

National Disability Insurance Agency

***Home and Living Consultation – An ordinary life at home***

Occupational Therapy Australia submission August 2021

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# Introduction

Occupational Therapy Australia (OTA) welcomes the opportunity to respond to the National Disability Insurance Agency’s (NDIA) *Home and Living Consultation – An ordinary life at home*.

OTA is the professional association and peak representative body for occupational therapists in Australia. As of June 2021, there were more than 24,800 registered occupational therapists working across the government, non-government, private and community sectors in Australia. Occupational therapists are allied health professionals whose role is to enable their clients to participate in meaningful and productive activities.

OTA notes that the NDIA has also released a *Support for Decision Making Consultation Paper*. Our response to the themes of this paper are incorporated into the following response.

# The role of occupational therapists in the NDIS

Occupational therapy is a person-centred health profession concerned with promoting health and wellbeing through participation in occupation. Occupational therapists are allied health professionals who enable people to engage in the occupations that bring meaning and purpose to their lives. They achieve this by working with participants to enhance their ability to engage in the occupations they want, need, or are expected to do; or by modifying the occupation or the environment to better support their occupational engagement.

Occupational therapists provide services across the lifespan and have a valuable role in supporting participants affected by developmental disorders; physical, intellectual, chronic and/or progressive disability; and mental health issues.

Given their expertise and area of practice, many occupational therapists deliver NDIS- funded services to participants. Services focus on promoting independence in activities of daily living and enablement of social and economic participation. These services may include functional capacity assessment and intervention; disability-related chronic disease management; prescription and implementation of assistive technology and/or environmental modifications; mental health interventions; positive behaviour support; driving assessments (when specifically trained to do so); and targeted, goal-focussed rehabilitation.

# Vision

OTA agrees in principle with the vision described on page 4 and 5 of the Consultation Paper and believes that occupational therapists are well placed to assist the agency to achieve that vision. Occupational therapists currently play a significant role in planning, enabling and sustaining person-centred housing outcomes for people with disability. This role includes but is not limited to:

* Functional assessment and identification of suitable living environment;
* Documentation of support needs, including person-to-person supports, environmental modifications and assistive technology;
* Utilisation of a care team approach, including development of a care plan and training of support workers where needed;
* Trialling of living environments, including consideration of dignity of risk, and planning a housing transition with support needs broken down into stages from pre- to post-transition;
* Provision of a tailored therapeutic approach which focusses on capacity building; and
* Supporting goal attainment and outcome measurement.

OTA is, however, concerned about one aspect of the vision, namely, its scope. On page 4, the NDIA notes that “this paper only looks at how the NDIA can help support improved outcomes to live an ordinary life and improve your experience of the NDIS. It does not look at what actions may be needed by others”.

OTA believes there are important issues to consider regarding what these other government agencies fund. Clarity is important to ensure that clients do not fall through the gaps.

# What the NDIS funds

OTA acknowledges that the NDIA’s vision must be achievable and that in some circumstances, a participant’s ideal situation may not be possible.

However, OTA members have expressed concerns around the intent of the new Home and Living Policy in terms of access to Specialist Disability Accommodation (SDA) and Supported Independent Living (SIL).

On page 7, the Consultation Paper argues that “living alone is more expensive than living with other people” and that “the NDIS cannot afford to pay for the support required for all participants to live alone.” OTA members have expressed concerns that this may mean participants who wish to live alone will need to self-fund the added costs of this choice.

As noted by one OTA member:

*I found this part very concerning; this is all setting the scene for if you want to live alone, you need to fund it (whether that is care or difference in SDA payments, which almost no person on DSP [disability support pension] can do).*

OTA members have requested clarification from the NDIA regarding any changes to funding for SIL or SDA, including whether this will be considered a personal choice which participants must partially or fully self-fund.

More broadly, OTA believes it would be highly useful for the NDIA to develop plain language statements about the purpose of the scheme and what it considers to be ‘reasonable and necessary’ in the context of home and living supports. This would support a shared

understanding between the NDIA, participants, families, carers and indeed, providers, about what the NDIS should fund.

# Features of a home and living approach

OTA has reviewed the proposed features of a new home and living approach and is pleased to provide the following feedback on the key features.

## Supporting you to be an informed and empowered consumer

OTA welcomes the proposed initiatives to build consumer understanding of their home and living options; however, we recommend that this is completed in tandem with strategies to build understanding of the NDIS more broadly.

