THE LEGISLATIVE COUNCIL SESSIONAL COMMITTEE - GOVERNMENT ADMINISTRATION 'B' – SUB-COMMITTEE INQUIRY INTO DISABILITY SERVICES IN TASMANIA MET IN COMMITTEE ROOM 2 AT PARLIAMENT HOUSE, HOBART ON 17 AUGUST 2021.

ALICE FLOCKHART, STATE MANAGER DISABILITY SERVICES, and **MARK JESSOP,** CHAIR NDS STATE COMMITTEE, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Ms Siejka) - Welcome to the public hearings of the Legislative Council Government Administration B subcommittee inquiry into Disability Services in Tasmania. All evidence taken at this hearing is protected by parliamentary privilege. I remind you that any comments you make outside the hearing may not be afforded the same privilege. A copy of the information for witnesses is available if you have not read it or are not aware of the process. The evidence you present is being recorded and the *Hansard* version will be published on the subcommittee website when it becomes available.

By way of introduction I advise the procedure we intend to follow is as follows: first you will have the opportunity to speak to your submission if you like and following on from that we will address questions to you. We are seeking information specifically relating to the terms of reference. So over to you.

Ms FLOCKHART - NDS represents a wide range of disability service providers. It provides information and knowledge to assist them to achieve outcomes for people with a disability. It also works with government to advocate for improved supports and better systems.

While we often end up talking about the 10 000 or so people in the NDIS we are also concerned about the quality of life of the 140 000 Tasmanians who have some level of disability. Our recent submission highlighted some key issues which we are happy to expand on today. In particular, some areas of concern are: mainstream interface issues particularly in family services, housing, health and education; how transport systems and funding are working to exclude people with a disability from active participation; the $140 million in NDIS participant plans is under-utilised each year and what this reflects about the capacity of our sector; the narrow funding of the information linkage and capacity-building ILC funding and the weakening of the capacity of this function in Tasmania; a growing tension between state law and commercial actions in the areas of industrial relations and work health and safety; and the growing anxiety that the NDIA is creating a false belief that the NDIS is too expensive and suffering a sustainability crisis.

Mr JESSOP - We are happy to take a stroll through some issues or do a Q&A.

CHAIR - I do not know whether to start you want to talk a little bit more in detail about some of the issues before we get into the questions because you have covered quite a lot in there. Would that be helpful? Even if you just wanted to go to the terms of reference, a little overview of each one. That would be great.

Mr JESSOP - I am happy to touch on that. I suppose one of the highlights of the committee's terms of reference is an understanding that there is a much wider group of people with a disability. We acknowledge we have gone from approximately 4500 people under state systems to 10 000 almost 11 000 now under the NDIS.

The issue for providers is that if we improve the service for the 10 000 or 11 000 who we deal with every day we also improve the level of services and interfaces for the other hundred and something thousand. Many of them are in aged care and I certainly encourage the committee to be across some of the royal commission findings on how people in aged care are provided a much lesser standard of quality of life I think is probably the term. At a systemic level, the state is an owner of the NDIS, and that is something that providers are very clear on. The state cannot walk away from the decisions that the NDIS make. There have been a couple of quite good examples recently at the ministerial meetings where the states have actually asked for greater clarity from the agency on a number of important issues.

So, providers and families, while they rally against some of the decisions of the NDIS, they are also well aware that the state is behind that system in one way or another. I suppose, ultimately, maximising the number of people who can utilise their plans is one of the most critical aspects for the agencies. So, not only the number of people who can access the system; we are quite aware that there are a number of push-backs on people accessing the system, particularly with mental health issues.

If any of you saw a well-backgrounded article in *The Australian* yesterday where the author talked about dementia as a bit of a case study of people who were never meant to be in the NDIS, and I think that was a specific term. So, there is an anxiety that there is 100 000 people more in Australia in the NDIS than they thought there would be. We know that mental health was bolted into the NDIS as an afterthought almost. Now we are finding an attempt by the agency to redefine people with high functioning autism, for example, and take them out of the system. I think that is quite relevant to your terms of reference because the fewer people in the NDIS, the more that they are in a limbo in terms of funding.

We are told by our gateway partners that there is still an ongoing request for access information sessions. We know in regional Tasmania, particularly, because there is not as good a density of providers, there is less exposure to the NDIS. We still know of cases where people are sitting on a farm, or sitting in a community, and the NDIS is almost irrelevant for them so they have not applied. So how can the state facilitate that process for those people? I get the feeling the agency is not as keen on facilitating some of those processes at the moment.

Ms FLOCKHART - Just to add with the utilisation, I encourage the committee to look at it down to a council level. There is data available on the NDIA website. When you look at some utilisation levels for people who have plans it is quite low and alarming, so for those people where they are getting their services? It is probably falling on state-based services in those areas. That is something I encourage you to look at as well.

Ms RATTRAY - Who is paying for that then? Is the state supplementing those services and then the NDIS is the one that is gaining the money to deliver them?

Ms FLOCKHART - So, if someone has a plan and they do not use it all, we can only assume that the support they need they are getting from somewhere else, or they are not getting the support.

Ms CHAIR - At this point it might be useful for the committee - it is in the submissions but it is still good to have for the hearing - if you could explain about the bilateral agreement and the change from block funding to individual funding.

Mr JESSOP - Yes, I can do that. I suppose the major change with the NDIS is the move to an individual package of funding. So, a planner will assess a reasonable or necessary level of funding that goes into a plan. Then the plan is drawn down through various means by a participant to providers of one sort or another.

CHAIR - Just include the eligibility and the fact that not everyone - yes, thank you.

Mr JESSOP - Yes, you are quite right. The first step is an access request. This is where the independent assessment concept was coming in, that there would be a standardised way of assessing people. The NDS and a number of other groups were very concerned that the instruments the agency were recommending were not fit for purpose to do that. There is quite clearly a feeling within the sector that the agency and the federal minister are trying to shut the gate a little bit, which will exclude people from the NDIS.

Once they are in the system, they then go through that planning process and get the planning.

CHAIR - At the moment, to clarify for the committee, how many people are living with disability in Tasmania, and how many are eligible for the NDIS?

Ms FLOCKHART - There are 140 000 living with disability, and just over 10 000 -

Mr JESSOP - I think 10 657 might be the figure in the quarterly report.

Ms FLOCKHART - who are receiving the NDIS. That second group of people are the ones who are dependent on the state services, primarily. NDIS is the small amount. The remaining people, which is 130 -

Mr JESSOP - Some of them will be in aged care.

Ms FLOCKHART - Yes.

Mr JESSOP - So, they're federally funded in that sense and receive home care packages. Again, the 140 000 comes from the Sensis data, so it's a self-report model. We certainly know that there are interface issues of people waiting in hospital to be discharged. Now, with good advocacy, they often get plans. We also know that there are interface issues in schools with children who are not yet diagnosed, but clearly have some level of challenges. Then there are people who just have a general level of things like mobility issues, such as after a stroke. Increasingly they are getting into the scheme, but that's where things like accessible design in our communities makes a big difference for those people.

I suppose the issue for many people with any level of disability is that we still expect them to change the way they request services, to meet what is a standardised way of delivering services. When we have a truly accessible society, rather than giving a standardised impenetrable wall for people, we should be looking at how we can adapt the service delivery to meet somebody who is vision impaired, for example. Are all our state government websites readable by readers? I bet you they're not. Do child safety services, when they interview somebody who is from a diverse background, or has a disability, is there an obligation that they have an independent advocate - not a lawyer in this case, but somebody who can sit with the person and interpret? No, that's not the case.

CHAIR - Your expectation is that some of those people, because of the barriers, are not able to access the NDIS, but might be eligible?

Ms FLOCKHART - Yes. I've definitely met people who would be eligible, but the only services they currently use they can get from the state, so they don't worry about it, because there's a lot of paperwork; it's very involved. One person said, 'I just used my transport - my taxi voucher - so what do I need a plan for?'

CHAIR - To round out our introduction, before we go to questions, perhaps you could outline for us who is eligible, in terms of what disabilities are eligible and which ones are not? Obviously, with only 10 000 who are eligible -

Unknown - There are 657.

Ms PALMER - Sorry, can I add a bit to that question?

CHAIR - Yes.

Ms PALMER - I was wondering if you have the breakdown, we know 140 000 Tasmanians, and 10 000 to 11 000 with NDIS; then with the remaining 130-odd, the breakdown between who is in aged care and who is not in the aged care system. Do you have those figures?

CHAIR - Or can you get it for us at a later date?

Mr JESSOP - I can provide that on notice. I don't have it off the top of my head, but we can look at that. There are other indicators, like people on DSP, for example, so we'll do some work on that.

CHAIR - Even roughly - eligibility and non-eligibility.

Mr JESSOP - At a higher level, eligibility is defined by two areas, I suppose. One is that it has to be a lifelong disability of some sort; functional impairment -

CHAIR - Permanent.

Mr JESSOP - And it has to be at a sufficient level that it impedes somebody's daily living. Now, they have specifically excluded some areas such as neurological disabilities - so epilepsy is not considered a disability, but it clearly has some functional impairment. Something like dyslexia would not be considered, but again it has some significant impacts on education, as the member for the education system would know.

The other pressure point is around mental health, where things that are acute are considered the state's responsibility. Somebody who is still recovering from a stroke, or still at Millbrook Rise or Wilfred Lopes - or maybe not so. But for somebody who is in the psychiatric ward at hospital after an episode, the agency would want that to stabilise before they then considered it a lifelong disability. There is that tension between an episodic functional impairment versus a long-term impairment.

The agency hasn't tried to have an all-in, all-out type of model, where all people with disability X are in. There are some examples of people with very mild cerebral palsy, for example, who don't have a functional impediment, so they're not eligible for the NDIS.

CHAIR - So, one was permanency, and what was the second one?

Mr JESSOP - The level of functional impairment.

CHAIR - Yes, the severity. Unless there's anything further you want to add by way of introduction, we might move to questions, if you are open to that? I might start with Ms Rattray.

Ms RATTRAY - Thank you very much for your very fulsome submission; it was very helpful. Can you talk to me about how $403 million has been committed to the NDIS plans in Tasmania, but only $261.6 million has been paid? There is that $140.1 million of under-utilisation. Alice, you did touch on that under-utilisation. I have some examples in my community where people have applied under the NDIS scheme and have been rejected, and I know that they have a lifelong prognosis that isn't good and that should be catered for under this. Can you talk me through this under-utilisation?

Ms FLOCKHART - The under-utilisation refers to funds that have been committed to people who do have NDIS plans. If someone was committed $200 000 for supports, but only accessed $100 000, there is a 50 per cent under-utilisation there.

When you break it down by council area, you can see there are some areas where it's assumed it's harder for people to access services, because their utilisation is lower than if they are in, say, Hobart or Launceston. There are a lot of factors that come into that - making sure there is the workforce there to provide the services, and making sure there's the understanding of how to access the services - so even once someone has an NDIS plan, making sure they understand that it is sometimes a bit different to access the service than if they were getting it through the state.

There are states that use more of their committed funds, so it's definitely possible for that utilisation level to come up - but there needs to be some intervention to make sure that people understand the NDIS in their local communities, and that they don't have to travel to access services.

Ms RATTRAY - As a follow-on question, should those plans then be readjusted, so that this $140 million might be used for other NDIS participants? If they're not using that, does that mean it goes back into the pool? We have people who are not being catered for under the scheme, but we have this excess money that could be used? Is there a way of reassessing the needs?

Ms PALMER - Can I ask what pool it goes back to? Does it go back into a federal pool or a state pool?

Mr JESSOP - It stays within the scheme. If the scheme was fully utilised now - I think the estimate would be about $31 billion at the moment. To some extent, the scheme is reliant on not spending all its money. That then goes back into the normal budget that's allocated for the NDIS, which is, I think, $24 billion this financial year. There's a built-in fudge factor to some extent.

Plans are generally reviewed every year, although there is a push in the agency to extend that for people with more stable conditions.

Each year, if you haven't spent the money, the planner will do one of two things. The planner might go, 'Well, you obviously don't need that so I'll give you less', or they might talk to you about needing some extra support to access services. There's a function called Service Coordination which is really designed for people who have larger plans and have some level of access, so that's almost an NDIS-paid case manager who's independent to the providers and they're meant to help connect you.

The local area coordinators also do that role but they are quite stretched. They're based at Mission and Baptcare. I think one of the significant benefits of the NDIS and a significant disadvantage is a growth in providers. We've seen a vast change in the number of providers. A lot of them are new; and there are some quality issues that we're conscious of and there are some broader issues around the rights of people with a disability but there certainly are far more people getting access.

The growth in the sector employment-wise: across the sector we estimate that there are about 7000 people employed now. That's going to grow by another 2000 to 4000 over the next three years, so there's still a growing demand.

There are some other structural issues within the NDIS and there's a level of frustration with providers. We have things like 'plan gaps'. So, a plan stops. The money might be used for that and, through delays, it might take two or three months to get another plan. Then that person gets an annual allocation 20 per cent into the year. Then they have to try to spend it. Those sort of administrative challenges create problems.

There are certainly critical skill shortages in things like allied health. It's hard to spend your OT money if you can't find an OT. Speech pathology is almost as rare as hen's teeth.

Ms RATTRAY - Just ask the education system about accessing that.

Mr JESSOP - Absolutely. That's something the state -

Mr WILLIE - There are only 50 of them for 60 000 students.

Mr JESSOP - We are encouraged that UTAS is looking at bringing in some of those allied health trades into their skills set, which is great.

Ms RATTRAY - Not before time.

Mr WILLIE - If I can just go back to the terms of reference, we have to home in on the Tasmanian Government's responsibility. I am aware of some states stepping in where there might be a gap in services. Our state Government has done that at times too but there have been some flash points where the state Government has said, 'We're paying twice' and they've tried to walk away. The taxi subsidy comes to mind and the Early Childhood Intervention Service. There's a range of other areas. How important is it that the state Government steps in to manage those service gaps until it can be worked out at a national level?

Mr JESSOP - I think there are probably a couple of practical and principled issues. One is just an issue of parity. Why should somebody who, say, has a functional impairment due to epilepsy, who is challenged by interacting, say, with the child safety system or the education system, not get the same level of support as someone who has a neurological disability that is in the NDIS? That is one issue.

We believe that, while the NDIS model has some flaws, at least it is a standardised funding model. So, a person who gets services for example under MAIB, a provider who provides those services is paid the same rate over the weekend, for example; it is a flat rate. There is much less incentive to provide a service on the weekend for those participants whereas the NDIS the funding factors in penalty rates and things like that.

Parity is a really significant issue for us: all people who have a disability should get some level of service.

CHAIR - Josh, your question was about the state's responsibility.

Mr JESSOP - Is it the state or MAIB paying for it?

Certainly, the significant interface issues are around education. My understanding is some issues have improved. I am not an expert on education and there are people more qualified than I am.

