APS Response to Joint Standing Committee on the National Disability Insurance Scheme: NDIS Workforce

Australian Psychological Society | **Submission, May 2020**

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We acknowledge the Traditional Custodians of the lands and seas on which we work and live, and pay our respects to Elders, past, present and future, for they hold the dreams of Indigenous Australia.

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The Australian Psychological Society

The Australian Psychological Society (APS) is the largest national professional organisation for psychologists, with over 24,000 members across Australia. It seeks to help people achieve positive change, so they can confidently contribute to the community.

Psychologists are experts in human behaviour and use evidence-based psychological interventions to enhance human performance and functioning, prevent people from becoming unwell, and assist them to overcome mental and physical illness. Economic evaluations highlight the cost-effectiveness of psychological interventions to support functioning, prevent people from becoming mentally unwell, and to treat a range of mental health symptoms and disorders when they do occur.

The APS has a long history of working collaboratively with the Australian Government, State and Territory governments and other agencies to help address major social, emotional, and health issues for local communities and ensure healthcare is equitable and accessible to all members of the Australian community.

Executive summary

The APS welcomes the opportunity provided by the Joint Standing Committee on the National Disability Insurance Scheme (NDIS/the Scheme) to provide feedback on the Scheme's workforce and guide improvements that will support the lives of many Australians living with disability and the communities in which they reside.

The APS offers the following recommendations in relation to the Terms of Reference set out by the Joint Standing Committee.

APS Recommendations

The current and future size and composition of the NDIS workforce

The APS recommends that the Australian Government takes the necessary steps through the National Disability Insurance Agency (NDIA) and NDIS to ensure that a viable and sustainable NDIS workforce of the requisite quality is established as a matter of priority. This will be enabled by:

1. A thorough participant-care needs analysis, conducted with input from key stakeholders (including peak professional associations) across the disability and other relevant (e.g., health and mental health) sectors.
2. An analysis of the workforce supply and demand. This analysis should specifically seek to establish (a) the number of NDIS participants with a mental illness and/or a psychosocial disability, (b) what proportion of those participants with such needs have current plans that include psychological goals and (c) which professionals are providing the required services, and (d) the impact of recent changes to auditing/registration requirements on provider workforce numbers, and impact on eligible participant access to psychologist providers.
3. Development of workforce benchmarks for successful service delivery predicated on the needs analysis and conducted with input from key stakeholders (including the peak professional bodies) across the disability sector.

Workforce attraction and retention challenges

The APS recommends that the Australian Government takes the necessary steps through the NDIA to address the workforce attraction and retention challenges facing the Scheme. In particular, it recommends that the NDIA:

4. Ensure NDIS planners, Local Area Co-ordinators (LACs) and support co-ordinators recommend the use of psychologists as the preferred providers of psychology interventions for NDIS participants for neurocognitive, behavioural and mental health and psychosocial disabilities.
5. Address the cost of Third-Party Verification (TPV), especially for small practices with small customer bases.
6. Reduce unnecessary "red tape" and the burden of administration in service delivery.

Impact of Commonwealth Government policy on the NDIS working environment

The APS recommends that the Australian Government develops comprehensive policies in relation to the NDIS working environment regarding education and training of NDIS staff, fee setting and regulation of providers, and that, via such policies, NDIA and NDIS take the necessary steps to:

7. Fully assist the NDIS workforce to develop to its optimal potential. This includes developing operational policies that are supportive of the needs of staff and providing training targeted to workers and NDIS staff (including planners and LACs) and
8. Appropriately engage with professional organisations in the development and implementation of NDIS targeted programs of education and training.

Government's role in NDIS workforce development planning

The APS recommends that the Australian Government takes the necessary steps through the NDIA and NDIS to develop a comprehensive strategic workforce development plan. To facilitate this, the APS recommends the:

9. Development of workforce benchmarks for successful service delivery predicated upon a needs analysis and conducted with input from key stakeholders (including the peak professional bodies) across the disability sector and the close involvement of the Quality and Safeguards Commission.

The interaction of NDIS workforce needs with employment in adjacent sectors including health

The APS recommends that the Australian Government takes the necessary steps through the NDIA and NDIS to better design the arrangements that apply to interaction of NDIS workforce needs with employment in adjacent sectors. To facilitate this, the APS recommends that:

10. The NDIS/NDIA commence high level government, industry and peak association consultations aimed at clarifying the best set of working relationships of the Scheme to all adjacent sectors for their workforce and service delivery implications and impacts.

Other matters

The APS recommends that the Australian Government takes the necessary steps to ensure that the NDIA and NDIS act to:

11. Improve the quality of communications with practitioners, industry representatives and peak professional bodies.
12. Review the role of NDIS planners for their impact on the NDIS workforce and the availability and quality of service delivery through the NDIS Quality and Safety Commission.

Introduction

The APS welcomes the opportunity to provide a submission to the Joint Standing Committee (JSC) inquiry into the Workforce of the National Disability Insurance Scheme (NDIS).

Psychologists are an important part of the workforce involved in providing support to people with disability in Australia. In making this submission, the APS liaised with members who are working or have worked in the NDIS environment as sole practitioners, staff members of service provider organisations or members of other entities. The APS believes it is critical that the workforce issues it identifies in this submission are addressed if the NDIS is to operate as the originally envisaged landscape-altering scheme for the provision of care to Australians with a physical, intellectual, sensory and/or psychosocial disability.

The operation of the NDIS is underpinned by a philosophy that places autonomy (though choice and control in decision making about services). It decentralises service delivery from state government providers to the non-government and private sectors via various funding mechanisms that aim to improve the quality of life of Australians living with disability.

The market-place environment in which the NDIS operates has potentially profound consequences for participants and practitioners through the NDIS workforce. Ongoing scrutiny of the NDIS workforce is essential in ensuring that the best possible outcomes for participants are being targeted and delivered. Based on APS member comment, this submission focuses on the Terms of Reference set out by the JSC Inquiry into the:

a. the current size and composition of the NDIS workforce and projections at full scheme;

b. challenges in attracting and retaining the NDIS workforce, particularly in regional and remote communities;

c. the role of Commonwealth Government policy in influencing the remuneration, conditions, working environment (including Workplace Health and Safety), career mobility and training needs of the NDIS workforce;

d. the role of State, Territory, Commonwealth Governments in providing and implementing a coordinated strategic workforce development plan for the NDIS workforce;

e. the interaction of NDIS workforce needs with employment in adjacent sectors including health and aged care;

f. the opportunities available to, and challenges experienced by, people with disability currently employed, or wanting to be employed, within the NDIS workforce; and

g. any other matters.