This is because OTA members advise that accessing and navigating the NDIS remains confusing for many participants and their families.

According to one OTA member:

*When I worked in client-facing role delivering the NDIS both with ECEI and school age to adult clients, I often found I was needing to use my therapy hours with families to explain their plans and help identify where to go for support…Some families would be on their third or fourth NDIS plans and still not understanding what it all meant.*

OTA welcomes the NDIA’s suggestion that it “provide key information and communication to peer networks” and “promote growth of peer support networks” (page 26). OTA members report that peer support programs or services led by people with lived experience – either as a participant or the family member of a participant – help guide participants to information, supports and services that are accessible, practical and relevant to their circumstances.

## Expanding support for decision-making

OTA notes that the NDIA is separately developing and consulting on a Support for Decision- Making Policy Framework. OTA members advise that this Consultation Paper accurately captures the challenges associated with supported decision-making but lacks detail in terms of how the NDIA will address these challenges.

OTA members have raised the following questions for consideration by the NDIA:

* How will the NDIA assess capacity for decision-making and the need for decision- making support?
* Who will be responsible for building decision-making capacity when this is required?
* What will be the role of disability intermediaries, such as Support Coordinators, in supported decision-making?

OTA members note that it would be highly inappropriate for assessment of decision-making capacity to be conducted by unqualified, unskilled or inexperienced stakeholders, as this may lead to risks for participants.

Instead, OTA recommends that such assessments are carried out by suitably qualified allied health professionals, including occupational therapists. OTA notes that occupational therapists and other allied health professionals are also well placed to support participants to build decision-making capacity when required.

## Reforming the funding model

OTA members have noted with concern that the Consultation Paper makes a number of references to participants utilising their personal finances, in conjunction with their NDIS budgets, to fund supports.

For example, on page 16, the Consultation Paper states:

*“In future, your budget will be much more flexible. You will be able to use your NDIS budget (alongside your personal finances) to get the supports you want, when you need them.”*

For some NDIS participants, the only other source of income may be the Disability Support Pension (DSP), which OTA understands is only sufficient to fund basic living expenses.

OTA members have requested greater clarity around co-contributions under the new Home and Living Policy, including whether there have been any changes to what the NDIS will fund and what participants are required to self-fund.

## Improving choice and control through flexible budgets

OTA believes that participants’ choice and control over their personal budgets should be maintained wherever possible and agrees that participants should receive support to manage their budgets effectively when they need it.

This support is essential for participants who do not have the understanding or ability to manage a budget, or the capacity to advocate for themselves and what they need.

Otherwise there is a risk that the implementation of flexible budgets will amplify the inequity between participants who have greater self-advocacy and management skills compared with those who do not (Carey et al., 2017).

OTA agrees that a separate budget would be appropriate for some capital items (e.g. assistive technology, home modifications, specialist disability housing). We also see value in having a separate budget for capacity building, as this funding may need to be ringfenced to ensure participants are able to live as safely and independently as possible, and to reach their full potential.

For example, for participants with complex needs, significant psychosocial issues and/or those who have difficulty managing behaviour, essential daily tasks and decisions, it may be appropriate to ringfence funds for therapeutic and behaviour support services. Such safeguards will provide participants with greater capacity to genuinely work towards their goals.

Without this, OTA believes the most disadvantaged cohorts – who typically have the greatest need for capacity building and therapeutic support – may not have access to it.

OTA also notes that genuine choice and control can only be achieved with an adequate budget that covers the necessary costs and does not require a participant to have to choose one support over another.

OTA would be extremely concerned if a flexible budget put core support and capacity building funding in competition with each other. This is essentially asking a participant to choose whether they want to exist, or whether they want to access reasonable and necessary supports to improve their independence, quality of life and chance of independent social and economic participation.

The NDIA must either ensure there is sufficient funding for both or put safeguards around capacity building to ensure it is retained.

## Assisting implementation and maintenance

As noted above, OTA agrees that participants should have access to supports to understand how to implement their flexible budget, if required. However, OTA members have expressed concern regarding the following comment on page 18 of the Consultation Paper:

*“You may even be able to access Support Coordination and specialist support with exploration and design, separate from the providers of home and living supports to reduce potential conflicts of interest.”*

OTA would welcome greater clarity around what this will mean for allied health professionals who currently provide this support. OTA believes that therapists need to have early involvement to support decision-making regarding reasonable, sustainable, practical and affordable home and living options.