But getting access to the delivery of therapy services when you do not have those people is a significant issue. There is a significant interface issue around children in care. I will use an example of a case study. I have seen this both with families with psychosocial needs with acquired brain injuries and with intellectual disabilities. For those who do not know this, for three years I worked as the manager of intake and response for child safety in southern Tasmania so I am quite aware of how that system functions - or doesn't function sometimes, which is probably the term.

It is a very hard gig for sure. In a case I looked at recently, both parents had a mild intellectual disability. One had been incarcerated previously so there was a whole heap of social issues as well. They had unstable and inadequate housing, a conflictual relationship with extended family. Despite regularly attending neonatal appointments, no attempt was made to provide any training or parenting support prior to birth. One social worker said to me, 'If they had booked in preconception they might have got into the one course that the hospital runs'. We seem to have lost our way in a whole heap of generic services that used to offer that.

Instead of getting support, a few weeks prior to birth a notification was made to that family. After ruling out where they were living - Child Safety looked at what was substandard housing next to their mother's house - they were told they could not have the child there. Because the mother didn't respond to the system in the way the system wanted it to, they decided that the mother was not a supportive enough person to support that child. After birth an assessment order was granted by the courts and now this has transitioned into a 12-month order. So, despite numerous assurances that when they were found stable accommodation they would be prioritised for a parenting-under-pressure program it did not happen. Instead access has been patchy, heavily influenced by the paternal grandmother's views, who is also the kinship carer, by the way, and the couple's goals have been largely been dismissed.

There hasn't been pressure on that service to have an advocate at all at meetings. They have sometimes had support workers to get them there but there has not been somebody advocating for their rights. They now live in stable housing and they have around 30 hours of NDIS funded support each week. When the provider pressured around the start date of this program they were told that the parenting program was not appropriate because it was not suitable for people with an intellectual disability. Again, this is an example of the state saying, basically you need to overcome your intellectual disability to be in this program because it is not suited and can't be modified to adjust to that.

Both people in the family have been depressed. One of the parents has been suicidal. As we know, and I am also a registered psychologist so I can say this with some authority, that first six months of bonding with the mother is the most critical period for the long-term adjustment of that child.

I understand the risk perspective of child safety but again it is a system that is not willing to say with the right supports, be it funded - and there is a capped level of funding but again it is not an insurance level. And I understand that the state does have limited resources. There is no way that family can automatically get support from Child Safety to learn how to parent.

The NDIS is willing to throw in some money and had a plan review and will probably provide supported accommodation to that mother long term but again, the system has basically said, 'You cannot prove your capacity as a parent therefore you are not allowed to parent'. That is a good example of where a very much state-funded system under the bilateral needs to be responsive.

Hospital is another area. The traditional model and enshrined in the bilateral is basically up until admission the provider supports a person to get -

CHAIR - Can I jump in with a question on the bilateral agreement? My concerns are the people who aren't eligible for the NDIS and are unlikely to be in the foreseeable future. The state pays into the NDIS and then retains the money to provide services. There are obviously difficulties accessing the services and so forth but how much of it do you think is down to confusion around potentially who's responsible for what? When I talk to varying people, some people think it's really clear in the bilateral agreement and other people think it's not. To what extent is that, and what are the impacts of that potentially?

Ms FLOCKHART - The health interface is a perfect example of that.

Mr JESSOP - I have a quote from a doctor and she has said I can use this. She said:

> I'd like to highlight what appears to be a significant lack of duty-of-care by the disability service provider when 'X' - who has severe cerebral palsy, severe intellectual disability, is unable to communicate verbally or point to pain or express physical symptoms - is left in hospital on his own during times of illness. This is post-admission.

> From what I have been led to believe today his disability support staff have been directed to leave 'X' there and they go home.

'X' in the position is highly vulnerable.

It's clearly stated in the NDIS that whenever NDIS-funded disability supports are required for an inpatient due to a communication or behavioural problem, this is funded.

So, again that's taking one part of the bilateral - so even -

CHAIR - Maybe, just speak to what the bilateral responsibilities are for state and federal.

Mr JESSOP - It's about a 30-page document.

CHAIR - The short version.

Ms FLOCKHART - Say if someone is admitted to hospital, once they're admitted it is the state's responsibility.

CHAIR - Within the bilateral agreement is it very clear that those who aren't eligible for the NDIS must be provided for by the state, or is that wording at all -

Ms FLOCKHART - No, it just talks about NDIS.

Mr JESSOP - It's purely NDIS.

Ms FLOCKHART - With anyone who is on an NDIS plan who goes to hospital, there's going to be some confusion most of the time but if you don't -

CHAIR - Not just health but other -

Ms FLOCKHART - Yes, but if they don't have an NDIS plan then they should get the same supports like anyone else going to hospital.

Mr JESSOP - But they wouldn't have a service provider in that sense anyway.

Ms FLOCKHART - No.

Mr JESSOP - And this is where the Independent Living Centre Tasmania (ILC) is so important for those people as well.

CHAIR - For those disability services providers generally though there's been a trend from the block-funding to individuals. Is that the same for state-based organisations, or what's happening - because your membership is a lot of different disability providers and so forth - what's happening with their funding? Has it been the same given the NDIS or has it changed?

Ms FLOCKHART - They rely on grant funding now, so it's variable. Some still get some funding but there's a lot of work that goes into a grant application as well and project funding is very different. For these kinds of services they shouldn't have to rely on project funding because -

CHAIR - This is state-based.

Ms FLOCKHART - Yes. Justice is a good example. It's not a project; it's not a two-year project, it's something that's needed all of the time. That interface is always going to be an issue if people don't have the understanding to navigate the system by themselves, so when you speak to Deb from ILC she should be able to go into detail that there is a review that will happen but project funding cannot replace what was previously funded.

CHAIR - The ILC is federal but organisations such as TADTAS Inc, those sorts of ones, they aren't funded federally, they're state-funded.

Mr JESSOP - Take, for example, the Australian Disability Enterprise (ADE), but I suppose ILC used to be state funded so as part of the -

CHAIR - I'm more interested in their core funding and the change to that.

Mr JESSOP - That core funding then was transitioned to the NDIS, which then in 2020 went to the Department of Social Services (DSS) - the federal government - and they have led a generally fairly high-level tender for project-related services. So the state to some extent has almost said, 'We'll step back from block funding'. I think one of the issues -

CHAIR - Are there gaps to that?

Ms FLOCKHART - Yes, going to core-funding to project-funding there are going to be gaps.

Mr JESSOP - If you look at the development of the disability sector over the years it's been family groups or disability-related groups or regional groups who have got together, got a little bit of funding and then suddenly formed Walkabout Industries, or suddenly formed the Children's Association for whatever. These days there are just so many costs to do that. They have to have a constitution, they have to be - all that sort of stuff and there is certainly ground for a small grant system that allows block-funding, so three years.

I'm sure Debbie will tell you that she spends a lot of her time just writing project after project-related grants. Now, that's good and there are some areas where government should say, 'We'll release some funds to target an area,' but without that core funding for those groups, they don't exist. So, it becomes a nonsense to -

CHAIR - So, they can't apply for the grants.

Ms FLOCKHART - No. And they lose staff; it ends up being one or two people. They don't have the capacity to apply for the projects because they don't have the core funding to have time to do it.

CHAIR - That would mean that there's potentially people who can't access what they need?

Mr JESSOP - It doesn't help those people have a voice. While government sometimes doesn't want lots of voices there, that's also how we advance people's supports and needs. So, I think there's a peak funding model, so NDS gets slightly reduced but we're funded under peak funding, but that next level down of all those groups, special interest groups, are really failing.

CHAIR - That would be where epilepsy support and those other things all fit?

Mr JESSOP - Absolutely.

Mr JESSOP - And it could be the 'Dover Special Kids Association' or something like that. So, without that grassroots support they then can't lobby - and it rests on individuals and this is a really unfair demand that a mother of a kid with a particular disability has to carry all of that for themselves. We need to think about the pressure that puts on carers to become the structural voice for their needs.

CHAIR - Presumably if the person doesn't have an advocate like that or can't advocate for themselves, it's another issue. I might go to you again, Mr Willie.

Mr WILLIE - I want to go back to that case study that Mark was talking about and the interface with the health system. You've talked about child safety. It's quite common for that confusion to happen across lots of different government areas. I'm aware of some schools that will allow families and children to have NDIS services delivered at the school. Other schools say, 'No, that stops at the gate', and the adjustments model takes over. How important is it for the state government to clarify that and give very clear guidance to service?

Mr JESSOP - It is difficult to find really good examples of where the state works across a number of agencies. I think Communities Tasmania does some exceptional work with a very a small number of exceptional cases, but we wonder from a peak-body perspective if there's sufficient staffing and resources at a policy level within government to really drive that.

The interface issue with THS is a really good example. We facilitated a meeting with the Royal Hobart Hospital with the NDIS and it was quite clear that there's no process by which a provider can say on a Friday afternoon, 'Bob’s gone in for emergency surgery. He'll need somebody there over the weekend to support him as he comes out.' There's just no structure for that at the moment and -

Mr WILLIE - So, is a resource needed to be put back into the state government to work on these issues?

Mr JESSOP - It either comes down to providers having a whinge or the state demanding that the interface works. That's where the problem is at a policy level. There's two or three people left in disability policy. And again, as it goes across service sectors as well is where it becomes departmental and falls down. THS is obviously independent to Department of Health to some extent, so each of the hospitals we found have their own different structures and policies and the NDS were very clear, saying no NDS funding -

CHAIR - NDIS.

Mr JESSOP - no NDIS funding will be expended post-admission unless the NDIS gives approval for that. But there's no approval process -

CHAIR - To continuity of support.

Ms FLOCKHART - Without the process there, there is a lot of energy that is spent on each individual case because there is confusion every time someone is admitted. Then a lot of times they will get a call from a service provider who isn't getting clarity from either the hospital or the agency. If you go to a different ward, different understanding of the bilat so there needs to be that process so that there doesn't need to be the energy spent and so there isn't confusion.

There are a lot of families and people with disability who get very distressed at admission because they're expecting to have support there. There are disability service providers that do understand the system and need the hospital to agree to pay for those supports because it cannot be covered by the NDIS plan and when the hospital says no that's already funded through the plan then there's a gap there. Someone could be used to having a support person there and does not have one; they have just had surgery and don't have anyone there.

Mr JESSOP - The example that this doctor wrote about, he turned up for his PEG tube to be inserted and the hospital said, well we can't support him and the provider said, well we can't support him and he was turned away. We have deemed that this guy needs a PEG, gastro feeding, but I think the provider has been negotiating with the hospital and the agency. They've had three meetings now and there might be a pathway but that's four weeks later.

The difficulty for a provider - and there's one example which we've been told about but we don't know who it is, who provided services in the hospital: $120 000 later was told by the hospital, we are not paying and was told by the NDIS you can't claim that. So, they're probably just purely a cost level because 90 per cent of the money we get from the NDIS goes out in wages, roughly. That's a pretty standard model. So, 90 per cent of $120 000 is they have probably paid over $100 000 to staff to support that person in goodwill. Maybe they didn't do their homework and get it signed off but these interface issues shouldn't be happening eight years into the scheme. I suppose that's one of the issues.

Ms FLOCKHART - With hospitals, the agency can approve for funds to be used in exceptional circumstances. It doesn't happen very often when someone is in hospital for a health reason. But if they are ready to be discharged and they're not in hospital for a health reason and they have no house to go to, that's a time when often they can access their NDIA funds, because they're not in hospital for a health reason so that's not the state's responsibility. But then whose responsibility is it to find housing? That gap, that would be the majority of people who would be able to access funds in hospital because they don't have a house to go to.

Mr WILLIE - Still on the state's responsibility but picking up on something in the submission which I was quite aghast at and that's the fact that only 1.3 per cent of participants live in remote or very remote areas in Tasmania. Obviously, the state is picking up those service provisions significantly in remote areas. It seems quite disproportionate and unfair to me that those are the statistics. Then you have 64.8 per cent of participants living in Hobart and Launceston so it seems like a very urban scheme.

Mr JESSOP - That relates a little bit to my earlier comments about not having providers in regional areas.

Mr WILLIE - So thin markets.

Mr JESSOP - We had a guy from the north-west say that, as a provider, they tend to be the go to for people coming in asking, 'How do I get access to the NDIS?'. Bearing in mind the remote and very remote is the Commonwealth definition which is actually somewhere like Dover is still just remote so very remote is pretty rare.

Ms RATTRAY - Like St. Marys.

Mr WILLIE - There's obviously a significant cost to the state government in remote and regional areas picking up these services where the NDIA has no market.

Ms FLOCKHART - Yes, and long term it would be in the state's interest if more Tasmanians understood the NDIS and how to access it and then if they were eligible they could receive funds. I think the further you get out of the capitals the less understanding there is.

Ms ARMITAGE - I was probably on the same track with the 1.3. When you say 'more understanding', does that come down to the GPs and medical practitioners and others to maybe explain to some of these people in the remote areas? Is there a lack of understanding from them too? They don't have the time because of shortage of appointments to actually explain, or is there no-one really to explain to these people?

Mr JESSOP - There was a briefly funded program that was designed to seek out people who should be in the NDIS. They did liaise with people like GPs but that has not been funded for 12 months at least, I think. Again, people like the LACs at the gateway should be actively engaging with GPs to ask, 'Do you have clients who should be in the scheme who are not?'.

Ms ARMITAGE - They are the ones who would actually know who is out there in the system because they are seeing them.

Mr JESSOP - Correct.

Ms ARMITAGE - The other follow-on from that was to do with the actual transport costs or the money going down - the government is going down from $1000 to $350 per annum - particularly when you relate to people in the remote areas. Any idea of the reason? Costs go up; costs do not go down for those people we are looking at. Is there a certain pool that has been overused?

Mr JESSOP - There are probably two issues: one is the funding; taxi voucher funding has to be spent on a taxi. If you can find an accessible taxi outside of Launceston or Hobart you are a very lucky person. When the NDS senior management were over here a couple of years ago were aghast at my colleague from Multicap up in the north-west saying there was no accessible taxi in Devonport. They could not understand how that was true, let alone that there were no accessible tramways or anything like that for the people.

The concern we have is that the advice we have had is that people generally do not spend beyond that $350 but there are a number of people who do have to spend more. My concern is that they are probably people in the regions. So how is there a risk assessed model by the state to give people more when they need it? Again, we are not a one-size-fits-all community.

Ms ARMITAGE - Perhaps change it from a taxi voucher to some other transport that can be used by people who do not have access, like the community cars in other areas.

Ms RATTRAY - That is what often happens, they do use community cars.

Ms ARMITAGE - It is just that 1.3 per cent and then those people are further disadvantaged.

Mr JESSOP - The CPS picks up some.