The APS Response to the Inquiry's Terms of Reference

Term of Reference (a): The current and future size and composition of the NDIS workforce

Individuals who require care and support under the NDIS can be affected by a range of sensory, intellectual, developmental and/or behavioural impairments and disabilities. Importantly, research demonstrates that people with a disability have a higher prevalence of mental health disorders compared to those without a disability.

The impairments and disabilities experienced by NDIS participants and the psycho-social disability associated with them impact significantly on their capacity to function within the community. Scheme participants are, therefore, among the most disadvantaged Australians and the challenges involved in working with them are considerable.

Scheme participants are entitled to best-practice care and interventions for their disabilities. For this to occur efficiently and effectively, however, two things are required:

1. **Clarity of scope:** There must be clarity about what disabilities are within the scope of the Scheme. APS member feedback indicates a serious lack of clarity among planners about the mental health conditions accepted under the NDIS and whether psychosocial disabilities will be funded for intervention. The APS stresses the critical importance of addressing this issue as it creates significant uncertainty for participants and providers.
2. **Fit for purpose:** The NDIS workforce must be fit for purpose if it is to deliver best-practice care and interventions. To ensure this, the NDIS workforce must not only be of appropriate size and availability, but appropriately qualified, with the requisite capacities and skills for delivering best practice care and interventions to NDIS participants.

The work required to address participants' psychological needs under the NDIS is specialised and often complex in nature. The role of psychologists in providing assessment, care and interventions to participants is vital to assisting them and their families, guardians and carers, to cope with their disability. Psychologists working under the Scheme provide a variety of supports and interventions to participants. This includes services related to assessment (e.g., of neuro-cognitive disorders), early childhood disabilities (e.g., in intellectual function and learning disorders), complex behavioural deficiencies, developmental issues (e.g., sexual maturation), the co-ordination of life stage transitions (e.g. from special to mainstream schools and vice versa and from school to adult day care programs) and capacity building (e.g., for community participation).

In mid-2018, the NDIS predicted that 64,000 Australians with severe and persistent mental illness will be eligible to access the Scheme by the time it is in full operation (NDIS, 2018). Around a year later, it was identified that the Scheme is likely to fund plans for over 500,000 Australians over the next five years (NDIS Ministerial statement; August 2019), many of whom will also experience psychosocial disability.

In the face of this demand, the NDIS in August 2019 projected that up to 90,000 FTE equivalent NDIS workers will be employed in the field in Australia by 2023. As the APS understands it, this is twice the current disability workforce. Given the projected number of NDIS participants with mental illness (13% of the total NDIS population) and that those with psychosocial disability arising from or associated with disability are not included in this, the demand for psychology interventions that is facing the NDIS is, and will continue to be, significant.

As at 31 January 2020, there were approximately 1000 psychology practices (most of which likely employ more than one psychologist) registered to provide services under the Scheme across Australia (NDIS, 2020). Based on this data, there is uncertainty regarding the capacity of the current psychology workforce to meet current demand, and even more uncertainty regarding its capacity to meet expected future demand. The psychology workforce must increase if the supply and availability of psychology services is to cope into the future.

There are demonstrable service gaps in regional, rural and remote Australia and in relation to those with neurocognitive disorders, early childhood disability and behaviour support. APS member feedback, from surveys in 2018 and 2020 and contacts to the APS's Professional Advisory Service, identifies an inability of the current workforce to address these

gaps. In the absence of any hard data provided by the NDIS – for example, that which compares psychology registrations for the Scheme against the numbers judged by the NDIA as necessary for the successful operation of the Scheme – the indications are that the Scheme is failing to keep pace with the needs of many participants with mental ill health and/or psychosocial social issues associated with their disabilities.

APS member feedback also highlights that the current supply and demand ratio may be worsening and that, contrary to any idea that the psychology workforce will increase, practitioners are reluctantly deciding to leave the Scheme and, in some cases, the field. Illustrative of this, a March 2020 APS member survey about the NDIS, to which there were 963 respondents who indicated they intended, were currently or had recently worked under the NDIS, 10 per cent of those surveyed indicated their intention to discontinue providing services under the Scheme. These practitioners were very experienced, with 29 and 26 per cent of them having respectively worked for more than 10 or 20 years in the disability field.

If the current supply of psychologists as a proportion of the NDIS workforce was maintained, this would provide for a doubling of the number of psychologists under the Scheme over the next three years. However, such an increase in the psychology workforce would simply maintain parity with the current supply and demand ratio which, as noted above, appears insufficient to meet the current needs of many participants in the Scheme and would certainly be insufficient to address the likely increase in demand for psychology interventions in the future.

There is a significant likelihood that an increase in the psychology workforce will not occur without NDIS intervention to sharpen the demand-supply curve. The APS is not aware of any plan by the NDIA to address this and meaningfully grow the psychology workforce and accelerate the supply of psychology services.

The development of an NDIS disability workforce plan (see Term of Reference (d)) which provides for a proper matching of the supply of psychology providers against demand for psychology services has been a glaring omission in the operation of the Scheme to the present time.

The APS has expressed its concerns to a range of inquiries (e.g., those conducted by JSC and Australian Productivity Commission (APC)) about the impact of market forces on the capacity to ensure quality services. The importance of developing the correct workforce trajectory for the NDIS cannot be overstated. Any strategy that deskills the workforce, encourages practitioners to work outside their scope (eg. to provide psychological services without the requisite training) or encourages growth in unregistered providers at the expense of registered providers via unregulated price incentives is a risk to the appropriateness and quality of services. The composition of the workforce and the balance between registered and unregistered providers is incredibly important and as the APS has previously observed there is a paramount need to

> *engage the right person with the right knowledge and skills for the job. There will be considerable pressure on agencies to recruit a cheaper workforce with inadequate knowledge, skills and experience to undertake the more high-level services that might be required by a person with a disability* (APS, 2018).

