and control in their own group home accommodation due to lack of support staff available to monitor and support during the night. Equally, people have been left in bed until 11 am to be provided breakfast, showered and dressed or released into the community due to staff unable to commit to early morning availabilities.[11]

[10] Joint Standing Committee on the National Disability Insurance Scheme (2018) *Market readiness for provision of services under the NDIS*
[11] Also refer to Advocacy for Inclusion (2014) *I Make My Own Decisions* paper.

We argue that there is currently an immature market framework under the NDIS – that is already well known, acknowledged and possibly burnt to a crisp where awareness is concerned. The NDIA also appears to be working in isolation and not building on existing service delivery models, which in turn, falls back into the disability advocacy organisations where capacity is overflowing, and the availability individual advocacy is narrow and based on the severity of individual cases.[12] A thin market, except in a different context. This is not surprising where the Joint Standing Committee has pointed out "there is currently no clear national strategy to grow the workforce despite the need for an additional 70 000 disability workers by 2020".[13]

Through the AAT process, AFI has found that Local Area Coordinators (LACS) and NDIS Planners do not have the training, skills or direct experience to support people with complex and high support needs. The high reliance on the diagnosis of psychiatrists and GP letters in which is influencing whether people are supported or provided the level of support required.

Accountability remains key. To promote and actively drive a market that is unable to deliver, and the workforce is unable to supply, there is an assumption that providers and advocacy organisations will assist to plug those gaps. Ideologically, this is possible as AFI cannot effectively deny advocacy and the increase in AAT has proven that.

Recommendation 11: The need for the NDIS workforce to grow is paramount and the number of NDIS providers will need to increase to create balance and support choice, control and individualisation of services. NDIA needs to create a national strategy between Commonwealth and State and Territory governments in addressing and improving the disability services workforce.

There is also a need to begin addressing the potential growth in a growing aged population of people with disability over 55 where the NDIS age cap and participants are then reliant on the aged care system for system. Effectively and realistically, both sectors and service provisions are requiring growth in support and specialised staff. This is going to place additional strain on the current thin/weak market structure where NDIS funding for the participant is supplied, but the aged care sector and those ineligible for the NDIS may potentially require just as frequently and urgently.

[12] Productivity Commission 2017, *National Disability Insurance Scheme (NDIS) Costs*, Position Paper, Canberra, p.34
[13] Joint Standing Committee on the National Disability Insurance Scheme (2018) *Market readiness for provision of services under the NDIS*

Recommendation 12: By identifying where innovation is currently occurring in the disability services and the overall service provisions, it is necessary the NDIA effectively work with providers and community organisations to match demand and plug future gaps.

On the flip side, there is a necessity to reconsider the staffing cap of the NDIA staffing ratios. Adjusting the issue of the 'thin markets' requires monitoring, increasing the quality and safeguarding and transparency to allow providers and participants to have increased capacity. The lack of capacity of NDIA staff is becoming extremely problematic, particularly as more participants enter the scheme. The NDIA staffing cap has been a notable criticism[14] [15] as to whether capacity and current resources allow for the NDIA to address the issue of 'thin markets' effectively across a number of issues. The management of the issue needs to be balanced with ensuring that providers and specialists have support to deliver the support required under the NDIS without additional and unnecessary constraint.

Recommendation 13: The NDIA to reconsider the staffing cap to have the capacity to address and implement changes to plugging thin market gaps for participants.

Behavioural Management Support

The severe lack of behavioural management support in the ACT has been a highlighted issue for our clients. There is a Catch-22 within the ACT where (1) NDIS participants cannot receive funding to support them to receive Behavioural Management Support, creating difficulty to find services that fit their needs whilst also liaising with education and health outside of NDIS remit and, (2) there are extremely limited capacity of behavioural support specialists to sign and support further behavioural management support in line with the current and new *Senior Practitioner Act 2018*. In the ACT, this has created a stalling of supports as they toe the line with education and health.

In the ACT, there is a severe shortage of NDIS behavioral support planning available, and it falls to the requirement of the provider who must be registered creating backlog and urgency where qualified behaviour specialists are available. This in turn must be provided to the NDIS Quality and Safeguards Commission for quality assessment, monitoring and recording

[14] Australian National Auditing Office (2017) Decision-making Controls for Sustainability: National Disability Insurance Scheme
[15] Joint Standing Committee on the NDIS (2018) Market readiness for provision of services under the NDIS: Final Report

Lack of Support Coordination

At 31 December 2018, 40 per cent of NDIS participants had support coordination in their plans and many more require it due to the complexity of sourcing appropriate supports. [16] In the week of supplying this submission, AFI welcomes the changes to the NDIS Price Guide for 2019-2020, in particularly noting an increase of 2.3% in support coordination with the included ability for travel.[17] However, supply is still considered a thin market in the ACT with low supply and capacity with evidence that supports coordination is commonly not provided or adequately funded in plans.[18] [19]

Aside from lack of support coordination, capacity-building funds were not being put into plans[20]. We continue to find people with complex needs are being provided with high levels of core supports that are not being spent and receiving less capacity-building funding, but also the reverse.

In our experience, we continuously find people with complex support needs are falling through the gaps and are facing a significant risk of homelessness, reoffending and without continuous supports due to the lack of support coordination. We have questioned the previous 76 hours[21] of support coordination in NDIS plans was considered as significant for those with core supports, it remains from enough for people with high complex support needs particularly when dual psychosocial and mental health is also a factor. Under the current market economy, support coordination has an impact on people gaining services and support they require. In the mental health space, there is a lack of service providers which offer support coordination for people who have a large core funding amount in their packages.