This section of the Consultation Paper also notes that plan reviews will not be required in most cases, “unless there is a change to your functional capacity and disability support need” (page 18). OTA members have noted that there are additional factors to consider which may trigger the need for a plan review. For example, should the original funding amount or chosen housing model be found to be inappropriate, at high risk of breakdown or harm to the participant, or no longer sustainable.

# Other matters

## Transition from ‘closed system’ group homes and other institutions

OTA welcomes the NDIA’s suggested action to target participants in traditional housing models, such as large group homes, aged care and closed setting SIL homes, to explore and design other options, where that is their choice (page 27).

OTA members note that participants may require substantial therapeutic support and capacity building to overcome the impacts of living in an institutional environment. These environments are notoriously regimented and frequently lead to participants losing valued living skills and decision-making abilities.

Without tailored capacity building, particularly in the months after leaving such an environment, they risk not reaching their functional ability, and becoming overly reliant on a high level of person-to-person support, sometimes indefinitely. This is particularly apparent for people who live with psychosocial and cognitive disability.

Regarding which participants should be included in this strategy, OTA wishes to draw the NDIA’s attention to a large cohort of NDIS participants whose disability support and housing needs remain largely unmet: those living in Supported Residential Services (SRS).

OTA understands that SRS are found throughout Australia, with the largest proportion located in Victoria, where they provide accommodation for over 4000 people with disability and those who cannot live independently. They are legislated under the *Supported Residential Services (Private Proprietors) Act 2010* and provide a privatised group-home model of care.

One OTA member describes SRS as “a throwback to institutional care systems,” noting that they function as medium- to large-sized institutions offering accommodation and board, predominantly to people who have no alternative options. This might include people with complex needs; people with psychosocial or cognitive disability; or those who are homeless, discharged from hospital or estranged from family and other support systems. OTA understands that staff may have limited training and staff ratios may be low.

In 2020, the Office of the Public Advocate published the Annual Community Visitors Report, in which it documented 669 abuse-related issues in Victoria, an increase of 36 per cent from the previous year (Office of the Public Advocate, 2020, p. 6). Significantly, the report also found that some SRS proprietors with attached NDIS businesses had excluded other services from the premises, effectively removing choice and control and forcing residents to move their NDIS funds in-house, thereby running ‘closed system’ accommodation (Office of the Public Advocate, 2020, p. 21).

***Case study of NDIS participant living in an SRS***

*\*Nick has both psychosocial and cognitive disability and spent three years living in an SRS. He recently moved out with the assistance of NDIS-funded support and capacity building strategies devised with his occupational therapist. On the Disability Support Pension, he describes paying $880 fortnight to share a room, plus signed over a large proportion of his NDIS funds for care he feels he did not receive. If he missed a meal, he had to wait until the next formal mealtime for food. “It felt like living on a psych ward or in prison”, he said.*

*\*Nick’s occupational therapist has described the impact of living in an SRS for extended periods of time. According to the therapist, “due to the institutional environment, residents can’t use their living or decision-making skills, and often become de-skilled and unnecessarily reliant on care systems”. For example, most SRS residents are not given the opportunity to plan, prepare or cook their own meals, do their own laundry or cleaning.*

*Residents have low levels of autonomy to make day-to-day decisions. Their daily routine is imposed by the SRS. “This makes transitioning out of the SRS to an independent living environment even more unattainable.” In \*Nick’s situation, he hadn’t made himself a cup of coffee in over two years, prior to seeing an occupational therapist to re-build living skills.*

\*Name has been changed.

OTA members request that NDIS participants living in SRS are prioritised alongside other group home residents, in terms of having their home and living needs met under a new Home and Living Policy.

# Conclusion

OTA thanks the NDIA for the opportunity to respond to its Home and Living Consultation. Please note that representatives of OTA would be pleased to meet with representatives of the NDIA to expand on any of the matter raised in this submission.

# References

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, 16*(1), 1-12.

Office of the Public Advocate. (2020). ‘Community Visitors Annual Report 2019-2020.’ Government of Victoria. Retrieved from [https://www.publicadvocate.vic.gov.au/opa-s-](https://www.publicadvocate.vic.gov.au/opa-s-work/our-organisation/annual-reports/community-visitor-annual-reports) [work/our-organisation/annual-reports/community-visitor-annual-reports](https://www.publicadvocate.vic.gov.au/opa-s-work/our-organisation/annual-reports/community-visitor-annual-reports).