As the APS argues in relation to Term of Reference (b), there is a need to remove workforce barriers and undertake a campaign to attract and retain psychologists within the NDIS. As the APS argues in relation to Term of Reference (d) this can only be done on the back of a comprehensive workforce plan that gives due prominence to psychology.

Recommendations

The APS recommends that the Australian Government takes the necessary steps through the NDIA and NDIS to ensure that a viable and sustainable NDIS workforce of the requisite quality is established as a matter of priority. This will be enabled by:

1. A thorough participant-care needs analysis, conducted with input from key stakeholders (including peak professional associations) across the disability and other relevant (e.g., health and mental health) sectors.
2. An analysis of the workforce supply and demand. This analysis should specifically seek to establish (a) the number of NDIS participants with a mental illness and/or a psychosocial disability, (b) what proportion of those participants with such needs have current plans that include psychological goals and (c) which professionals are providing the required services which professionals are providing the required services and (d) the impact of recent changes to auditing/ registration requirements on provider workforce numbers, and impact on eligible participant access to psychologist providers.
3. Development of workforce benchmarks for successful service delivery predicated on the needs analysis and conducted with input from key stakeholders (including the peak professional bodies) across the disability sector.

Term of Reference (b): Workforce attraction and retention challenges

The APS has repeatedly identified areas of particular workforce challenge and the issues that mediate the attraction and retention of the NDIS workforce[1]. These issues and influences are described below.

i. *Areas of particular workforce challenge*

Regional maldistribution

The most obvious challenge to making the Scheme operate to full capacity relates to attracting suitably qualified practitioners to work in rural, regional and remote Australia. The APS has in its previous submissions cited examples of serious delays in the provision of interventions to participants outside of metropolitan Australia[2].

The APS considers it imperative that the existing workforce in rural, remote and regional Australia is activated and supported to develop capacity services under services under the NDIS. The APS is strongly of the view that the problem will not be solved by markets and timely, creative solutions are required if workforce-related service shortfalls are to be successfully addressed.

The NDIA is urged to consider mechanisms to expand capacity rather than leave it to market forces (with all of the implications that this would create for rising prices and unit costs).

Possible capacity-building mechanisms include funding:

- indentured trainee placements and registrars in practices and provider organisations
- practitioners to travel to regional, rural and remote locations to provide concentrated "sessions" of appointments
- fly-in clinic-type services and
- the use of tele-health or video conferencing (including for individual and multidisciplinary teamwork) that is offered in a manner that it consistent with best practice guides. The APS has developed a range of resources for psychologists related to telehealth, such as using telehealth with children and young people which could easily be adapted to the NDIS environment.

High need participant groups

No less important, but often less visible, is the problem of inadequate workforce supply for, and service delivery to, specific high need participant sub-populations. Members of the APS have identified several areas where workforce deficiencies are acute:

(i) in the treatment of Autism and other Neurodevelopmental disorders (like Intellectual Developmental Disorder, Global Developmental Delay, Learning Disorders, Attention Deficit/ Hyperactivity Disorder, Other Specified Attention-Deficit/Hyperactivity Disorder, Unspecified Attention-Deficit /Hyperactivity Disorder, Specific Learning Disorder and Stereotypic Movement Disorder).

(ii) in the provision of Early Childhood Support (ECS) and Behaviour Support Service, where there are indications that providers – who often have provided a highly-dedicated and expert service – are choosing to not do this work because Scheme-driven difficulties

(iii) in services to participants with mental health issues and/or psychosocial disability, where they, their families, carers and practitioners are continually referred to the MBS for assistance. Although the APS has repeatedly raised this as a problem with the NDIS and government, there has been little improvement in this area.

Intrinsic to these problems is the failure of the Scheme to effectively and unambiguously define and/or appropriately translate which conditions are within the Scheme's scope and which conditions are not, and for planners, LACs and support co-ordinators to be obligated to act in accordance with that definition. Autism is a key example of where there is frequent failure to accept participants into the Scheme or approve sufficient interventions within participant plans and where there is an attempt to inappropriately cost shift the needs of participants to the health system under the MBS.

This leads to significant problems for those attempting to provide care. The following example provided by a member illustrates the dilemma that

1 Roufeil, L. (2017). *APS Response: Joint Standing Committee on the National Disability Insurance Scheme (NDIS) inquiry into transitional arrangements for the NDIS*. APS: Melbourne. DOI 08/2017.

1 Roufeil, L. & McHugh, T. (2018). *APS Response: Joint Standing Committee on the National Disability Insurance Scheme (NDIS) Inquiry into Market Readiness for the NDIS*. APS: Melbourne. DOI 02/2018.

2 Roufeil, L. & McHugh, T. (2018). *APS Response: Joint Standing Committee on the National Disability Insurance Scheme (NDIS) Inquiry into Market Readiness for the NDIS*. APS: Melbourne. DOI 02/2018.

2 Roufeil, L. & McHugh, T. (2018). *APS Response to the New South Wales Parliament Legislative Council Portfolio Committee No. 2 – Health and Community Services – Inquiry into the Implementation of the National Disability Insurance Scheme and the Provision of Disability Service*. APS: Melbourne.

faces participants, their families and carers and practitioners in the psychology space. It involves:

> *a 36 yo male client who lives in supported accommodation. He has a moderate intellectual disability and ASD and has a substantial NDIS package. He was displaying increasingly erratic behaviours leading to four admissions to a mental health facility over a short period of time. The mental health facility eventually deemed him to be "unsuitable" for their care due to his intellectual disability. The NDIS planner was contacted to obtain emergency respite but because there was no funding specifically allocated to emergency respite, the request was rejected by the planner. Thus, the mainstream mental health service rejected the client due to his intellectual disability but the NDIS planner was also unable to provide suitable care for the client*

As this example demonstrates, the absence of a clear definition of scope results in decisions that directly affect the care provided to participants.

(ii) *Issues in the planning process*

There are several patterns of planner decision-making behaviour that result from the lack of clarity around scope, which affect service delivery and as a consequence affect the experience of psychologists working in the Scheme. These issues have been identified by members as contributing factors to their decisions to review – and in some cases discontinue – their involvement in the Scheme.