CHAIR - I'm looking at the time. Is there anything very quickly that you wanted to say?

Ms FLOCKHART - I wanted to go back to the previous question. In terms of the understanding of the NDIS there are place-based solutions that can work. I encourage you to speak to or have a look at HR+. They are based out of Launceston but they are doing a program in George Town that they are self-funding. It is aimed to increase the understanding of the NDIS and also the workforce that is needed to implement the services there. That is getting good results and that might be worth looking at.

Mr JESSOP - If I can have one quick repechage. We know there are people sitting in expensive state funded services now like Millbrook Rise, Wilfred Lopes, who cannot get out of those services because there is inadequate quality and style of housing. It is much more about the style of housing. Those people often need to live by themselves in their own units but they need a cluster of units where they are supported by staff. Housing wants to build one style of housing only. If there were probably four or five clusters like that across the state it would allow people to come out of that high-cost institutional care and again that has been 100 per cent funded by the state. Even though those people are often eligible for NDIS funding they cannot utilise that funding because they cannot leave the institution so that would be another. We have reached out to Housing a couple of times to look at different models but it is very challenging to get access there.

CHAIR - Thank you very much for coming along today.

Ms RATTRAY - Thank you, it was very interesting.

Mr JESSOP - We will come back to you on those statistics.

CHAIR - That would be wonderful, thank you.

The witnesses withdrew at 10.19 a.m.

CHAIR - Good morning, I will introduce the members. I am Jo Siejka, the member for Pembroke. We have Rosemary Armitage, the member for Launceston; Tania Rattray, the member for McIntyre; Josh Willie, the member for Elwick; and Jo Palmer, the member for Rosevears.

The sub-committee is taking sworn evidence and we need you to make the statutory declaration that is in front of you.

CLINICAL ASSOCIATE PROFESSOR ROBYN WALLACE, WAS SWORN, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Welcome to the public hearings of the Legislative Council Government Administration B subcommittee inquiry into Disability Services in Tasmania. All evidence taken at this hearing is protected by parliamentary privilege. I remind you that any comments you make outside the hearing may not be afforded such privilege. A copy of the information for witnesses is available if you have not read it or you are not aware of the process.

The evidence you present is being recorded, and the *Hansard* version will be published on the sub-committee website when it becomes available.

By way of introduction, I advise that the procedure we intend to follow is as follows: first, you'll be provided with the opportunity to speak to your submission, if you would like and, following on from that, the sub-committee will direct questions to you.

We are seeking information specifically relating to the terms of reference. I will now hand it over to you for any introduction you might like to share with us.

Dr WALLACE - Good morning and thank you very much for having me. I have presented to the Legislative Council before in matters of intellectual disability for adults. It's a real privilege to come again.

By way of background, I'm a physician in internal medicine. I'm Tasmanian, but I did a lot of my studies in Queensland. I've been back for about 10 years. For about 20 years, I've been involved in a professional clinical healthcare service for adults with intellectual disability - outpatients mainly - and it's probably one of its kind in Australia.

I have many friends with intellectual disability. I've been on the board of a disability service provider. I spend a lot of hours every week in matters concerning adults with intellectual disability. I'm in an advisory group at the moment; we have a meeting tonight on palliative care in adults with intellectual disability.

I'm a member of the Internal Medicine Society and I regard my contribution there to those mainstream services any matters in relation to intellectual disability.

I've done academic studies - a PhD - in intellectual disability and health, and also recently completed a Masters in disability practice. I've done a lot of work on the NDIS as well.

I heard the previous gentleman and woman explaining about the problem with the NDIS health disability interface with a non-credentialled but multidisciplinary group, with people from communities, people with disability, advocacy, health. We solved the problem of the NDIS health disability interface in terms of hospitalisation. I will talk to that later if you wish.

I'll get to the point now. My brief is the health of older people with intellectual disability who aren't in the NDIS - specifically preventive health, chronic health, acute health, hospitalisation and palliative care. Bearing in mind that 'health' adopts a bio-psycho-social approach. It's not just in the numbers, it's in the whole context of wellbeing. There are lots of influences on a person's health, not just the GP or the hospital.

I estimate there would be about 500 adults with intellectual disability in Tasmania who are not on the NDIS. I gain that figure by knowing that 20 per cent of adults are over 65 in Tasmania, and then approximately 1 per cent of those - we're talking about 500, or less than 1000 people, with intellectual disability in Tasmania are not on the NDIS. Too old. Possibly some of that group have been institutionalised, or around that era. Possibly they have a trauma background, but not necessarily. Because they are living longer, they're likely to have a lower level of intellectual disability - and a higher level of ability, in other words. Seeing as they have lived this long, they are likely to have a health profile more consistent with the general population, so there will be conditions like cancer, ischaemic heart disease, strokes, dementia, falls, frailty, musculoskeletal issues. This is my first point about describing the profile.

Without attention, however, they are still likely to experience all the conditions that people with intellectual disability experience in hospital, such as high risk of preventable adverse event, high risk of a preventable death - very high figures.

Socially, their parents are likely deceased by now, or very old; even their siblings are older. So, there is less advocacy, and that other dimension of vulnerability. Although guardians may be appointed - and they are very good at the Office of the Public Guardian - they are not the same as a family member. They do not have that level of vigilance, by the limitations of their job. They may be retired, but not necessarily.

So, there is an element of social isolation, and from the studies for this population, we know that socialisation is a really key factor to their health and wellbeing. Social networks and the ability to talk to people is as important as getting your blood pressure checked.

They are also likely to have lower socioeconomic status, so they endure all the usual cluster of negative determinants of health. They likely have low health literacy.

I understand that the scope for the services they need would be in relation to accommodation, community support, community access respite, and individual support or service packages, which will be funded by our state.

That is the profile of the people in this group.

The second point - and I have four points altogether - is that overall, as the previous speaker said, you can't beat the NDIS for values. We need to have quality standards, even though it is going to be state run. We need to have a sort of supervision role, such as the NDIS Commission - a mechanism to report events and incidents. We need to adhere to all the legislation - the United Nations, the disability services act, the mental health act. We need to have the same values and ethics and everything like that in any disability support services to these older individuals, as in the NDIS. You can't beat that as a gold standard.

The third point is the issue with health overall - and this is consistent with all the disability values. We have to bear in mind some unique features of this group of people, but by and large the issue is access to mainstream health. We do not want a separate hospital for people with intellectual disability. We want the THS, RHH, Calvary Private, the Launceston General - mainstream services which are very good, but adapted, having reasonable adjustments for people with intellectual disability to access them.

In this potential funding model, we need disability supports in place for that healthcare. People talk about how the NDIS does not cover health. Well, it does not cover health but it does fund the disability support to access that health. That is the distinction. The NDIS goes with the person wherever they go, even into a hospital, by the guidelines in the 2015 COAG agreement, which is still relevant.

With any new proposal for disability services, we need to ensure there is funding for the disability supports for older people with intellectual disability to access their GP, to make appointments with their dentist, for healthy living, for exercise half an hour a day, for healthy diet, a healthy weight. We need the disability supports for managing their chronic health conditions, which may be increasing and now may be having an impact on their mobility and their general wellbeing.

We know that - and this is another specific feature of this group - the impact of lifelong disability, the impact of lifelong lower socioeconomic status, the impact of lifelong difficulties can create a resilience, yes, but it also is a risk factor for more rapid functional decline and deterioration of medical conditions. It is a risk factor for frailty starting a little bit earlier than it would in a person without intellectual disability and functional impact. We really have to address the health so we can keep the function of older people with intellectual disability as good as can be.

The quality of social interaction is one of the biggest influences on function of skills so that is a high priority in any disability services support system we develop for older people with intellectual disability in Tasmania.

Examples of mainstream: we have a fantastic older persons' unit in THS. We don't want a separate older persons' unit for people with intellectual disability, but we do want 'reasonable adjustments', as we call them, in that unit and the way it runs for older patients with intellectual disability. We have the same terrific physicians and geriatricians. How do they need to adjust their care and the system and the policies and the processes for when they have older patients with intellectual disability? That is the sort of approach I am talking about.

There are a few other issues that come into it in any service provision for these people. There are guardianship issues, as I mentioned, advocacy and goals of care as well as some particular problems for any person with intellectual disability. For example, the Poisons Act bans the administration of S8 medications, meaning opioids, for severe pain by disability support workers. It is legislatively not allowed if the person cannot consent to it. There would be a lot of people who do not have the capacity to consent to opioids yet who might need them. They might have a broken hip or cancer. Who is going to give it to them? That is a problem that is a legislative issue. It needs to be tackled and could be more relevant for older people.

Ms RATTRAY - Robyn, are you suggesting that with a change in legislation those carers should be able to - you can do a medication course.

Dr WALLACE - I had a meeting with Ingrid Ganley and Mary Ann Lewis [TBC] on this on Friday. There is a legislative barrier. There is a terrific medication framework but even with this and even signing for the right dose it is still not legal. The legislation needs amendment and work has just started.

Ms RATTRAY - So you think there is a pathway to resolve that?

Dr WALLACE - Definitely, taking into account the seriousness and the danger of these drugs and the need for a very safe way of prescribing them. It is a real barrier now and it is a barrier in palliative care.

CHAIR - That would be a barrier not just for people with intellectual disabilities but for other people with varying -

Dr WALLACE - If you can consent to the medication but cannot literally give it to yourself, the carer can give it to you. It is all about capacity.

CHAIR - Okay. Would there potentially be a broader application of those who cannot give consent in some cases?

Dr WALLACE - Aged care workers can provide them; this legislation exists specifically for disability support workers. I have looked at it in a number of places. Families can give it, so you could call over a family member if they are around. But in this age group, they might not have the family members. If you are in pain you want pain relief now, that is an issue.

Then the fourth issue is sort of a solution. Earlier I mentioned a new body in Tasmania. This body is concerned with issues of health disability, NDIS and non-disability non-NDIS interface. Regardless of the funding model, we have a body which can problem solve. For example, we had this group a couple of years ago and I think I submitted a paper on that. We know that the COAG agreement between the states and the Commonwealth on the NDIS has health, justice and education. At the end of the health section they have which bits are NDIS funded and which bits aren't. In the column of the which bits are NDIS funded, if the person has communication limitations or behavioural problems because of their intellectual disability then their NDIS can be used in hospital. It specifically says that. Their NDIS disability support doesn't provide any of the health care; that is the hospital's job but it's the disability support; the history, the understanding, the menu-filling out, the 'This person is not right today' or 'Look they're looking much better', to help with communication.

CHAIR - Just for clarification, previously we heard that a lot of time was spent on negotiating who would be responsible, but you're saying it should be really straightforward?

Dr WALLACE - No. First of all, going back to square one. How much support does a person need when you're in hospital? That's the first thing. They might need more than usual because when we're sick we often need a bit of a hand more than we normally do. So, a person who can live in a house with three other flatmates and have a carer there six hours a day might need 24 hours a day, at least initially, when they get to hospital.

Everyone should have a plan before a crisis happens. People with intellectual disability are high users of the hospital system. They should have a pencilled-in plan of what supports they would need if they needed to go to hospital. Their doctor, family and the disability support team should help them with that. So, I might need 24 hours of support disability support when I first go in, but when I settle down I might only need it during the day, or I might need it 24 hours, or I might only need it when I get there and when I go home. You have an individual person's centred plan. You might figure out that it's X number of hours per day you need of NDIS-funded supports or any non-NDIS disability support.

If you live in a group home you have the equivalent of only two hours a day of NDIS-funding supports. You might have six hours but it's shared. You'll need one to one in hospital so you only have the equivalent of two hours a day but you really need 24. What are we going to do with that 22 hours of missing funding?

The National Health Reform Body, which is a Commonwealth body, has informed me that if the hospital funded that 22 hours, the NDIS funded two hours which is already in place and the state hospital funded those 22 hours, the hospital would then be refunded by this National Health Reform Body.

CHAIR - But that is not happening as a matter of course.

Dr WALLACE - Just as the hospital should get more funding for complex patients, say, indigenous groups they can get refunded for that. If that doesn't work then there are a couple of other options. There's an urgent review with NDIS or there's an acceptance that we have to share this. We can't draw a line.

CHAIR - There seems to be confusion between hospitals and providers and everyone involved that that's a possibility to be refunded, so by way of solution what do you propose? If that's the case, is it more education?

Dr WALLACE - Yes, so first of all it's the individual with intellectual disability thinking about what disability supports they need when they're in hospital - a provisional plan - and in fact any healthcare, going to the GP, what do they need, and then work out what their NDIS funding is now.

Many people on NDIS, for example, have a bit of flexibility so they might go to a day service, they might have six to 10 days off work, so they've got a bit of 'kitty' if they can't go to their day service so that if they're sick they've got money to be used.

CHAIR - But the plan is quite prescriptive, isn't it? There's not a lot of flexibility in how you -

Dr WALLACE - In the core supports there's flexibility, but there's a bit of a logistical nightmare for the service providers because there might be a bit of swapping. So be it, it's solvable. The funding is for the individual and wherever they go it goes, so there's a bit of patch-up from other sources.

CHAIR - Who would negotiate that on behalf of the person? They have identified that in advance but -

Dr WALLACE - This is all sorted out in the planning stage. For example, you would need a doctor's input in conjunction with the person and their family or carers, a sensible idea of what would they need if they were in hospital, what sort of disability supports would they need. Then you would look at the funding. What do they need and then how do we bring in the sources of funding so we've got that there, and that over there. Do we need to activate an urgent review? There are a number of ways of solving it.

Mr WILLIE - What happens if it escalates and there's a disability provider and the hospital at loggerheads, with the person with a disability at the centre? Is there a need for an independent disability commissioner or something like that to resolve disputes?

Dr WALLACE - If we had this body, knowing that that's a problem now and I've borne the brunt of lots of bad emails from service provider CEOs who tell me I'm saying the wrong thing. We can solve this. We've got a solution in part, if not all. We've got the fundamentals of the solution, but that's an important detail that needs to be sorted out. In terms of the overall plan of disability services we do need an overall authority to check and double-check, just like we've got the NDIS Commission.

CHAIR - You mentioned that people in the demographic you are talking about may not have someone to advocate for them, a family member, and so on.

Dr WALLACE - That's right.

Mr WILLIE - On that point, if there was say an independent office with oversight do you think that would improve the way the health service was delivered and the service providers and the way they interacted, because there is that independent referral that's possible?

Dr WALLACE - Definitely. Health doesn't get off scot free, because it's got to make the reasonable adjustments to its service to better provide its services for adults with intellectual disability, and the disability supports have to provide the disability support to optimise access and participation in the mainstream. Both have to put in a few more resources. Health has to put in more resources to make it more open and accessible. The disability supports, non-NDIS, we need to have this flexibility and scope to increase the disability support when the person needs inpatient care or any healthcare. It's a recognised factor of life, health and ill-health.