The original design of the NDIS was to enable participants to have choice, control and flexibility in how they utilize their individual support funding. Coordination of supports is funded as a reasonable and necessary supports plan and/or provided by a registered provider. In our experience, people have required assistance in setting up for the right supports and services outside of our advocacy capacity; however, support coordinators have a tougher job when services, supports and programs, needed, based on a participant's goals, pre-existing supports (informal, mainstream and/or community

[16] Ibid
[17] NDIS Price Guide 2019-2020
[18] Joint Standing Committee on the National Disability Insurance Scheme (2018) *Market readiness for provision of services under the NDIS*
[19] Ibid, p.32
[20] NDIA Quarterly Report, 2018
[21] Previous NDIS Price Guide 2018-2019

supports), within the plan period – are non-existent and there is a risk of services closing down or are unequipped and trained in providing services to people with high and complex needs.

Recommendation 13: The NDIA ensure support coordination and its supply is now flexible with the increase of the Price Guide 2019-2020 and not for a fixed period due to the changing nature and circumstances of participants.

In another context, AFI has experienced questions of confusion from participants as to what and how Support coordination is supplied, regulated and managed as an NDIS funded requirement. There is confusion of from participants of what constitutes support coordination and how it differs the role of advocacy. Advocacy for Inclusion acknowledges that 'advocacy' is separate support and cannot be meddled with the roles of support coordination or even case management.

Recommendation 14: The NDIA track, monitor and evaluation the position of support coordination, particularly against the confusion of where advocacy can overlap.

The Inaccessibility E-Market Approaches

In our technology-reliant age, the NDIA and DSS have actively pushed for an e-market approach. There is also push-back regarding the accessibility[22], availability and ability for participants to be able to access information and be active in their choice and control of their own services. Bluntly: if the NDIA cannot produce a world-class accessible website meet the Web Content Accessibility Guidelines for AAA requirements, then should participants trust and use an e-market approach?

Accessibility should be jargon-free, pre-tested and made to accommodate all participants who may wish to engage in the e-market. As the world is beginning more technology-reliant, the NDIA and DSS must recognise that not all people with disability have access to technology, particularly in institutional settings where they are largely excluded from the wider population. This also includes areas that are regional, rural and remote where technology is far less advanced than those in metropolitan areas. So far, the reliance of pushing people with disabilities to engage with an e-digital approach (i.e. NDIS portal engagement as opposed to face-to-face, the expectation for clients to navigate complex systems to find supports) has been unpractical and unethical in the design and execution.

[22] News.com.au (online), *The National Disability Insurance website below best practice standard for accessibility*, 26th June 2019: https://www.news.com.au/technology/online/the-national-disability-insurance-website-below-best-practice-standard-for-accessibility/news-story/dd5a45763c5ea98ad59d4bdf6398bbd1

Whilst an eMarketplace development would benefit people with disability who are able to navigate systems and source their own information confidently and with limited to no assistance, the expectation that pushing towards an E-Market approach will not benefit others. AFI welcome the initiative of a platform that "can support information discovery, encourage innovation, and build community capacity", feedback needs to be open and receivable this time about what is working and what is not from participants and their families. The early failure of the NDIS Portal was pushed by advocacy organisations due to the inaccessibility, reliance on organisations to assist in the navigation and the unwillingness of the NDIA to accept feedback from the general public.

What Next? The Path Forward

The necessary approach is not to expect the market to grow at will nor demand providers step up to provide services or support. The ACT, an established regional major city, has fewer behavioural or specialised therapy supports to supply with providers struggling on increased pricing, as well maintenance of their services under NDIS contractual guidelines including quality assurance and monitoring of service provisions. Due to heavy constraints and inability to source quality and experienced staff, providers opt out of the market without reassurance to return, leaving participants in limbo. This is far more apparent in further regional and rural areas.

The NDIA needs to work with the revamp of the *National Disability Strategy 2020-2030* and in support of a changing National Disability Agreement. The interface between the NDIS and mainstream services remain complex. The growing evidence that participants with complex needs are being denied services and care due to funding dispute between the NDIA and other jurisdictional government services, in some cases, leaving people in prison or hospital for months. The situation has become unsustainable and requires immediate action from both federal government and the state and territory governments – the question of whether it is an actual thin market, or simply negligence from the NDIA to address gaps where they have been identified time and time again is to be recognised.

The failure of the market and availability of service need is critical where there should be 'providers of last resort' to match service needs. Equally, the failure by the NDIA and State and Territory governments has been highly noted[23] and has created profound consequences on people with

[23] Australian National Auditing Office (2017) Decision-making Controls for Sustainability: National Disability Insurance Scheme Access; Joint Standing Committee on the NDIS (2018) Market readiness for provision of services under the NDIS: Final Report

disabilities and dual psychosocial disabilities where services are not being delivered as promised and are non-existent and urgent. It remains a concern that people with disabilities whom are ineligible for the NDIS continue to fall through the gaps.

AFI continues to recognise and appreciate the complexity in which the NDIA presents on the current market and the impact that it may have on NDIS participants and those ineligible for supports. Interim and permanent solutions must be identified from this submission round and put in place by the Commonwealth and State and Territory governments collectively to ensure that market weakness is addressed, and gaps are plugged for people with disabilities who remain in crisis and emergencies.

We will continue to work positively with both NDIA and DSS, and we look forward to future collaboration following this submission.