Inconsistent decisions

First, there is demonstrable variability in the decisions made by planners for participants with similar care and support needs. APS members report on the considerable variation between NDIS plans in terms of what services, skills and degree of intervention is required, particularly when a participant presents with psychosocial disability.

In its 2017 submission to the APC, the APS observed that

> *If an individual has significant anxiety and/or mood and/or behavioural issues as a result of their disability and this is contributing to their inability to function within the community, should services be provided under the NDIS or via the health system? The experience of members is that this depends on what planner is working with the participant, or the location of the participant. Some participants are provided psychological services via the NDIS, yet for* ***the same issue or circumstances****, other participants are told to obtain a GP Mental Health Plan and see a psychologist under Medicare. This anomaly cannot be explained by participant choice. Member feedback strongly suggests that planners in some locations are much more likely to send a participant who mentions they have anxiety, behavioural or mood issues to the health system without even exploring the genesis of the issue.*

The most recent 2020 APS survey of members confirms that the issues encapsulated within this example remain significant problems.

Inadequate support

Second, members report that what is approved by planners in participant plans (where psychology is warranted) is inadequate. The most frequently cited concern is that NDIS approved interventions for complex problems are not of sufficient frequency and duration to address the impairment or disability of focus. An important example for this relates to the development of evidence-based behaviour support plans (BSPs) for individuals with complex behaviour issues. Members have informed the APS that plans do not include functional behaviour assessment or time to devise, implement and monitor a BSP.

The Institute for Applied Behaviour Analysis – internationally acclaimed service providers for children and adults with disability – estimates that it can take over 80 hours to adequately complete a behavioural analysis[3]. This contrasts with the experience of an APS member providing psychological care to a 58 yo male participant who is an amputee with an acquired brain injury, high medical support needs, high-need support for all activities of daily living and who exhibits high levels of physical and verbal aggression, has inappropriate sexualised behaviour towards other residents and staff in community-located supported accommodation who frequently returns to the facility in an intoxicated state. She reported that despite the enormity of his needs,

> *his NDIS plan included only 6 hours of behaviour support, when [in line with best-practice] he needed a ... functional behaviour analysis, baseline cognitive assessment and (associated) adaptive measures ... BSP and an (implementation) instruction for the staff of the residential facility. The psychologist also needed to be available for monitoring and review of the BSP over 12 months.*

Cost-shifting to Medicare

The APS is particularly concerned by the consistent feedback from members that planners are inappropriately and incorrectly instructing participants and their carers that the NDIS does not permit psychological interventions and they are to receive treatment under the Medicare Better Access to Mental Health Scheme (Better Access).

3 see www.iaba.com

This attempt to push participants to Medicare has been particularly common in relation to Autism, which is not approved for treatment under Better Access and interventions are not funded. It also applies to ECS as indicated by the following member comments:

- *I have seen the introduction of NDIS result in children with brain injuries receiving less services or recognition of their disability.*
- *There has been a lack of knowledge by NDIS staff in relation to ASD [autism spectrum disorder], stating it was required (not recommended) that children with ASD be reviewed because it was mandatory that they were provided with an ASD level. This was not the case, after I spoke to NDIS but still occasionally a planner or LAC will tell the family this and there have been many upset parents in my practice who are very confused. Even in the early intervention arm of the stream I have had children denied access until they have an assessment.*
- *One of the key concerns I have had in early childhood is NDIS planners giving families inappropriate information about the role of psych and or recommending to families that even though they have NDIS funding that they should save this for OT/Speech Pathology etc. and use Better Access funding for psych sessions.*

Despite the APS having consistently raised these concerns in submissions and in direct communication with the NDIA, there appears to have been little change for the better and the feedback is that, to the contrary, the incidence of such advice is increasing. Several members have suggested that planners are following an NDIS operating protocol or directive to direct psychology services to Medicare. The APS has not been able to establish the accuracy of this assertion but would be very concerned if it were the case. Further detailed comments from members are appended to this submission.

Non-psychologists delivering psychology interventions

A further concern of the APS relates to the preference of planners to advocate for non-psychologists to deliver mental health interventions where psychosocial disability is accepted as a target for interventions.

The APS is firmly of the view that decisions about who is best to deliver interventions cannot be left to the marketplace, as there is significant potential for the market to operate to meet service demand via for-profit organisations and large Non-Government Organisations (NGOs) using a low cost and low capacity workforce.

This is because the NDIS inadequately distinguishes between the high-level knowledge, skills and experience of psychologists in behaviour management (especially complex behaviour management) and those of the less qualified workforce who are currently delivering behaviour support under the NDIS. (such as OT assistants). The APS has been advised by members over some time that there is evidence of active advocating by planners against the inclusion of psychology interventions in plans and/or in favour of the provision of interventions by other providers, who lack the expert skills for the delivery of specialist psychology interventions for the conditions and behaviours involved on the basis of cost.

The overall result of such planner decision-making in developing plans for participants is that it directly influences the care, services and interventions that are made available to participants. This inappropriate restriction on the provision of psychology interventions in relation to neuro-cognitive disorders, ECS needs, mental health problems and psychosocial disability has unequivocal consequences for workforce retention and attraction.

There is also evidence that participants with behaviour support needs (especially those with complex needs) are being denied to the opportunity to make choices and exercise control over the services they need. Member feedback suggests that this is primarily due to the development of plans by planners that do not reflect what is needed for behaviour management plans for clients with complex needs (in terms of both cost and time). The APS is aware that highly credentialed psychologists with long histories of delivering best practice interventions to the disability sector have left or are intending to leave the NDIS because of the inability to deliver best practice interventions to clients.

These planning deficiencies are common and are particularly problematic for participants with multiple or complex needs, who are among the most disadvantaged members of our community. Such deficiencies have the potential to place the safety of participants, and their families, guardians and carers at risk through the provision of sub-optimal care.

Ultimately, such planner decision-making has the potential for very significant impacts on participants. If psychologists de-register their services, depriving vulnerable NDIS participants of true choice, then default services are likely to be less appropriate for their condition(s) and needs.

To summarise, the APS's view is that there are serious structural and behavioural deficiencies in the NDIS planning process as it has operated in relation to the approval of psychology interventions in participant plans. Given it is acting as a deterrent to the continued involvement of some practitioners in the Scheme, the APS believes is critical that planner decision-making behaviour be addressed for their impact on workforce availability development.