CHAIR - We don't actually have a lot of time left and that's been really helpful so far but we do have a question from -

Ms RATTRAY - For clarification: what is the average age group here? We're not talking over 65s, are we?

Dr WALLACE - We would be at the moment.

Ms RATTRAY - Who are not covered under the NDIS.

Dr WALLACE - That's right. The problem applies for NDIS so they're mainly -

Ms RATTRAY - So that age needs to be extended.

Dr WALLACE - Well, this brief I thought was for those not in the NDIS who would be the older group. They would be 68 onwards.

Ms RATTRAY - Exactly. I wanted to clarify that was the age group you were talking about. Parents have gone, perhaps siblings have gone too. They don't have that care support, family network, and so they need to have a case worker and they need to have support, but they may well be living in aged care.

Dr WALLACE - Well, that's a poor second choice.

Ms RATTRAY - I'm just saying that's probably the reality now.

Dr WALLACE - Not necessarily, but I've got quite a number of patients who are not eligible for the NDIS -

Ms RATTRAY - They're in a group home.

Dr WALLACE - and they're in group home. They're on the old continuity of supports. One of those patients has been in hospital a few times and she hasn't had a disability support worker with her. I heard about the chap who couldn't speak and couldn't point - a severe intellectual disability - on his own. Now, it twists you up inside, that vulnerability, and what could happen and that explains why people with - who die.

So, any services that we develop for people who aren't eligible for the NDIS - we've got to take that into account. We've got to clarify that and they're probably going to be higher hospital users than the younger group possibly, with their age. But both parties have to give a bit and so be it.

CHAIR - Thank you very much, Robyn. Is there anything finally that you wanted to draw our attention to? You've been very thorough. We really appreciate your time.

Dr WALLACE - The importance of this combined group I'm talking about is to design and implement these reasonable adjustments I'm talking about, to cross-fertilise ideas and get rid of that conflict - health and disability nudging up each other - to resolve that. To learn from each other. Problem-solving, more importantly. Reaching-out networks.

Ms RATTRAY - Which should have been done in the eight years that this has been in operation.

Dr WALLACE - Yes. And to cater for our rural and remote indigenous and ethnic populations, of course, in a substantial way. But it's about mainstream as well, ensuring quality healthcare, optimal disability and continuous improvement would be an overseeing role of this.

CHAIR - Thank you so much, Robyn, and thank you for your advocacy for this particular cohort.

Dr WALLACE - Thank you. Thanks for having me.

CHAIR - Thank you. We might stop the broadcast and we will return at 11.05.

The witness withdrew at 10.58 a.m.

Professor LEONARD ALFRED CROCOMBE AND **Dr ANNIKA WILSON** WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - I will introduce all our members. I am Jo Siejka, member for Pembroke, we have the member for Launceston, Rosemary Armitage, the member for McIntyre, Tania Rattray, the member for Elwick, Josh Willie, and the member for Rosevears, Jo Palmer at the end.

Welcome and a reminder that all evidence taken at this hearing is protected by parliamentary privilege. Any comments you make outside the hearing may not be afforded such privilege. A copy of the information for witnesses is available if you have not read it or are not aware of the process. The evidence you present is being recorded and the *Hansard* version will be published on the subcommittee website when it becomes available.

You will be given an opportunity speak to your submission if you would like and following on from that the subcommittee will address questions to you. We are seeking information specifically relating to the terms of reference.

I will hand over to you to introduce yourselves and provide us with an overview.

Prof CROCOMBE - I am Professor Len Crocombe, Professor of Rural Oral Health at La Trobe University but I live in Tasmania - where else would you live? - and Dr Annika Wilson, Researcher, The Centre for Rural Health, The University of Tasmania, is a dentist and a researcher into nurses and oral health and what they can do about it.

I am basically looking at the main message I would like to get with disability services, which is please don't forget oral health because it usually does get forgotten. So, as an overview the consequences of neglecting oral health are serious. They include pain, infection, loss of teeth, and they may lead on to functional difficulties like not being able to eat properly, have a poor diet, on their speech, and it also affects their behaviour. We do know that people with disabilities can suffer a lot of pain in their mouth and not be able to articulate that and hence can become violent in the process.

I have trouble with my medical colleagues getting through to them that oral health is strongly linked with general health, particularly diabetes. We know that if we improve their gum health their blood sugar levels go down; if we improve their blood sugar levels, their gum health improves so it's really a one-on-one relationship. There's also increased risk of cardiovascular disease and adverse outcomes with pregnancy and we are talking early childbirths and low birth weight children. Have I forgotten any?

CHAIR - I imagine there would be social consequences too.

Prof CROCOMBE - Exactly. Imagine trying to get a job if you have terrible teeth. Imagine trying to concentrate in school if you are suffering pain at the same time.

The social determinants are exactly the same as for general health. So if you have a low socio-economic status, if you are indigenous, if you live rurally and there are one or two others, but, basically, they are exactly the same. So the same people with poor oral health are going to have poor general health and the causes are the same: it's poor hygiene, poor diet and poor access to dental care. The only thing that is different is your fluoride exposure from either water from fluoridation or the use of fluoride in toothpastes or in dental surgeries.

The barriers to the care for people with disabilities, the first thing is they can't afford quite a lot to go to private practice. Secondly, public dental services have limited resources and long waiting lists which are blown out even more under these COVID-19 days.

In Tasmania, people with disabilities often languish for long periods of time on the waiting list with their oral health deteriorating. I'd like to suggest that at a state level, we should consider people with disabilities as a priority group.

The dental workforce has limited skills with treating people with disabilities. Australia's National Oral Health Plan does not include enough detail regarding upskilling dentists to do work on people with disabilities. Most dentists are unable to provide dental treatment under Medicare. There is literally no funding for these people.

There is a lack of services, this is more a state role, for being able to treat people under a general anaesthetic. We also need to make carers aware of the negative impacts of oral problems and train them to identify by looking at behavioural changes and the effects on their quality of life and the suffering that the people are going through.

I mentioned my medical colleagues but is true across the board that there is a lack of knowledge in the community about the importance of oral health for general health. If GPs and allied health professionals considered oral as part of overall annual health assistance for people with disabilities and are provided the appropriate oral health message and then referred them to general health professionals a lot of problems that people with disabilities -

CHAIR - Is that a historical thing, or is it just a knowledge thing?

Prof. CROCOMBE - I don't want to go into its history but just quickly, dentistry and medicine have developed separately since we have had massive increases in tooth decay rates and gum disease.

Ms RATTRAY - Is that an area that you are looking at, Annika?

Dr WILSON - Essentially, yes. As Professor Crocombe said, medical and dental have often developed separately. There has been considerable research trying to bridge them together again.

Ms RATTRAY - We will be looking forward to your paper.

Prof. CROCOMBE - The current NDIS practice standards do not address oral health in any specific or meaningful way, although it does call for increasing oral health capacity of the broader health professionals' research.

It is concerning to note that currently dental visits to facility residents are not mandatory. An inclusion of oral health assessments within facility care plans would be an appropriate addition to the NDIS to achieve this outcome. The NDIS must broaden its approach to the oral health of Australians with disabilities.

Alterations are required to the Medicare procedure banding systems so dentists can provide equitable care with realistic time frames for people with disabilities, but there is also an opportunity to lobby the state government to consider people with disabilities a priority group.

Ms RATTRAY - Thank you. It is certainly an area that I was not aware was not covered under the NDIS except it does say in 'extreme situations'. Is that extreme situation where, if doctors were aware of the value of dental health, they would refer a patient to a dentist for oral health services?

Prof. CROCOMBE - That's right. Then they would probably just refer it to the local person who may not have a lot of expertise on people with disabilities. I am representing the ADA so I have to be careful, but basically there is not a lot of money in treating people with disabilities. So, they are really caught between not having the money, people who are not going to go out of their way because it is difficult. It is like going into aged care homes.

CHAIR - We have all had people come to our office at varying times needing dentistry and cannot afford it.

Prof. CROCOMBE - If you want to make money in dentistry you set up in high SES areas. Look at the number of dentists in Sandy Bay in comparison to Bridgewater - actually, there is none in Bridgewater when I think about it - the northern suburbs.

Ms RATTRAY - Part time in Scottsdale.

Prof. CROCOMBE - That would be a supply and demand thing. There have to be enough people coming in to make it cost effective; they have to feed their families like everyone else. Basically, you will find you need a much higher population in low socio-economic areas to make your practice viable than what you need in higher socio-economic areas.

Ms RATTRAY - Has your association done any work with the RFDS who are delivering across the state in some of those more isolated areas, and particularly rural areas?

Prof. CROCOMBE - I am the consultant for the Royal Flying Doctor Service Dental Program.

Ms RATTRAY - I am interested in what discussions you may have had with the RFDS about providing dental services for people living with a disability.

Prof. CROCOMBE - As a consultant, I am always suggesting things to them. The RFDS got its money from the Commonwealth directly. Maybe I will explain some of the funding. I am going to answer your question.

About two-thirds of the money that goes to Oral Health Services Tasmania comes from the state government, one-third comes via the Commonwealth, via either the Child Dental Benefits Schedule or via the partnership agreement to reduce public sector waiting lists. Then, on top of that, the Commonwealth supplied funding for the Royal Flying Doctor Service to provide dental services in rural areas, and they are not allowed to provide services in competition with existing private or public sector facilities.

Ms RATTRAY - But if they are providing a different service, one that does not cover does with a health care card or maybe NDIS, if the rules changed.

Prof. CROCOMBE - I do not like the term, but the working poor, in other words, those who don't have a health care card, who do have an income, have great difficulty in accessing care. So, yes, the Flying Doctor Service has been going, as you probably know, to the north-west, Smithton, up to the north-east and to the islands in Bass Strait providing care there. They have had strong associations with the indigenous community in the process, have not specifically picked out people with disabilities, but they do come and access care.

Ms RATTRAY - So, their services could be expanded if the rules changed?

Prof. CROCOMBE - We were lucky in Tasmania. The Commonwealth gave $11 million to the dental services when it started, and equally divided it between the states, not on the per capita basis. So, Tasmania, did quite well. But we, at the Flying Doctor Service had to start from scratch. They did not have anything. That is when they dragged me into help, because this grumpy old man knows this type of stuff.

Ms RATTRAY - I have been a grumpy old woman this morning, so that is okay.

Mr WILLIE - Can I say something I picked up from your opening address? It was lobbying the state government to make people with a disability a priority in the system. I want to unpack that a little. Would we see a surge in caseloads? How would it work? How would you implement it? I have heard of other cohorts being prioritised, like kids in the child safety system for example. If you could just unpack that a little.

Prof. CROCOMBE - In a past life I was head of the Tassie Dental Service, so there is no way I am going to be critical of Health Services Tasmania. Their resources are extremely limited.

Basically, if you take into account health care card holders and school children, about 40 per cent of the population are eligible for public dental care. If you look at the number of dental practitioners in the Oral Health Services Tasmania compared to those in the private sector, you can understand why we have a problem. So, they have this constant problem, not just with disability, but in trying to prioritise the resources. As you can imagine, if people are coming in with pain and have infections, you need to prioritise them first and you can very easily get into a cycle where you are seeing nothing but people with problems. And of course, once you get into that, you are not seeing people for checkups, so people with problems are going to be coming back in a cycle.

CHAIR - And people with disability, if they do not go regularly, then that would be a very unfamiliar and frightening experience too.

Prof. CROCOMBE - They have tried to introduce a triage system, but it does not take long to get out there what answers you should give to get in, if you understand what I mean. Once they are in, if suddenly they don't have pain or something, it is a bit hard to kick them out.

So, what we have done with children is run a trial - actually, I led the trial - looking at what we call minimal intervention dentistry, which would be doing only the minimum that has to be done to fix up the tooth decay.

Mr WILLIE - Such as fissures and things like that.

Prof CROCOMBE - Yes. So, quite often you don't even have to pick up a drill. You can just scoop out the worst of the decay and cover it with a glass ionomer, which leaches out fluoride. The trial was basically using silver diamine fluoride, and they found it arrests the tooth decay. It stops it in its tracks, rather than just preventing it. So, we did it with children on a general anaesthetic waiting list at Royal Hobart Hospital, and found we didn't have to put any of them under general anaesthetic, which we thought was pretty good.

Now I'm thinking that would be of great use for people with disabilities, particularly those who are having trouble with mental problems, but also in the aged care sector. My parents' generation had lots of tooth decay and gum disease, and had their teeth out, so you walk into an aged care place and you see all these lower dentures in plastic cups beside the bed, because they can't wear them - there's no ridge left and no saliva left.

CHAIR - Something to look forward to.

Prof CROCOMBE - Well, no. The difference with our generation is that we're going to hit the aged care facilities and we're going to have teeth. A lot of them have been saved by pretty heroic procedures. Now, I'm going to be crude here, but the carers don't like cleaning teeth. Basically, I asked them, you'll take them to the loo and wipe their bums, but you won't clean their teeth? Why? The common answer I get is that 'bums don't bite'. And you can understand that. A person with dementia, they probably don't even remember who you are, even though you've been seeing them every day for the last six months - and then there's a high turnover of carers, as you would know. You put them on a high-sugar diet, and you've got them on drugs, which dry up the saliva. It's a major crisis, and it's going to hit Tasmania first, because we have the oldest and sickest population with the worst oral health.

Mr WILLIE - If I can just get back to the priority here.

Prof CROCOMBE - Sorry.

Mr WILLIE - That's all right. I'm not sure whether you can put some numbers on the sort of intervention that would be required to make people with a disability a priority in the public system?

Prof CROCOMBE - No, I can't, I'm sorry. But by trying to use minimal intervention dentistry, the silver diamine fluoride, I'm hopeful that the cost of doing so would be much less than the usual drilling and extractions that dentistry has been doing for the last 50 years.

Mr WILLIE - Would that maybe require earlier interventions in the school system as well, to pick that up earlier?

CHAIR - Or just a change in approach?

Prof CROCOMBE - Well, if you remember, Oral Health Services Tasmania vans used to go to all the dentist schools. The problem with that was twofold. One was occupational health and safety, because you had the surgery and the doors, and if a fire happened in the waiting area, you were stuffed. When I was the boss, if you like, one oral health therapist rang me about a security issue. At the schools they were often put beside the toilets, because these had the plumbing and the power, and they would still be there after the schools had closed, about 3.30 or 4 o'clock. One guy actually started threatening our dental therapist - in Bridgewater, I'm sorry to say. She told him to go away and he climbed on the roof and was stabbing the roof with a knife. I rang the police station and said the name of the person - and like Rumpole was the lawyer for the Timsons or whoever it was, they had one policeman to look after that one family. We didn't have him arrested, but he was told he couldn't go anywhere near it.