(iii) Barriers and costs

Also affecting the attraction to and retention of psychological practitioners in the NDIS are the barriers and costs involved in being a registered provider for psychologists under the Scheme.

Remuneration

With respect to the framework for pricing, the APS has long argued that the NDIS inadequately distinguishes differential credentials within the Psychology workforce.

Psychologists with advanced training and competency (as recognised within the psychology profession by the Psychology Board of Australia through Areas of Practice Endorsement) bring a level of additional expertise, which is not adequately recognised in the current NDIS pricing regime. The APS has laid out its view on this issue in previous papers[4].

Another area of concern relates to the cost of travel. It is often not only highly desirable, but clinically necessary for psychologist practitioners to travel to deliver interventions to NDIS participants. Remuneration for travel has long been considered insufficient by practitioners who operate to deliver services in a client-located manner. This is a particularly acute problem in the dormitory suburbs of Australia, where practitioners can travel long distances to provide participants with services.

Third party verification (TPV)

Of particular concern to members is the introduction of costly Third-Party Verification (TPV) and particularly certification (as applies in relation to work with children or participants with challenging behaviours). They have indicated that it has either made it unaffordable or cost ineffective for smaller (including sole practitioner) practices to take on children under the age of seven years. This is particularly concerning, given evidence that smaller, quieter and less sensorially stimulating environments are what is required for these participants groups.

Currently, only NDIA registered providers who have satisfied audit requirements are able to provide services to participants with Agency-managed plans. This is inherently problematic, given evidence recently made available to the APS's survey of members about the NDIS. The number of psychologists choosing to work as registered providers is decreasing due to of their experience of the registration and auditing process as cumbersome and excessively expensive.

Psychologists are remunerated for their work across a range of third-party payment systems (e.g., in workers compensation, traffic accident and victims of crime and services systems related to current and ex-serving military personnel) and primary health care systems. None of those systems has a comparable level of administrative burden and cost although some (e.g., Comcare) provide for similar rates of remuneration.

The APS acknowledges the need for only suitably credentialed and experienced practitioners to deliver services. It believes, however, that the cost of registration and the necessity of re-registration needs to be addressed to reduce its deterrent value. The APS is of the view that it is not enough to assume that the business model of large provider entities can be applied to the whole workforce without deleterious impacts on engagement. The attached appendix of sample comments about the impact of TPV from the recent APS survey of practitioners in the disability field is illustrative of this.

Recommendations

The APS recommends that the Australian Government takes the necessary steps through the NDIA and NDIS to address the workforce attraction and retention challenges facing the Scheme. In particular, it recommends that the NDIA:

4. Ensure NDIS planners, Local Area Co-ordinators (LACs) and support co-ordinators recommend the use of psychologists as the preferred providers of psychology interventions for NDIS participants for neurocognitive, behavioural and mental health and psychosocial disabilities.
5. Address the cost of TPV, especially for small practices with small customer bases.
6. Reduce unnecessary "red tape" and the burden of administration in service delivery.

4. Australian Psychological Society. (2019). *The Future of Psychology in Australia: A blueprint for better mental health outcomes for all Australians through Medicare* – White Paper. Melbourne, Vic: Author.

Term of Reference (c): The impact of Commonwealth Government policy on the NDIS working environment

The importance of the Commonwealth Government in influencing the remuneration, conditions, and working environment of the NDIS workforce through policy cannot be over-stated: government policy is critical to the ongoing viability of the NDIS workforce.

There is an obvious and significant role for government policy in price setting, defining what conditions and impairments are within Scheme, and safeguarding quality and safety by regulating the behaviour of providers and workers and NDIS staff.

However, the environment in which the NDIS workforce operates extends beyond government policy settings. It is also necessary that the NDIS/NDIA sets supportive operational policies and develops competency-based education, training and supervision to build workforce expertise across the sector that supports the Scheme's vision.

A factor that should not be overlooked in the NDIS working environment is the potential for caring professionals and workers in disability and mental health field to "suffer because they care". This is not uncommon in such workforces and carries a significant personal cost (Sabin-Farrell & Turpin, 2003). The NDIS requires a workforce with good mental health literacy and that is supported by management and peers who are aware of the principles of trauma informed care. It also requires access to Psychological First Aid (PFA) which permits safety, calm, connectedness, self-efficacy and group efficacy, and hope.

To this end, it is important that the NDIS partners with professional organisations to help drive change in the planning process via targeted programs of education and training for provider organisations, workers and NDIS (especially planners and LACs).

Recommendations

The APS recommends that the Australian Government develops comprehensive policies in relation to the NDIS working environment regarding education and training of NDIS staff, fee setting and regulation of providers, and that via such policies the NDIA and NDIS take the necessary steps to:

7. Fully assist the NDIS workforce to develop to its optimal potential. This includes developing operational policies that are supportive of the needs of staff and providing training targeted to workers and NDIS staff (including planners and LACs) and
8. Appropriately engage with professional organisations in the development and implementation of NDIS targeted programs of education and training.

Term of Reference (d): Government's role in NDIS workforce development planning

The APS believes that it is critical that a comprehensive strategic workforce development plan (Plan) be developed as a matter of the priority to enable the delivery of best-practice care and interventions to NDIS participants. Such a Plan is fundamental to defining the appropriate workforce to deliver the services required under the NDIS. It is critically important that it clarifies who is best qualified and safest to deliver the services required for participants.

To accommodate situations where it is not clear which health professionals are best placed to deliver certain types of services, or where less complex services may be delivered by a non- or lesser-qualified worker, the Plan must articulate closely managed delegations with appropriate protocols and provide for easily auditable paper trails.

Benchmarks that assure the quality of interventions are central to proper workforce planning. The APS suggests that the establishment of effective benchmarks be facilitated by a range of actions; for example,

- the development of prototypical industry position descriptions for workers that articulate Key Selection Criteria and required and desirable experience
- the identification of a preferred supervision arrangements and encouragement of supervision networks
- ongoing targeted and supported professional development activities that relate directly to the disability field
- the implementation of training so that the workforce has the disability relevant skills and mental health literacy required for successful role accomplishment (see Term of Reference (c), page 14) and
- benchmarks for intervention activity that guide the content and intensity of intervention required for psychology work approved in plans.

The benchmarks should reflect appropriate implementation guidelines and frameworks such as the Victorian Government's Allied health capability framework (Department of health and Human Services; DHHS, 2020).

The Plan must carefully anticipate where there is likely market failure (see Term of Reference (b)) such as for regional, rural and remote NDIS participants and those with neurocognitive, ECS, mental health and psychosocial disability service needs.

The APS acknowledges that the NDIS has commissioned considerable work around the role of allied health assistants in the NDIS. The APS has contributed to this work and looks forward to working with the NDIS and governments across Australia to ensure that best practice arrangements are identified and implemented.

The APS is also aware that it has been decided that as of 1 July 2020, on the basis of October 2018 recommendations from the Disability Reform Council, a new tole of Recovery Coach will be introduced into the NDIS.

The APS was not involved in consultation on the introduction of this new role and is not aware of what evidence was used to inform that decision. It is notable that a recent study into recovery-oriented practice and the impact on clients (see Meadows et al., 2019) reports a small but significant intervention effect. Importantly that article, which represents one of the few reviews of recovery coaches, acknowledges the paucity of evidence to support such roles and that they make little if any difference to most mental health clients.

The APS acknowledges the view in the disability field that "recovery coaches" are required to assist NDIS participants with complex needs. It understands that a typical target group of recovery coaches would be those with complex behaviours, such as those requiring a BSP.

As the APS has previously observed in its submission to the JSC and again reiterates in this submission, the NDIS is complex in its operation. Often it is difficult for participants, their families and carers to navigate the system with its diverse workforce of NGO providers, workers and health professionals, each with different enterprise agreements/fee schedules, skill levels and professional roles and capacities.

Recovery coaches may be able to assist participants with that navigation. They may also play an important role in the implementation of plans and co-ordination of the care provided by the variety of practitioners, workers and organisation who may be involved in the delivery of care. They could also fruitfully be involved in the linking and coordination of that care and the "Team" that sits around participants.

The APS is strongly of the view, however, that recovery coaches must not operate to deliver interventions under the NDIS. This is because they do not possess the required qualifications, experiences or capacities.

Rather, they must act under the direction of LACs and support co-ordinators to assist Participants to access

best-practice care and interventions. Given the role difference and capabilities involved, allied health assistants, LACs, support coordinators and recovery coaches, must each have clear job descriptions and will need to worker under clear delegations and supervision with clear audit trails.

The APS recognises the need for workforce development at the low intensity end of the support spectrum and acknowledges the potential for allied health assistants and recovery coaches to play a valuable role. However, the APS is concerned that both will be seen inappropriately as solutions to psychology workforce issues in the NDIS and may introduce new complexities. Issues of accountability, supervision, delegation and potentially loss of service quality will need to be addressed. The introduction of recovery coaches has the potential for adding further complexity and confusion into the system; unless practice in all parts of the system shifts to assume a recovery focus, there is potential for inconsistent messaging, confusion and ultimately harm to NDIS participants. Issues such as what team care arrangements will be in place to support this (this cannot be undertaken via the MBS) will need to be addressed. How these issues will be mitigated appears not to have been considered by the NDIS.

The insights of the 2019 Victorian Royal Commission into mental health and the APS submission support this view and should be considered. The APS submission strongly emphasised the need for skilled clinicians providing evidence-based care to be an integral focus within that system. For case coordination and supporting roles (such as recovery coaches), provisional psychologists (who work under supervision) could be considered.

The NDIS has developed a range of critical guidance documents including practice standards, business rules, codes of conduct for providers and workers and NDIS Codes of Conduct for Service Providers and Workers and the Guidelines associated with each. Such documentation is well supported by Federal and State Government Disability Plans and state government practice frameworks and advisory statements (such as the Victorian Government's allied health capability framework) and by professional association Codes of Ethics (such as the APS Code of Ethics, which has been adopted as a matter of National law, and its associated Ethical Guidelines). The development of a comprehensive workforce development plan represents a missing link in the documentation required to fully support the Scheme.

In this context, this workforce plan must be subject to monitoring by an independent agency. That fits well with the mandate of the NDIS Quality and Safeguards Commission and it appears well placed to oversee the ongoing operation and maintenance of a viable NDIS workforce.

Recommendations

The APS recommends that the Australian Government takes the necessary steps through the NDIA and NDIS to develop a comprehensive strategic workforce development plan. To facilitate this, the APS recommends the:

9. Development of workforce benchmarks for successful service delivery predicated upon a needs analysis and conducted with input from key stakeholders (including the peak professional bodies) across the disability sector and the close involvement of the Quality and Safeguards Commission.

Term of Reference (e):The interaction of NDIS workforce needs with employment in adjacent sectors including health

The NDIS makes it clear that it is not a surrogate for all systems that fund the provision of care and health services to all Australians. Such systems include federal and state workers compensation, Road Traffic Accident, Victims of Crime, Aged Care and Department of Veterans Affairs systems and public health systems and programs directly funded by government and public health activity funded by the MBS. Those systems employ significant workforces.

The point of separation between these systems and the NDIS is the individual's permanency of impairment or disability. That separation requires careful judgment based on what individuals are reasonably entitled to receive in those systems and when those systems have objectively discharged their responsibilities toward those individuals. This will often hinge on whether evidence-based treatments have been applied with effect and whether the individual's condition has become stable (i.e., no more improvement can reasonably be expected).

An example of this relates to chronic pain and the intersection of impairment and disability related to it in accident and compensation schemes and the NDIS. To the APS's knowledge there are, as yet, very few cases of participants with chronic pain receiving NDIS funded interventions. The best way to meet the needs of the individuals must be carefully considered and the correct course of action planned within context of the NDIS's responsibility and other schemes within the wider funding environment. The achievement of that could provide a useful point of comparison for defining what is outside the Scheme for a range of other conditions.

Up until the age of 65 (when the aged care system assumes responsibility for the (non-health-related) care of people with disability) or where individuals are no longer eligible for care and interventions under other Schemes and their impairment and disability is judged to permanent, the NDIS is responsible for the care of those individuals.