Going back, the trouble was that parents started to rely on the dental service, thinking the dental service was looking after all the kids - so they were seeing 90 per cent of kids in primary school, and that dropped to 40 per cent in secondary school. Then the private sector would see them when they were getting to 18 to 19 years old and their mouths were a mess, and they're saying, what's going on?

Now what's happening is they are treating them in clinics within the schools.

Ms PALMER - My primary school had an office onsite, from memory.

Prof. CROCOMBE - Exactly, and then they can put two oral health therapists in there for security. The downside is that people from other schools then have to bring them in, so there's a lower incidence of kids being treated, because there's some responsibility put back on the parents to bring the kids in. You could argue it's better for them to have the trouble while it's in the deciduous teeth stage, even though that's not too good, and then the parents might work out that they have to do something - but to be honest, in lower socioeconomic groups it's not happening.

Ms PALMER - I was wanting to flesh out your comments around prioritising people with disabilities, but we've covered that a little bit.

Prof CROCOMBE - The Oral Health Services do prioritise some groups, and this is just one of the others - but yes, there is that problem of who misses out if you prioritise one group. Obviously, it would be great to double the amount of money, but what we found when I introduced the Commonwealth Dental Health Program into this state was that, yes, we increased its service delivery everywhere, then the Commonwealth stopped the program - which they said they wouldn't, but that's another story.

What happened was that people during that period realised they could actually access care, so it never reduced waiting lists, because as more people came in, more treatment was done, but once it stopped we ended up with bigger waiting lists than we had before.

That's the trouble. You double the funding, but you won't get lower waiting lists. What you will end up with is more treatment being done, so from a political point of view, you would sit back and say, 'Well, geez, why am I getting into this?'

Ms PALMER - We have covered it a little, but I was interested in data collection. Data collection completely equals funding, so it was quite concerning to see a lack. Could you flesh that out a bit for us? I know it is with the federal government, but I was intrigued by that. It is concerning that there isn't sufficient data collection with regard to the oral health for people with a -

Prof CROCOMBE - You are right. The data has been collected by the Australian Research Centre for Population Oral Health, which is based at the University of Adelaide, where I did my PhD. Basically, they have had adult and child oral health surveys, and they have national ones. They had one in 1988, 2004, 2006, and 2017-18. They survey about 15 000 people, and end up examining about 4000 to 5000, then they spread that around the Commonwealth, depending on the population. What happens in Tasmania is that 500 people are surveyed. That's enough to give them population-representative data for around Australia, but it's not enough to, for instance, pick out Glenorchy and say, 'Is the oral health of people in Glenorchy worse than the oral health of people in Sandy Bay?'.

They have to regularly get grants to support that, to actually get it going. That's why there's that time period.

Ms PALMER - Is there data collection in Tasmania that's a bit more specific that can contribute to that?

Prof CROCOMBE - Oral Health Services Tasmania collects data on all the people it treats, but that's a biased sample because it's going to be only people with health care cards or who are eligible for public sector treatment and then it's only going to be those who try to get access and actually access the service. If you prioritise some groups, it's not going to be representative of the population.

Looking back at the national survey data, we do know, first of all, oral health has improved during each of those time periods. The improvement is the same between rural and metropolitan areas. Rural oral health is still poorer than metropolitan oral health.

We do know that Tasmanians' oral health has improved faster than on the mainland but we did come from the worst or the lowest base. The reason for the improvement is attributable to fluoride in the water supplies. We're the only state in Australia where all towns down to 1000 people have the water fluoridated.

CHAIR - I wasn't aware of that.

Prof. CROCOMBE - It's water fluoridation, it's fluoride in toothpaste and fluoride that's done in the clinics, and reducing rates of smoking. I was upset when the T21 bill didn't even get past the upper House. It was a concern to me because we have extremely high rates of smoking in this country and Tasmania has a pretty high rate of oral cancer. The survival rate of people diagnosed with squamous cell carcinoma in the mouth is 50 per cent over five years, and that hasn't changed in 40 years.

CHAIR - I'll ask you if you have any final comments or points that you want to make before we finish up?

Prof. CROCOMBE - Maybe Annika could say something about the interprofessional approach.

Dr WILSON - Touching on a few points, you asked whether it's a school system or whether it's the model of care. I can probably provide the concept that it might be better as a model of care and Len touched on a few factors. It should be a component of at least a medical assessment. On saying that, if the focus is on school care, where are the adults with intellectual disability, as an example, who need that? It's looking at the model of care and whether we can essentially have it as an obligatory component of their medical assessment and whether we can provide, on the NDIS, whether they receive benefits from that in terms of receiving dental care as well.

We're looking at it from a dual approach. The dentists, I'd imagine, would come from a different component, but the ADA, whether we have special workshops or training to upskill dentists in terms of providing that care. In terms of the model, it's not looking at what we call secondary care or whether it's treating disease, it's looking at prevention. If we're getting people earlier from their medical assessment, dentists can then provide education or oral health promotion. That is the main factor we can see that actually works in people. That's the only thing that I can provide.

Ms RATTRAY - Is there any reason why working with people with a disability is not part of the training for dentists? Surely there would be a module that says that you must complete this as part of your qualifications?

Prof. CROCOMBE - I'm going through right now doing a report on the La Trobe University Dental and Oral Health Therapy programs. We don't have one in Tasmania.

Ms RATTRAY - I was going to say, you go to South Australia or somewhere else.

Prof. CROCOMBE - Yes, that's right. Basically, they might go and observe, but not a specific training module.

Ms RATTRAY - Should there be?

Prof. CROCOMBE - Yes, I would have thought so.

CHAIR - Thank you very much for coming along today and sharing your knowledge with us, and answering our questions.

Prof. CROCOMBE - Thank you. We hope we've been of some help. I guess the take-home message is don't forget oral health, please.

CHAIR - Thank you. We will stop the broadcast.

THE WITNESSES WITHDREW.

CHAIR - First of all I am going to introduce the members present. We have got the member for Launceston, Rosemary Armitage; the member for McIntyre, Tanya Rattray; the member for Pembroke, Jo Seijka; the member for Elwick, Josh Willie; and the member for Rosevears, Jo Palmer. The sub-committee is taking sworn evidence and we ask you to make the statutory declaration that is there in front of you, if you could do that please.

Mr PETER JOHN HATTERS WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED

CHAIR - Thank you, welcome to the public hearings of the Legislative Council Government Administration B subcommittee inquiry into Disability Services in Tasmania. All evidence taken at this hearing is protected by parliamentary privilege. I remind you that any comments you make outside the hearing may not be afforded such privilege. A copy for the information for witnesses is available if you have not read it or are not aware of the process. The evidence you present is being recorded and the *Hansard* version will be published on the sub-committee website when it becomes available.

By way of introduction I advise that the procedure we intend to follow is firstly will give you the opportunity to speak to your submission for as long as you like or whether you like and following on from that we will address some questions to you. We are seeking information specifically relating to the terms of reference which I am sure you are aware. I will hand it over to you now Peter, if you introduce yourself.

Mr HATTERS - This is the first time I have done something like this so I am a bit nervous.

CHAIR - It is the first time I have done something like this as well.

Mr HATTERS - I will start with a bit of the history about the Tasmanian Amputee Society. We were formed somewhere around 1994 at the time that the federal government transferred responsibility of amputees over to the state government. At that time there was a report called the Barry Leech Report which determined which services would be required. At that time Tasmanians received, proportionate to amputee community and other states, the best result over all.

Our focus for the Tasmanian Amputee Society has always been peer support and mentoring for people who might be facing amputation or living with a limb difference. The majority of our support are major amputation, lower limb, upper limb, or arms, but there also are a huge number of amputees with toes, partial foot, fingers, mostly as a result of diabetes. Once we became aware of that we also focused on providing support for them.

The support we provide is overcoming everyday obstacles, like showering, how do I access services, how do I solve this problem? Our focus is on providing practical solutions for everyday amputees and our service is free.

CHAIR - Are you funded by anyone?

Mr HATTER - Yes, we were originally funded by disability service or the Tasmanian Government - we used to get about $3000 to $4000 a year. When the NDIS -

Ms RATTRAY - Did you used to run your own organisation, Peter?

Mr HATTERS - Yes.

CHAIR - To provide the free service.

Mr HATTERS - Yes, so it is on the smell of an oily rag.

CHAIR - It's less than a smell of an oily rag.

Mr HATTERS - Once the NDIS came in we were successfully giving some ILC grants, we have one going now.

CHAIR - Project funding.

Mr HATTERS - Yes, the only challenge we find with that is it has to be specific to a project.

CHAIR - It is obviously time-limited.

Mr HATTERS - Yes, usually about 18 months.

Ms RATTRAY - You have got to keep re-applying.

CHAIR - And still delivering the -

Mr HATTERS - The focus has always been on providing mentoring and support - but we are not counsellors - to people who have the amputation.

Ms RATTRAY - How do you find those people?

Mr HATTERS - That's a very good question because back in the late 1990s early 2000s there used to be something called the statewide amputee committee run by Tas Health. On that committee there were people like doctors, prosthetists, and people within the committee who used to come together and have a chat. In that early period, we made great advances and there was a lot of communication solving issues. That committee doesn't work today. It would be great if it did because then it would be a good opportunity to engage with the people delivering the services.

Ms RATTRAY - Is there a privacy issue now? Is that why it was disbanded?

Mr HATTERS - One of the obstacles why we can't get any information is - and we would like to know who are the amputees out there. Do they know about us? Are they given information about the services that out there? We don't know. People come to us by word of mouth. We've just developed our website so people can find us on our website.

CHAIR - To clarify, do you still receive the $3000 to $4000 from the state government?

Mr HATTERS - No. Once we transitioned over from the state government to the NDIS that ended.

CHAIR - So it is only the project funding when you get a project funded?

Mr HATTERS - Yes.

Ms RATTRAY - So somehow you incorporate what you do into the project for which you apply for funding?

Mr HATTERS - That's right.

Ms RATTRAY - Good on you for being able to manage that.

Mr HATTERS - We don't have any paid people.

Ms RATTRAY - All volunteers.

Mr HATTERS - It is all volunteers. It's a bit of a headache sometimes because we like to do things where we're not funded.

CHAIR - Where you see the need.

Mr HATTERS - The other thing we would like to see at some point is for people to have the opportunity to choose where they want to go to get their limbs serviced or built.

CHAIR - What happens now?

Mr HATTERS - At the moment, Orthotic Prosthetic Services Tasmania (OPST). They have about 90 per cent of the market we think. There is one other private provider who does the other area but that's mainly for NDIS people and people who might have compensation or veterans. Other than that, everyone else has to go to OPST and usually they get the standard componentry, the basic stuff.

Ms RATTRAY - You can't get any Rolls Royce models?

Mr HATTERS - No, and just because you might be over 65 doesn't mean that you're not active and you live a life going bushwalking or whatever. If you have the right prothesis that helps you get along to do normal day activities.

Mr WILLIE - Can you talk a little bit more about the people who aren't eligible for NDIS and then fall into the state system?

Mr HATTERS - Generally speaking anyone over 65 has to go through the aged care system. Some people who may not be deemed eligible for NDIS also have to go through the state-based system.

Some of the reasons why people may not be able to are silly because if you have an amputation, particularly a major amputation below or above the knee or arms, the national access team might say that you don't meet the eligibility for whatever reason; the forms weren't filled out correctly or there wasn't enough information provided. So that person has to go through the process of getting more information to demonstrate that they meet the eligibility.

CHAIR - There is cost associated with that.

Mr WILLIE - When they are not eligible for the NDIS or aged care and they fall into the state system how is that system working? Is there a waiting time? You've talked about some of the equipment available.

Mr HATTERS - We understand there could be an extensive waiting period.

CHAIR - How extensive are we talking?

Mr HATTERS - A couple of months just to get an appointment.

CHAIR - Okay. It can be very long.

Mr HATTERS - It gets very long but I can't provide evidence of that because it's not available.

Mr WILLIE - You do not know how many are accessing it?

Mr HATTERS - It is only anecdotal evidence.

Mr WILLIE - Perhaps we will ask the Government that when they appear.

Mr HATTERS - It would be good to know that and to know how many amputees are out there. We think there is somewhere between 500 and 1000 major limb difference but we do not know.

Ms RATTRAY - Thank you, Peter. You are doing a great job for the first time in front of the committee, and so is the Chair. In your submission you talk about a large percentage of allied health professionals are deregistering as an NDIS provider due to the cost and burden of auditing compliance processes placed on mainstream and community sectors under stress. I am not sure whether you can expand any more on that?

Mr HATTERS - Yes, I can. Anyone who wants to be a registered provider has to go through the Australian Safety and Quality Framework for Health Care. Once they are accredited as a provider they have to say what service they are providing. They then have to be audited. I do not know if you are familiar with Disability Employment Services? They have the same sort of system. That cost could be anywhere between $8000 and $16 000 to the provider, that is what they tell me. If you are a single person working for yourself that is a big cost, but if you are a larger organisation you could probably absorb that.

Ms RATTRAY - That reference is probably more to a single operator who would like to be registered and can't be.

Mr HATTERS - People like your OTs, physios, nurses.

CHAIR - Can I ask a follow up on that? You said deregistering - and we already know that there is a workforce shortage, or people are having to wait for OTs and all of that allied health. What do you see as the impact with people that come to you for assistance?

Mr HATTERS - The impact on us is referring those people to the services they can access or assisting them to change their NDIS support plan to have it either self-managed or plan managed. Self-managed is where that person does everything themselves, and plan managed is when it goes through an intermediary and they pay the bills on behalf of the NDIS participant.

CHAIR - If that deregistering is meaning that there is more demand on the existing OTs and others and we already have a shortage, I presume there must be difficulty in accessing services.

Mr HATTERS - Even if you are an NDIS participant there is still a long waiting list, you are talking nine months maybe. A lot of people are going with Telehealth if they have the capacity to do that and that service is provided on the mainland. If that person needs a wheelchair, for example, it is very difficult to do that on Telehealth because you have to trial the wheelchair and so forth.

CHAIR - The membership support, the people who come to you for assistance, what are you advising them to do in terms of that allied health if it is not there and there is a wait time?

Mr HATTERS - Write to your local MP.

CHAIR - Is there a lot of distress for people in having to wait?

Mr HATTERS - A lot of people give up.

CHAIR - So what does that mean?

Mr HATTERS - They just have to carry on and suffer.

CHAIR - Do you see that very often?

Mr HATTERS - We see that very often, yes.

CHAIR - That is troubling.

Ms PALMER -We have had a couple of other presenters today talk about - and the way you have worded it in your submission - is that the lines are blurry when it comes to the confusion between NDIS participants who cannot access funding that is duplicated by mainstream. I was wondering how you've found that was impacting the people that you advocate for? For example, when they have to go to hospital for different things.

Mr HATTERS - That's very difficult because the state government might say, 'No, that's an NDIS responsibility'. And the NDIS will say, 'No, that's mainstream or community responsibility'. So, it's very difficult. It would be very good if there was some sort of firm line of responsibility between the state government and the NDIS.