However, there is a grey area where judgments are made regarding whether support needs are or are not a function of disability. Where the NDIS deems an individual is not eligible for funding in relation to some aspect of their care – for example, because they have mental health issues that are neither permanent nor related to their disability – there is a need to assist those persons to find support through the mainstream and community sectors (e.g., referral to the public mental health system and private mental health service providers including psychiatrists and psychologists).

Although this is a process identified as necessary by the NDIS, there has been no reporting (e.g., by the public release of data) to date of its success. While it is the responsibility of support co-ordinators and LACs to assist participants/families in the planning process, and to identify suitable service providers, the effectiveness of this is open to dispute. Additionally, where they coordinate with non-plan related services is unclear.

The APS is strongly of the view that the current arrangements at the interface of systems are not working. The archetypal example of this relates to psychosocial disability.

Given its nature, psychosocial disability requires a mixture of evidence-based psychological interventions and broader social supports to enable functioning. Some individuals with psychosocial disability will also require psychiatric interventions.

Psychosocial disability, however, can have its roots in intellectual, sensory or physical disabilities; for example, an individual with permanent severe physical disability derived from stroke is likely to experience psychosocial disability (e.g., depression, anxiety and irritability) directly related to their disability.

Additionally, many NDIS participants with mental health conditions or psychosocial disability may not have been formally psychiatrically diagnosed. This does not mean, nevertheless, that their psychological state does not affect their wellbeing and functionality and – based on the intention of the Scheme – they are legitimately entitled to mental health and capacity building interventions under the NDIS.

The APS continues to have significant concerns about the intersection of the health and disability sectors around psychosocial disability. Evidence provided by members suggests that gaps in services for Scheme participants with psychosocial disabilities are not narrowing and may be widening.

It can be challenging (and in many cases impossible), to identify the components of disability that warrant a mental health as opposed to an NDIS response. Consequently, planners, LACs and support co-ordinators operate in a grey area that too often leads them to – contrary to the control and choices of participants – refer (or "opt out") participants to the mental health sector.

Given this, the APS draws the JSC's attention to the need for the Government to definitively reinforce

to the NDIA and the NDIS that for participants with either mental health conditions and/or psychosocial disabilities requiring inventions, that they be ruled as fitting within the Scheme's scope in the absence of evidence that their conditions and difficulties are in no way connected with either a physical and sensory or psychosocial disability. This will effectively redirect the Scheme from the "opt out" decision-making that has become the defacto norm under the Scheme in relation to mental health and psycho-social disability.

A well-functioning process would see fewer complaints of people ineligible for NDIS funding struggling to source alternative options. This is not the case and there is an urgent need to resolve the current lack of clarity regarding where to distinguish a person who should be treated under the NDIS from those whose care should be funded by another system. This is best to occur at peak government level, involving agencies, councils (especially the Disability Reform Council and the National Mental Health Commission), industry representatives, associations (including the APS) and "think tanks" (such as Safe Work Australia) and state and federal government departments. The insights of the 2019 Victorian Royal Commission into mental health and the APS submission to it are noteworthy.

Recommendations

The APS recommends that the Australian Government takes the necessary steps through the NDIA and NDIS to better design the arrangements that apply to interaction of NDIS workforce needs with employment in adjacent sectors. To facilitate this, the APS recommends that:

10. The NDIS/NDIA commence high level government, industry and peak association consultations aimed at clarifying the best set of working relationships of the Scheme to all adjacent sectors for their workforce and service delivery implications and impacts.

Term of Reference (g): Other matters

Communication with stakeholders

The stated intention of the NDIS and NDIA is to act in a timely and consultative fashion with key stakeholders to address existing and emerging concerns so that the Scheme's goals can be effectively realised. It is the experience of the APS and its members that the NDIS does not provide timely responses to practitioner enquiries about or clarifications of decisions about psychology care, support and interventions.

Many APS members have provided feedback about the psychology 'unfriendliness' of the NDIS, reporting that:

- getting clear answers from the NDIS about what is needed to have psychology approved in participant plans is very difficult
- there is difficulty obtaining clarification about anything!
- when matters are formally raised with the NDIS – for example, by posting an entry on the NDIS Providers page on the NDIS portal – these entries have been removed by NDIS staff without the permission of the author of that post
- NDIS staff have a poor grasp of the challenges that face practitioners outside of provider organisations and the pressures upon individual practitioners.

It is important that the NDIS establishes appropriate consultation mechanisms not only with participants (which the APS recognises as fundamental to the proper operation of the Scheme) and health providers, but also other stakeholders, such as the APS, at both peak representative and day-to-day levels of communication, so that early advice is sought from providers in a collaborative top-down and bottom-up manner. The development of the Workforce Plan discussed in Term of Reference (d) provides an excellent opportunity for demonstrating a change of approach.

The role of Planners

The successful operation of the NDIS depends on central planning that attends to the functioning and wellbeing of participants and their choice and control in decision-making about what will be included in their NDIS plan(s). However, the need for central planning can result in a variety of issues for the participant and practitioner as it impedes progress and creates roadblocks in the delivery of care. When this occurs, practitioners lose trust and can become disillusioned and participants' aspirations are thwarted.

The APS has consistently expressed concern about the impact of planners on the delivery of services to participants with mental health and/or psychosocial disability. Further, the APS is strongly of the view (based on interactions with its members) that the role of planners has a deterrent effect on psychologists entering or remaining within the Scheme as registered providers.

There are significant potential benefits in having the NDIS Quality and Safeguards Commission accept responsibility for addressing this by creating mechanisms for planning oversight. Such mechanisms will ensure that plans developed for individuals with a disability in need of psychological assessment or intervention are appropriate and enable them to receive such care.

The APS emphasises the need for urgent reform of the NDIS planning function so that:

- there are minimum industry qualification requirements for planners
- there are planning guidelines urgently developed for the inclusion of psychology in plan development, especially for complex cases
- the bases on which planners can reject participant requests and provider recommendations for psychology interventions are open to scrutiny and reviews are conducted efficiently
- the planning review process is streamlined, so that participants are provided with timely and responsive plans and plans reviews and
- professional organisations are partnered with by the NDIS to help drive change in the planning process via targeted programs of education and training for planners.

Recommendations

The APS recommends that the Australian Government takes the necessary steps to ensure that the NDIA and NDIS act to:

11. Improve the quality of communications with practitioners, industry representatives and peak professional bodies.
12. Review the role of NDIS planners for their impact on the NDIS workforce and the availability and quality of service delivery through the NDIS Quality and Safeguards Commission.

Summary

The APS again thanks the Joint Standing Committee for the opportunity to submit to this Inquiry.

This submission raises various important areas of consideration for the Committee's review. The APS seeks to convey to the Committee that several of the observations made and the associated recommendations relate to issues that have been brought to the attention of the NDIA and NDIS before via a range of channels.

The APS calls for government action on each issue identified and the propositions made. It does so on the basis that now is the time for action.

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Appendix

Appendix

APS Member comments about the cost-shifting to Medicare

- *I attended a meeting with my brother and his primary support worker funded by the NDIS funds. I did not introduce myself as a psychologist nor was anything said during the meeting that indicated my profession, as I was attending as my brother's endorsed plan nominee and at that stage, I was self-managing his funds.*

  When I raised the issue of funding for psychological services for him the planners response was so prompt and delivered so authoritatively that I had no doubt that it was established policy, albeit a policy that I was confident was incorrect, in which the assessors had been well drilled. That response was, "Have you a Mental Health Care Plan for B?" . I indicated we didn't and said that it was my understanding that Medicare was not intended nor appropriate for the psychological outcomes my brother required.

  She indicated that he wouldn't get weekly or fortnightly funding for psychological services under the NDIS and we should get a MHCP. She further stated you might get monthly funding for psychology. Given the assessor's confidence in her advice, there seemed to be no point in discussing it further with her.

  When I raised the issue of other recommendations in reports provided for example; physical training for him, the assessor asserted a similar theme to that of the question of psychology sessions; i.e., he wouldn't get weekly funding for an exercise physiologist and would likely only get 4 sessions approved to develop the program that would then have to be carried out with him by others.

  She stated again, "you can get a Medicare referral for that too". I replied that from my understanding the Chronic Diseases Medicare (EPC) referral only gave 5 sessions and did not pay the whole fee for any service used so it was unlikely to go very far for his needs. The planner then stated that we wouldn't receive all of what was requested and would have to prioritise what we used it on.

  I am very concerned about what is being told to clients by NDIS planner about psychology and how it should be funded. Many clients would not be able to advocate for themselves very well nor would they have the knowledge or professional background that I have and would likely just accept what they are being told.
- *I have a young client who was referred to me for management of anxiety and depression associated with high functioning autism ... but the planner refused to include psychological services ... [and it] has been difficult to achieve good clinical outcomes because the 10 x 50 minute sessions under Medicare are inadequate given the client's disability and the client has insufficient funds to extend the number of sessions. The mental health issues are now impacting on the client's level of functioning and community involvement.*

Member comments about the cost and impact of Third-Party Verification

Having to go through a very costly audit which means I will not be renewing my NDIS registration

- *As a sole practitioner I deemed the requirement way too onerous and the auditing process too expensive to complete (especially as NDIS participants make up a relatively small part of my case load). I did not renew my registration*
- *We were registered as providers and we have now unregistered due to the auditing requirements being unmanageable for a sole practitioner clinic.*
- *The difficult and expensive process of maintaining registration status as an NDIS registered provider. (I was registered with them until Feb 2020 when it ran out. I did not re-register due to the exorbitant costs of preparing for audit, etc.).*
- *Openness of the audit process, particularly the costs involved. These are significant and could be termed crippling for a small Psychology practice.*
- *I used to be registered with the NDIA but the audit process has made it unworkable. Why would I pay thousands of $$ to get registered for one or two clients?*
- *The audit required to remain a registered provider is extremely onerous and expensive and for this reason after April 2020 I do not plan to remain*

registered with the NDIS

- *It became apparent that the auditing process would cost more than the entire fees of service provided to clients of the NDIS I reluctantly discontinued the process. As they are mostly children with autism spectrum disorder and the work involves long hours of communication with the school, other providers, teachers and parents, the paperwork hours (no fee) far exceed therapy hours, and together with the cost of auditing it has made seeing clients of the NDIS an act of charity and not sustainable for a small business*
- *They now want me to pay for my own audit, by their own auditors with no information about how much it will cost. They will de register me in December 2020 if I don't comply. It's not worth the money so I won't comply.*
- *I am abandoning my NDIS registration due to the expensive annual audit costs.*
- *I am a small business provider and these expenses are not viable.*
- *I have consequently knocked back several NDIS referrals*
- *The NDIS Commission audit process was too expensive and burdensome. As such, I ceased providing Specialist Behaviour Management and Early Childhood Support and only provide therapeutic support*
- *I am registered for psychological therapy until March, when I shall no longer be registered as the audit and process involved is too time consuming and expensive for a sole practitioner. Similarly, despite decades of behaviour intervention work, I was unable to register with the NDIA due to onerous requirements.*
- *The time and cost involved to undergo the audit process are excessive. For a 3-year audit cycle, I need to pay approximately $16000, and this does not include the time spent preparing (i.e., creating, reviewing and updating policies and procedures, contacting clients to ensure some can be available for direct contact with the auditor, and being available to sit with the auditor for a minimum of one day to go through the policies and procedures and explain how you interact with clients and conduct your work). I have several issues with my vulnerable client group being asked to interact directly with the auditor.*

The audit process involves checking that you have a range of policies and procedures in place – to ensure you work according to the NDIS Practice Standards, but there is no assessment of clinical skills.

At every opportunity during the audit process I have directed the auditor to the existing Code of Conduct and APS suite of policies that I adhere to as a registered psychologist. I also refer to these in my self-developed policies and procedures. I estimate the I have self-developed approximately 20 policies and procedures especially to satisfy the NDIS registration requirements.

As a registered psychologist, who has provided specialist behaviour support since 1995, it seems amazing that no credit is given for this in the registration / audit requirements. It seems a range of unqualified people are being allowed to register as providers of specialist behaviour support, or be employed by people / organisations under their Specialist Behaviour Support registration.

- *We are likely to remove our registration next year because the cost of audit is well above what is feasible for a small practice.*

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