Ms PALMER -That's definitely something that the people you advocate for are experiencing on a regular basis?

Mr HATTERS - Yes. And getting a response from NDIS. The decision could take a long time.

Ms PALMER -Okay.

CHAIR - There's a number of recommendations that you make towards the end of your submission. I thought it would be valuable if there were one or two in particular that you wanted to raise.

Mr HATTERS - The key one for us is to allow more providers in to create competition and more choice for people to get their limbs -

CHAIR - You are talking about where the people are deregistering and so forth.

Mr HATTERS - Yes. Recently Tas Health did do a Tasmanian artificial limb scheme review, which started in 2017 -

Ms RATTRAY - The review started in 2017?

Mr HATTERS - Yes. We have tried on numerous occasions to try to get a look at the review, which Paula Hyland at the time I think said, 'Yes, we'll give you a copy of draft so you can provide feedback', but at this stage we have never received it. Getting a response from anyone from Tas Health has been challenging.

CHAIR - Okay. To clarify, you said to let more providers in?

Mr HATTERS - Yes.

CHAIR - So, who's controlling that?

Mr HATTERS - Well, I guess it's Tas Health - the Tasmanian Health Department.

CHAIR - Okay. I'll let you continue. What are your expectations from that review that you've been waiting for all this time?

Mr HATTERS - I think it will be put on the backburner and forgotten but hopefully I'm wrong.

Ms RATTRAY - It's taking a while if it commenced in 2017.

Mr HATTERS - Yes, we were going to wait until the COVID thing is over.

Ms RATTRAY - Do you think we'll ever get over COVID, Peter?

Mr HATTERS - Well, there must be some point where it's going to be a bit more manageable and then start again to see if Jeremy Rockliff can be better for us.

Ms RATTRAY - See if he can unearth the review.

Mr HATTERS - Yes.

CHAIR - A lot of what you speak about is basically equity for people whether they're on the NDIS or not on the NDIS being able to access what they need.

Mr HATTERS - Well, there's no equity now. If you're NDIS you're probably at a significant advantage than other users of the service.

Ms RATTRAY - Do you have any idea what the age demographic is of your members? You know, how many of them fit in that over 65 and -

Mr HATTERS - Mostly they wouldn't be my age group.

Ms RATTRAY - Quite young then?

Mr HATTERS - I'm one of the young ones.

Ms RATTRAY - Right. Okay.

CHAIR - Is that due to the instance of amputee, or is it the people that are engaged?

Mr HATTERS - Well, I think it's because most of the amputations are caused by diabetes so it happens over a long period. So look after yourself now so you don't become like me.

CHAIR - Thank you.

Ms RATTRAY - Thanks for that advice. I noticed that you've got a northern, a north-west and a southern arm of your organisation. Do you meet up?

Mr HATTERS - Yes, we do.

Ms RATTRAY - How does that work?

Mr HATTERS - Okay. Our structure is that we have a board that meets by Zoom because of COVID. We're finding that works very well. We also have regional meetings in the north, south and north-west where we bring in a guest speaker and we invite people to come in and ask general questions.

CHAIR - Going back to one of your earlier points about the project funding and the core funding, to what extent have you been finding it a struggle without that very small amount of core funding, in my opinion, and how are you continuing to do this work? The submission is thorough. There must be people who need your assistance and who you struggle sometimes to support, I would think.

Mr HATTERS - There are and a lot of times we can't provide the practical support they need because we don't have the resources or the knowledge to tell them where to go.

Ms RATTRAY - Did you put this together as the three groups?

Mr HATTERS - No, there's one group. I did the submission and then I handed that over to a teacher to polish up the grammar.

Ms RATTRAY - Well done.

CHAIR - Any final questions? I will ask if there's any particular point that you want to make sure that we are across that maybe we haven't touched on or if there are any closing remarks you'd like to make?

Mr HATTERS - We'd like to see service improved for people over 65 years old and we'd like to see more choice in control where people can go. A lot of people are not happy with the services they go to now and they would like to go somewhere like the mainland because that's where the specialist knowledge is but they can't do that.

CHAIR - And that's because of cost and a variety of reasons.

Ms RATTRAY - Did you travel down today?

Mr HATTERS - Yes, I took the week off work.

Ms RATTRAY - Are you Westbury-based?

Mr HATTERS - Yes. A good place.

Ms RATTRAY - You belong to my electorate. I'll give you my card.

CHAIR - Thank you very much, Peter. I appreciate you travelling down and your work on the submission and the work that your organisation does.

Mr HATTERS - Thank you, I really appreciate the time you have allowed us to have a talk today.

THE WITNESS WITHDREW.

Mr PAUL DUNCOMBE, EXECUTIVE OFFICER, TADTAS INC. WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Welcome to the public hearings of the Legislative Council Government Administration B subcommittee inquiry into Disability Services in Tasmania. All evidence taken at this hearing is protected by parliamentary privilege. I remind you that any comments you make outside the hearing may not be afforded such privilege.

A copy of the information for witnesses is available if you have not read it or are not aware of the process. The evidence you present is being recorded and the *Hansard* will be published on the sub-committee website.

The procedure we intend to follow is that first we'll give you the opportunity to speak to your submission and other matters, if you'd like, and then we will address some questions to you. We are specifically after information that addresses the terms of reference.

If you'd like to start by introducing yourself and giving us a bit of an overview from your submission that would be wonderful. Over to you.

Mr DUNCOMBE - I'm Paul Duncombe. I'm the executive officer with TADTas. Executive officer means I do all the things that nobody else wants to do.

CHAIR - I've had that job before. I understand.

Mr DUNCOMBE - I've been with the organisation since 2004. I retired from another community service organisation, Family Planning Tasmania, in 2003. In 2004 I thought that was a silly idea, so I came back to work, and I'm still at work.

I probably do the most rewarding work that I've ever done in the bikes program with TADTas. We get a little kid come in, in a wheelchair or a walker, and in 15 minutes we've got them on a bike, and in another 15 minutes we've got them peddling the bike and steering the bike. I'm getting emotional just talking about that. It's just so rewarding.

Prior to that we were doing technical aids only, not bikes. The technical aids provide assistance for people with a disability, but aren't commercially available.

CHAIR - Can you give an example of this?

Mr DUNCOMBE - We're doing one at the moment, which is probably one of the most complex ones we've ever done. A little boy we'll call Adam can't move his body. He can move one hand slightly forward, back, left and right. Inside that compromised body is a very intelligent young boy. He loves music and he wants to write music. We can't even get him to talk.

We started working with him in 2014 and we are waiting for the technology to catch up. It's just catching up now, so we have devised a device that's in a box with a joystick on it. He can move about just half a centimetre, so he can move this device forward, back, left, right, north-west and north-east. We've got it reading onto a computer screen at the moment, and you can pick up 'yes', 'no', 'maybe', 'thanks', and other words we've programmed into it.

We find his eyesight isn't good enough to really follow the computer screen. We're experimenting with sound, so that when the joystick moves, the sound goes off. They're musical notes - the genesis of the musical notes that we hope he'll be able to produce.

My colleague, Tony, is in the Symphony Orchestra chorus, and his ambition is to have the chorus singing this boy's music. It's the most complex job we've ever done.

CHAIR - Goodness, wow. The example that always sticks in my mind of the work you do is the woman who was in a wheelchair and wanted to breastfeed, but had a challenge holding the baby, and there was a modification onto the wheelchair.

Mr DUNCOMBE - Yes, we hooked a bassinet onto the front of the wheelchair. The bassinet can spin around so that when mum's communicating with her child, they've got eye contact. When mum's off in the wheelchair, she spins the bassinet around so baby can see where it's going.

CHAIR - I'll let you continue, but there's no end to the variety of problems that you're solving.

Mr DUNCOMBE - There is a huge range of skills among our 10 volunteers. Only 10 of them, and they're just an amazing bunch of people. I can't drive a nail into a piece of wood without bending the nail, the piece of wood or the hammer, so I'm just in absolute awe of these people who can do this stuff.

Tony, our technical coordinator, is down in the Huon Valley at the moment helping a woman who can't do gardening anymore because, to use her own words, she has 'got too fat', and he'll come back with an idea. There'll be something that hauls her up, or puts her down slowly or something. It's all quite rewarding.

Mr WILLIE - How are you funded? How are you providing these services?

Mr DUNCOMBE - Tricky.

Ms RATTRAY - Not very well, from your submission.

Mr DUNCOMBE - Yes. With the bikes program that I spoke about, the NDIS is now recognising that it is a therapeutic aid; it's not just a bike, like other kids have a bike. In the early days we're getting back, 'Oh, all parents have to provide a bike'. Yes, but not one that's $2500 with all the -

Ms RATTRAY - Bells and whistles.

Mr DUNCOMBE - Bells and whistles and add-ons. The bikes are now covering the overheads that we need to provide them - that's the administrative side, the therapeutic, the OTs, everything. The other work that we do, the assistive technology - that's tricky.

CHAIR - With the assistive technology, you generally look to solve the problems that aren't solved elsewhere in the market - is that correct?

Mr DUNCOMBE - Yes. If it's commercially available we don't build another one. We will say, 'Buy one of those'. Sometimes they buy one of those and it's still not quite right.

CHAIR - You are only addressing the gaps at all times.

Ms RATTRAY - That's when you might modify something.

Mr DUNCOMBE - Yes. So we buy it and modify it.

CHAIR - Are you funded for that part of your work?

Mr DUNCOMBE - No, we're not funded for that part of the work.

CHAIR - You were previously?

Mr DUNCOMBE - We were previously, up until 2020.

CHAIR - Were you well funded?

Mr DUNCOMBE - It was adequately funded. In 2004 we started with $25 000, and it worked its way up to nearly $50 000 by 2020.

CHAIR - And that would cover overheads, insurance and such?

Mr DUNCOMBE - Yes, because our overheads are quite small. We work out of the front room of my house. We have paid staff of two. I'm paid for eight hours a week, Tony is paid for three hours, and that's returning to volunteers after that.

Ms RATTRAY - What changed in 2020, Paul?

Mr DUNCOMBE - Not very much. I'm an accountant who has been in the community sector since 1985, so I know how to stretch a dollar, and we've just managed. Last financial year was our first year without government funding, and it coincided with a coronavirus boost from the federal government, which we didn't really need. It was called the cash boost, and it just happened to come along. That was $10 000, which goes a long way to covering our overheads. We also had a bequest from a deceased estate, for about $30 000, so we got through the year.

Ms RATTRAY - You were funded up until 2020, and then you've been fortunate with a couple of funding streams, but obviously they won't be ongoing. So, what changed, for you not to be getting that regular source of funding?

Mr DUNCOMBE - The state government decided that not just us but a whole heap of community organisations could get their funding from the NDIS, which was not the case. Most of our clients who are not on bikes are over 65, and there's no way of getting them into the NDIS. We've always asked that they pay for the parts that we use; the labour comes free. It's volunteer labour, so it's not quite free, but it's cheap. We still have that problem with the over-65s, where we're supposed to be charging them to recover our overheads, but they don't have any money. We don't have a rich client. There isn't a rich client.

CHAIR - If they can't get the support from you, where do they go? These are very tailored solutions, and your capacity is stretched. They may not have any resources themselves, so what happens to those people?

Mr DUNCOMBE - The ones who contact us are the ones we know about. The ones that contact us receive a service from us.

I sent a bill out this morning for $50 to a man who had a modified toilet seat, but it wasn't high enough for him. He had to plonk down onto it, so our volunteer raised the toilet seat. He went out one morning, diddled round and got it working, and I sent out a bill for $50 because he hasn't got any money and the volunteer travelled from Devonport to Port Sorell twice, so that was the $50.

Ms RATTRAY - So, what sort of engagement does the government have with your organisation around 'oh the NDIS should fund you, so we do not need to.' Was there some consultation? Was there a discussion at least?

Mr DUNCOMBE - They set up a couple of forums to hear what we had to say, but I got the impression the decision was made long before they set up the forums. I guess, to be fair, they put a lot of money into the NDIS thinking it was going to come back again, but it does come back. The kids on the bikes will tell you that, but the people over 65 will tell you they don't see it very much.

Ms RATTRAY - Paul, I am aware that Lions Clubs Tasmania, and I think this is actually national, they do a bike for children or people living with a disability as well. Are you aware of that? Is that something that you have ever worked with? Or is that completely aside of the work that you do with your organisation?

Mr DUNCOMBE - The Lions Club one that I know about, is a funded one, not a developing one, and we can access for our bikes if they are not covered by the NDIS. But we have funding to cover that sort of thing anyway, because I have been out to talk to Gardening Club a couple of weeks ago and walked away with a substantial cheque in my pocket, but it was for the bikes program specifically. So, we have stuff set aside in our accounts for bikes funding.

Ms RATTRAY - So, it is really the other aids for those living with a disability in technology, that is really lacking from your perspective?

Mr DUNCOMBE - Yes, that is the gap in the marketplace.

Ms CHAIR - The conclusion of your paper said there is a clear economic and moral argument for adequate funding to continue to serve the needs and provide technical aids for all people with disabilities. What do you need? What would you like to see from the state, or what is the solution to enable you to, as you said, stand ready to assist? What is the baseline of what you would require to be able to do that work effectively?

Mr DUNCOMBE - I guess what I like to see is some state government funding to cover the overheads for the people who rely on us for assistive technology. In Victoria when the same thing was happening, the Victorian organisation lost half its funding. If we lost half our funding, I would not be here today talking about the problems, because the problems would be solved. So, the bikes will take care of themselves and we need, for the people under 65 who have a plan, we can charge full overheads for that, so half our previous funding would cover those people over 65 who don't have access to the NDIS. We are talking about $25 000.

CHAIR - To me that sounds like the bare minimum of what you would need, because I imagine there is a huge scope of work that you could provide with your specialised knowledge, because there is not anyone else who does that work.

Mr DUNCOMBE - We provide a unique service and we just got funding for a two-year program to get people with disability active, into activities - sport and recreation in particular.

CHAIR - Where is that funded through?

Mr DUNCOMBE - It is funded through the NDIS

CHAIR - Through the ILC grants or another stream?

Mr DUNCOMBE - Another stream. That has potential to do a lot of good, and we just appointed a 29-year-old project officer. He has brought the average age of the organisation down considerably, and he is doing great things and is getting kids into archery and dancing and all sorts of things.

Ms RATTRAY - That will be a really successful project, but two years and you will be scratching around. That's the difficulty with those two-year projects or one-year or whatever.

CHAIR - It is the potential economic input as you have raised as well. I do not know whether you want to elaborate on that but the people you are helping obviously can participate a lot more in society and the economy and everything else as well.

Mr DUNCOMBE - Yes, it is a knock-on effect. You find yourself in a gardening group and then you find yourself in a different sort of group and it goes on and on.

CHAIR - Is there anything else that you would like to say or make sure to draw our attention to in closing? Any final comments that you would like to share with us?

Mr DUNCOMBE - No, I think that's all I came to say and I appreciate the forum.

CHAIR - Thank you very much, Paul. We really appreciate the work that you do - it has been quite amazing.

THE WITNESS WITHDREW.

Ms TENNILLE BURNS, PROGRAM MANAGER, AND **Mr STEVEN McGREGOR**, MANAGER, TAS SERVICES, KITES THERAPY TAS WERE CALLED, TOOK THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Welcome to the public hearings of the Legislative Council Government Administration B subcommittee inquiry into Disability Services in Tasmania. All evidence taken at this hearing is protected by parliamentary privilege.

I will remind you that any comments that you make outside the hearing may not be afforded such privilege. A copy of the information for witnesses is available if you've not read it or are not aware of the process. The evidence you present is being recorded and the *Hansard* version will be published on the subcommittee website when it comes available.

We 'll now give you the opportunity to speak to your submission and provide an overview and then following on from that the subcommittee will address questions to you. I will remind you we are seeking information specifically relating to the terms of reference. So, I will hand it over to you and if you could introduce yourselves and the organisation and then give us an overview of your submission that would be fantastic.

Mr McGREGOR - My name is Steve McGregor. I work for an organisation called EverAbility Group and under the EverAbility Group we have VisAbility, Guide Dogs Tasmania and Kites. Kites and VisAbility provide therapy services to people - younger people through Kites and older people through VisAbility.

Our submission was prepared by three managers some time ago back in February. Tennille and I are very familiar with the content and have reviewed it. From my perspective, as the manager for Tasmania Services, the biggest concern we have across the board, and this would apply to aged care, state health and disability, is the lack of allied health professionals. Often when we advertise a position, if we get one person apply we're very happy; if we get two, we're ecstatic. And that happened recently. We had two people respond to a position, so we have to interview them. But that's very, very unusual.

If you can't attract therapists, we can't provide the services that people need. We've tried several things over the years, trying to encourage people to come from the mainland and telling them how wonderful Tasmania is. Tennille was involved in UTAS trying to get some educational programs set up and running. That is just the core focus for us. It's a bit heart-wrenching at times, knowing that all these people need the services but we just can't provide it.

That is my overview and that would apply to VisAbility and Kites Therapy Tasmania, which is therapy within the NDIS and therapy through aged care.

Ms BURNS - My name is Tennille. I'm the program manager and senior speech pathologist at Kites Therapy Tasmania. We predominantly provide early intervention services but we do see school-aged and high-school aged children as well.

Everything that Steve said, definitely. The only other thing I would add is sometimes access to funding can be difficult particularly for children if they haven't received a diagnosis yet. I know there are similar issues in the aged care population.

CHAIR - If you're willing we might go to questions, and you've started with what I was most interested in, simply because we haven't heard much about it today and that is the gap with children. Obviously, it takes a process to be diagnosed. Can you talk us through how long it might take before someone might be eligible for the NDIS and what happens in that period if they still have a disability, a need, aren't eligible for the NDIS, what happens?

Ms BURNS - Generally, most of those referrals are picked up through either child health nurse or GP checks, or the family would self-refer. At the moment in the south and the north of the state, the St Giles Society receives state government block funding to provide services for children who are not yet at school and who do not yet have NDIS funding or maybe may never be eligible for NDIS funding if they don't have residence status, for example. That funding is quite small and what services they provide is quite limited with quite extensive wait lists.

CHAIR - I've had constituents who have been referred and there's a very long wait time. This goes back to the other thing that you raised which seems to be the lack of allied health professionals. Is that true?

Ms BURNS - Yes, for sure. Probably the service that receives the most referrals would be speech pathology. Currently the wait list for that without NDIS funding is approximately 18 months.

CHAIR - And this is early intervention?

Ms BURNS - Yes, this is for early intervention.

CHAIR - Without the early intervention, can you give an example what the impact of waiting might be for a client?

Ms BURNS - I guess if a child has a communication delay and whatever nature that might be, the longer they go without services, then the more significant that becomes, the further behind they fall from their peers. Then they're left often starting school quite significantly behind. They may receive some kind of minimal or consultative services through their school once they start school.

Intervention being provided once they are already at school, which means they're already four or five, is not what we would consider early intervention when we think about typical speech or language development starting in that 12- to 18-month age group.

CHAIR - By waiting, if the severity has increased, that's going to require more resources to address as well?

Ms BURNS - Yes. We know a lot now about the long-term impacts of not providing early intervention for communication difficulties in particular. It leads to a lot of issues with learning, literacy, numeracy. A lot of research has gone into those significant speech or language delays that tie to adolescent and young adult mental health, job and social outcomes. The evidence is quite clear.

CHAIR - Which allied health services do you see the workforce shortages in?

Ms BURNS - I think for the most part it is predominantly speech pathology and occupational therapy with a little bit of physiotherapy. None of those courses are currently offered in Tasmania yet. The courses are starting next year at UTAS.

CHAIR - And we're not going to get all these people tomorrow. There's a process there too.

Ms BURNS - Of course. They will all be Masters courses, which take two years so we're looking at mid-2024 before we have graduates so it's not an immediate fix.

Psychology, social work are offered at UTAS.

CHAIR - Why do we have this shortage?

Ms BURNS - I have been working in allied health in Tassie for 17 years and recruitment has always been an issue. The last two years has been significantly worse and I think a lot of that is to do with border closures and COVID-19 and people not feeling like they really could uproot their lives and move interstate without easily being able to visit back home where they are from.

CHAIR - It was a problem before as well. I guess they are doing their training interstate.

Mr McGREGOR - They make connections and end up staying there and not coming back.

Ms RATTRAY - Why hasn't it been seen as a career of choice?

Ms BURNS - I think it is a quite popular career choice. Over the last five years in particular there have been lots of new courses starting on the mainland. In the last five years there are 10 new speech pathology courses, just as an example.

CHAIR - The fact that you have to go elsewhere to study that is -

Ms BURNS - I think that is the case. We have tried lots of things like engaging with students who are originally from Tassie who move interstate to study and offering them placements while they are students and getting then engaged in the workforce here. Often, they will move to Sydney or Melbourne and end up staying there.

Ms ARMITAGE - Is it salaries as well? I know with medical practitioners to come to Tasmania your lifestyle is fine but you are actually earning a lot less. Would that be the same with those specialties?

Ms BURNS - There is a gap in what they could earn for sure.

CHAIR - What role could the state government have in assisting recruitment or retainment?

Ms BURNS - It is getting harder and harder to get people to commit to moving here. There are some other things on top of that that makes it more difficult, things like securing housing and work for other family members or partners. It is all in the mix. Some support around relocation could possibly work. We have certainly tried that from an organisational point of view. I know in years gone by - and I am talking many years ago, probably 20 years or more ago - the state government did have scholarships and things like that they offered for Tassie based students to come back and work here. That was quite successful at the time, I understand.

CHAIR - Is there a role in the workforce planning or development - and obviously there are gaps - would they have any role in influencing that side of things, or does that lay more with the university?

Ms BURNS - I think there is a place for that. Certainly, at a Tasmanian branch organisation level, and I can only speak from a speech pathology perspective given I am a speech pathologist, we do try to engage in career days and work experience opportunities with college and high school students to encourage that interest. I am sure that will become more prevalent over the next couple of years given the UTAS course and getting that interest amongst the students and making them aware of it.

Mr McGREGOR - I don't know if there is a role for the state government to play in advertising how wonderful life is in Tasmania to encourage people to come to Tasmania.

Ms RATTRAY - At the moment we are keeping them out.

Mr McGREGOR - That is another issue. There are a few things we have tried that have been halted because of COVID-19. As you know, rental and buying houses is a nightmare in Hobart at the moment and any support with that, or advertising how good life in Tasmania actually is.

We are doing one thing at the moment to try to encourage people to come here. The process of setting up a graduate program where we are supporting people who apply, who are successful to come to Tasmania. We are looking at finding some accommodation to put up graduate therapists and then support them for nine months to a year to be out in the community in the hope that they like Tasmania and make connections and then stay here. At least there is an avenue to bring people through Tasmania to let them get a feel for what it is like. Plus, they will be skilled straight out of university and have mentors and support people like Tennille helping them through it all.

CHAIR - Can you estimate how many allied health providers in your field, how many additional specialists do we need to meet our current demand?

Ms BURNS - That is a really difficult question to answer. All I can say is at the moment, if you have a child who requires speech pathology or professional therapy there are no services that can see your child in a short time period.

CHAIR - That's private or public?

Ms BURNS - Yes. Even those who provide NDIS services, the workforce just doesn't match the need at the moment. They are just exhausted. I'm not aware of any services that have open books. It's waitlists, waitlists. It's heartbreaking, really.

Mr McGREGOR - We have to watch with the kids to provide therapy more or less across the board. In Launceston, we don't provide that type of support. It's mostly for adults living with a vision impairment and only about, say, 2 per cent of the population will have a vision impairment. It's a very specialist skill set, especially in Launceston. We've been without an occupational therapist in Launceston for a couple of years. They've stopped taking people onto their waitlist. They don't want to raise their hopes. They already have a year and a half waitlist.

CHAIR - What do they do?

Mr McGREGOR - They can try going back through the health profession - through the state system - but that specialist support, they would struggle to provide it as well because of the lack of that skill set. Even when we get occupational therapists quite often they don't have the vision skill set that we need so we're relying on people in Hobart and WA to provide that technical support.

CHAIR - I imagine these services are generally ones that are going to be as 'productivising' -

Mr McGREGOR - It's funny you should say that because one of the things we're trialling in this area and you might have heard the term before is Google glasses. We've researched them. We have what we call technical assistance or therapy assistance. So, they can put on the Google glasses and they have a technical expert in WA. They are there with the Google glasses, the person who is receiving the support can hear and talk to the therapist in WA and the technical assistant on the ground can provide whatever hands-on support is needed. We are just about to start trialling that. It's not something up and running. If it takes off it's something we can advertise for families.

CHAIR - Who's funding the trial? Are you doing it to solve that problem partly?

Mr McGREGOR - We are doing that. The thing is not every family, parent or person would like that because they think they've been short-changed if they're not getting a therapist. Some people are okay with it, especially because it is a technical assistant, you can charge the cheaper rates and you can get more hours. If we can show that it works for them, potentially more people will use it.

Ms RATTRAY - How do you choose the right technology, if you like, or the right service to match those people who are your clients? Do you think, 'Oh, that one won't take to that but this person will'?

Mr McGREGOR - That's a very interesting question because to understand somebody's needs, you need to be spending time with them, engaging with them and understanding what they want. Sometimes the pressures of NDIS and lack of funding, you have pressure to meet with the family and get onto the (indistinct 12:38:24). It is very challenging for our guys to spend quality time with families.

So, yes, it is a challenge. Luckily, with VisAbility and Kites, our head office is in Perth, WA, and there's quite a lot of very specialised knowledge and technical skill sets we can tap into from a vision impairment point of view, which we do. You set it up fairly frequently. At the end of the day, we can only do so much due to the lack of therapists that we have.

Ms RATTRAY - We heard earlier today - and I was looking back through my notes - that there's quite a lot of under-utilised capacity in the NDIS scheme by clients who are already in the system. I'm talking $140 million.

CHAIR - The problem then is workers are still not there.

Mr McGREGOR - Yes, if you don't have the therapists to engage they can't spend the funding so it just sits there. The worry for families is that one day somebody might say you're not using that funding. We're going to take it off you. As an issue, if you're not using the money that could be used elsewhere so often it's a legitimate question to ask but it's always a stress for families if they're not using the funding that it might be decided that they don't need it.

CHAIR - Can you speak a little bit to the comments that you made about transport? That's something that I'm aware of but it hasn't come up over much today so far. You talked about vision-impaired persons' travel pass and the transport access scheme. Can you tell me the situation there and what your concerns are around the accessing?

Mr McGREGOR - Sure. Essentially if you go back to pre-NDIS there was the mobility allowance and generally speaking that was quite good in meeting people's transport whether that was the bus, train or taxi subsidy, or whatever. When the NDIS came along you could apply for transport funding through the NDS level one, two, three - level three being the top-end, which was lower than what they used to get in the mobility allowance, so there was a gap formed straight away there. That then put the pressure on the state government to provide the taxi subsidy. I think it's different from state to state, so families and organisations including NDIS have gone back to the state government to encourage them to continue to provide the taxi service which they do in Tasmania through the Tas subsidy which I think is about 60 per cent discount on your travel.

CHAIR - And the cohort that you represent would be active users of that scheme?

Mr McGREGOR - Yes, with their vision impairment you certainly have multiple capabilities and you need to be out there working, accessing the community, and you just can't do that without the transport. You can't drive if you have a vision impairment, so it's probably very important to these guys that we support.

Ms RATTRAY - You did talk about driving instructors in your submission, driving instructor training.

Mr McGREGOR - Some people with low vision are not necessarily completely blind. There is lower vision, and with training and support they may be able to pass the test but, again, it would be a therapist that's working through that, and they not available. They are orientation and mobility instructors (OMI). Say if you've suddenly lost your vision, particularly in the over 65s, and they want to get from A to B, you've probably lost your bearings so an orientation mobility instructor will come along and help you walk that route with a cane, or if you think you might match with a guide dog they'll get a guide dog for you and train you to do certain routes. If they want to go somewhere they haven't been before, they need guidance to work out that route and get familiar with it. Again, that is a very specialised skill set.

We had two in Launceston and one has just retired so we're down to one OMI in Launceston. They are quite busy because there's only one of them and they can maybe see two or three people a day, but they'll be seeing them over several weeks so they know the route that they're working on.

CHAIR - I might ask if you have any closing remarks or any particular points that you want to make sure that we are across? We have discussed the workforce skills quite a lot but if there's anything else particular to the cohorts that you represent? There's a lot falling through the gaps by the sounds of it.

Mr McGREGOR - You mentioned earlier about this being going on a long time, this lack of allied health support, and it's not through lack of families engaging and organisations engaging with federal and state government. As good as the NDIS is in a lot of areas, it caused a lot of confusion as to where our accountability and responsibility lie for providing services, so there's been a real lag of several years of people living with disability identifying an unmet need and then the ability to meet that need.

Ms BURNS - Probably the only thing I wanted to add was allied health in Tasmania are all very excited about the UTAS course happening. It has certainly been a long time coming and it's really welcome but I guess it also highlights that it will have an impact on the workforce and potentially services available to clients in the short term in that for a lot of us in the field, time will be taken up with providing that education, training and clinical placements to students so that they can meet their requirements and graduate. When they do graduate they will be entry-level, they need a lot of support in the workplace.

CHAIR - You still need to recruit varying levels.

Ms BURNS - That's right. We are a limited pool and it just adds more work.

Ms RATTRAY - Where do we get more Tennilles? That's the question.

CHAIR - It just adds more work.

Mr McGREGOR - We have other therapists like Tennille who are actually considering applying to UTAS for positions as lecturers, so that is going to take them out of the hands-on stuff into the lectures, which is all needed. If that's what they want to do we will support them to do it. Potentially we can develop other people to stand-in while they are doing one week lecturing or something like that, to keep them employed and doing the lecturing. Yes, that will be an issue until people start coming out of the course.

Ms RATTRAY - You might have to get some of those retired people back just in a part time basis. It is an option.

Ms WILLIE - There is a great need across a lot of areas.

CHAIR - I suppose the other thing, that we have mentioned previously, it is not just the workforce shortage. It is also reaching into regions and things like that so, as much as there is a wait-list at least there is a wait-list to get on to in Hobart for example, but maybe not in Queenstown.

Ms BURNS - Yes for sure, the West Coast and north-west -

Mr McGREGOR - Tennille and I have spoken about this, so we are interviewing two therapists. The applications look really good. Potentially if you build a little bit of capacity out at Bellerive in Hobart, we could do a visiting service up to Launceston where we can base an OT there maybe a day or two per week and they can visit families from there.

Ms RATTRAY - Just employ them both, Steve.

Mr McGREGOR - Hopefully.

Ms ARMITAGE - Can I ask about taxis? I don't think it has been mentioned that we heard earlier that the Tasmanian Government cap on taxi subsidies for people living with disabilities is planned to reduce from $1000 to $350. You mentioned that a lot of your clients use taxis. Are you aware of the reduction from $1000 to $350?

Mr MCGREGOR - No, I am not up to speed with that so I cannot answer anything.

Ms ARMITAGE - I wondered how that would affect -

Mr MCGREGOR - It would be a big impact if it was going down to as low as $350. But, again, that is down to that interface issue between state and federal governments as to where that lies. NDS-wise it is a lot better than it used to be because the state/federal cutoff or misalignment was one of the main reasons for starting a federal system where there was consistency and standardisation across the country. You still get little issues like this where the state government is saying, 'No, this is an NDS accountability now, you should be providing it.'

CHAIR - I believe you said, and my understanding is, that the response differs in different states and territories.

Mr MCGREGOR - Because it is the state governments that decide, so we have been lucky in Tasmania that the government here has kept it going so far.

CHAIR - Is there anything else further that you wanted to say? Otherwise thank you very much for your time. I appreciate the submission and you both coming in. I wish you luck with your recruitment.

Mr McGREGOR - Good luck with your whole inquiry and interviews.

The Committee suspended from 12.48 p.m. to 2 p.m.

Ms BELINDA KITTO, CEO, AND **Ms PENNY NICHOLLS**, BOARD MEMBER, NEW HORIZONS TASMANIA, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Welcome to the public hearings of the Legislative Council Government Administration B subcommittee inquiry into Disability Services in Tasmania. All evidence taken at this hearing is protected by parliamentary privilege. I remind you that any comments you make outside the hearing may not be afforded such privilege.

A copy of the information for witnesses is available if you have not read it or are not aware of the process. The evidence you present is being recorded and the *Hansard* version will be published on the sub-committee website when it becomes available.

By way of introduction, the procedure that we intend to follow today will give you the opportunity to speak to your submission and provide an overview, and from that we will direct some questions to you. We are specifically seeking information relating to the terms of reference.

I will hand over to you now. Feel free to start at the beginning, because we are not all as across everything as others.

Ms KITTO - On behalf of the board and members of New Horizons Tasmania, thank you for welcoming our contribution to this inquiry.

New Horizons has been providing vital opportunities for Tasmanians with disability to be involved in sport and recreation since 1986. Through strong partnerships with sporting bodies, schools, community groups and government, and thanks to an army of passionate volunteers, our organisation not only runs our own inclusive programs, but we also work to establish pathways for participation in mainstream sport, as well as elite opportunities.

Currently, New Horizons runs 19 sessions a week. That is in winter, and in summer that does increase in Launceston, Hobart, Scottsdale and Wynyard, for over 400 members. And there are still enormous gaps.

We think all Tasmanians have the right to be included in sport, to experience the health and human benefits of leading an active, connected life. Unfortunately, inclusive movements like ours at New Horizons are still necessary to ensure this is possible. We know our work can be life-changing for individuals and families, but it also contributes enormously to building more inclusive communities in Tasmania, helping to create equity for people who so often miss out.

New Horizons is a dynamic, for-purpose organisation. We fund-raise hard, but the fact is that we will always require a financial contribution to continue to deliver critical opportunities. We have received core funding from the Tasmanian Government since our establishment in 1986, which concluded with the rollout of the NDIS. At New Horizons, we are passionate supporters of the NDIS. However, as a volunteer-based sporting organisation, we simply don't fit the funding model to be able to charge through individual plans, and critically break even.

We have worked for three years to try to overcome this challenge. Even NDIS experts have been unable to create a workable solution.

Since our submission to this inquiry in April, we received news that we have finally been successful in an application for the NDIS ILC project funding. Despite being a significant sum, this is a one-off and project-based, and must be spent within 24 months - or 18 months now that we're down the track.

From 2023, New Horizons will again be without any core funding, placing our existence in jeopardy. Our recommendation to reinstate core funding is vital for New Horizons' ongoing future.

Ms NICHOLLS - To add to what Belinda has said, applying for short-term or project-related federal government funding in a very competitive national market will make it really difficult for organisations like New Horizons to become sustainable, particularly in delivering the programs and activities that we do at New Horizons that don't align with the NDIS.

A large number of our participants are not NDIS participants, whether that is of their choosing or they are simply not eligible. Some sort of ongoing block funding really has to be reinstated to support some of our core staffing and other activities, so we're able to continue to provide some sustainable and inclusive sport and recreation programs state wide.

I'd like to reiterate Belinda's point that we have a responsibility to ensure that inequities are not experienced for people living with a disability, regardless of whether they are NDIS participants or not. There needs to be an appropriate level of funding, and that must continue to be provided to meet the needs of all people with disability. It is just not acceptable that those who are not on NDIS plans continue to fall through the funded gaps.

CHAIR - What general cohort are you servicing that is not eligible for the NDIS? Is there an age group or a location? Can you paint an image of who those people are, and what their needs are?

Ms KITTO - We've done an audit on our membership base and 61 per cent are on plans, so there's still a vast gap there. It is varied. Some participants may not have the support, or know how to access support to go through the process. Others have been deemed ineligible, and that age group is varied. We don't require that our members have to stipulate if they are on NDIS plans, so we can only report on who has chosen to do that.

The majority who seem to be falling through the gaps are in the 20-plus age group - not the juniors.

CHAIR - Is that because the younger people are more likely to have a family member advocate for them?

Ms KITTO - A number of them don't have family support at all.

CHAIR - For those 20-plus, they are less likely to have that support, I would think?

Ms KITTO - Oh yes, sorry. Those juniors are more likely to have that support to advocate for them. Correct.

CHAIR - What sort of negotiation process did you go through with the government around your core funding? Quite a few organisations fit into a similar gap where they have block funding, the NDIS has started, and everyone thinks NDIS is really great, but it seems there is a state-based responsibility gap. What was the process like for you in negotiating any change in funding, and losing funding, and all of that?

Ms KITTO - The doors were certainly open to speak with different government members around our issues, and we're very grateful for that. However, the response often was that we needed to apply for different grants, that we had to ride things out. We had to try to tick different boxes.

CHAIR - You would need some core capacity to do that, because grant funding can take a really long time. Is that fair of that process?

Ms KITTO - It's really difficult. With the first ILC round that came out, the recommendation from government was that they wanted us to apply for that and see how that went.

CHAIR - Each round is differently targeted. Is that correct? So you may not actually be eligible for that opportunity.

Ms KITTO - Yes, or you have to totally change your business model to try to fit, or a lot of that existing work that has been proven to be successful doesn't always seem to be funded.

CHAIR - Do you mean on an ongoing basis?

Ms KITTO - Yes, or the frustration when we find that what's been proven to work for 30-plus years - and the structure the way it is - can't be funded under a lot of these project-based grants. They want new projects, so you have to invent something new, but we don't want to let the members down in what is being covered.

CHAIR - It seems to me that in the case of a lot of community organisations, the reason that you can do things on the smell of an oily rag is because you have all the community connections. Do you think with time the move to project funding, in which you might have to become an expert in one area or provide a program in that area, do you think that intellectual knowledge will diminish if you cannot maintain that core? I imagine that would be a real risk. You might not be funded now, then in the future you are again but meanwhile there has been a gap and so you have lost some of that capacity.

Ms KITTO - Yes, absolutely. I totally agree. We had nine months without any core funding before we got this grant.

CHAIR - What did you do in that time?

Ms KITTO - Luckily, we have good partners and we had some savings but we really had to chip into those savings so that was scary. It got to the point where we thought in 12 months we may have to close the doors. Just covering insurances and things like that are really difficult. COVID-19, as horrible as it is, the silver lining was the JobKeeper that we were able to keep staff on. If that had not have happened we would not have been able to keep our staff. Definitely there are huge challenges. There are things that we find with the grant processes and they are massive. It took the two of us nearly three months to prepare the grants and we nearly had to stop our normal work of providing for our members.

CHAIR - That is without any guarantee that you will get the funding either.

Ms KITTO - We did not get that one and there were lots of tears in our office because you do put so much in. You are halting the work that you know is so important to be able to deliver those quality -

CHAIR - Is it the workload? With some grants, they ask you one or two questions and with others there is a huge process but that particular grant -

Ms KITTO - The ILC grants are really big, and the reporting, if you are successful, you nearly need a full-time person to be able to keep on top of all of the reporting. All of that has to be taken into consideration when you are applying, if you can manage that with small staffing levels.

Ms PALMER - Regarding the ILC funding, you said that is one-off funding. Is that something that in the lead-up to 2023, you apply for it again or is it a one-hit wonder and you cannot apply again, or you have to wait and see what their focus is in 2023?

Ms KITTO - Yes, that is right. Every time they have rolled them out the focus has been different and so that next round comes out, if it comes out - there have been no announcements yet - may not fit us to apply. We may be able to apply; we may not be able to apply.

CHAIR - I have heard if it was state-based and it is obvious you are looking locally for an organisation to provide the service, but in an ILC you are now nationally competitive. You might be a small place competing against some interstate player. Have there been instances where somebody external to Tasmania who does not have the community connections or the networks or the location, has been funded to do work here? Have you heard of that at all?

Ms KITTO - With the initial ILC grants we put in for and were unsuccessful, the team came down and spoke with us. They advised that our grant was very worthy of funding but unfortunately the funding pool was not big enough to fund all the great submissions that came through. One of the ILC grants that we have now was an organisation - we do not know who it was - that was unable to follow through on their submission and spend their funding. The state government lobbied hard to keep that money within Tasmania. Submissions were put up against that and so fortunately we were successful in receiving that funding. So that has happened where other organisations have received funding but then been unable to deliver their outcomes and spend the money.

CHAIR - Through that grant process you would be in competition with all manner of people and also other people in the same situation as you are, I think, where they are trying to make their service fit at times because they need the funding.

Ms KITTO - Yes, essentially.

CHAIR - There must be some consequence of that, having to compete on a national level?

Ms KITTO - There is. Many of the national organisations have a lot of resources at hand, specific staff who can focus on these grants and are not trying to run an organisation and do the grants. It really is tough competition. That first round we missed out on, the feedback was that the big priority was national organisations. That was one of the reasons we were pipped at the post.

Mr WILLIE - There is still some uncertainty about your future. In your submission you say that you assist 240 people with a disability. Given the terms of reference, if your organisation ceases to exist what impact is that going to have on state government and its delivery of services and picking up the need in the community? I guess that is the arguments for maintaining block funding.

Ms KITTO - Yes, it is going to be massive. The 240 that we were referring to, I mentioned before that there are more than 400 people on our books but unfortunately before we got this ILC we had to halt. We had amazing volunteers in the north-west coast who ran those programs. This is a perfect example of what would happen statewide if New Horizons had to cease. Through COVID-19, our volunteers who ran those programs who had elderly parents had to retire so everything stopped in the north-west. We were nine months without funding. We could not put the resources in to continue so that gap in numbers means there are participants down there who are not accessing any sport and recreation at the moment. Depression and mental health problems are really high in people with disabilities.

Mr WILLIE - The costs to the state government are going to be higher, aren't they?

Ms KITTO - A lot higher.

Mr WILLIE - There is a lot of preventative health that you are doing as well.

Ms KITTO - That is right.

Ms NICHOLLS - It is very much a volunteer-led structure.

Mr WILLIE - Which the state government cannot harness, the volunteer capacity.

Ms NICHOLLS - A lot of our programs and activities are led by passionate coaches, instructors and other types of volunteers and supporters, so that is an additional cost that we do not have to incur at the moment.

Ms RATTRAY - I guess it would be fair to say that people living with a disability like structure and they like to be able to do what they have always done. Trying to reinvent something that they do not understand is probably going to be equally as frustrating.

Ms KITTO - The advice that we have had from consultants who have looked at the model is that there are ways that we could deliver some programs under the NDIS model. The outcomes have come from that. We don't even cover costs to be able to do that as well as it being draining on the organisation. It will be costly to be able to register and the auditing is a huge cost that an organisation like ours could not sustain if our programs aren't going to be financially viable.

Ms RATTRAY - What is the core funding that New Horizons needs to continue the work that they have been doing since 1986?

Ms KITTO - Going back before it was taken away it was $115 000. That was when we were just northern based. Now we are looking at our statewide model that we know is really important and it is important for our funding as well. We have been told that if we were just a northern based organisation we would not be able to access a lot of funding. We are looking at $500 000 to be able to operate. That is the core funding that we need. Then we work hard to fundraise and with sponsorships we can top that up to be able to provide the full resources.

Ms PALMER - What is your fundraising capacity outside of grants and government each year? I know you work very hard in that space. What does that amount to?

Ms KITTO - Sponsorships aside, just the pure fundraising we target $100 000 a year.

Ms PALMER - And with sponsorships?

Ms KITTO - It depends if you take COVID-19 into account which is the same with our fundraisers, we have had to cancel a number of fundraisers but we tried to get at least another $50 000 in sponsorship, but $100 000 would be ideal.

Ms ARMITAGE - And with COVID-19 you haven't been able to have hardly any events.

Ms KITTO - No, we had a full year of no fundraising. A little bit of online fundraising and then we were able to produce the Cycle Challenge in March this year, which was great. But we've put off the gala again this year, which is at least 50 per cent of our fundraising.

Ms NICHOLLS - We have been successful in getting some grant funding from Sport and Rec but that's on an annual application process; however, it does help meet some of our core costs.

Ms RATTRAY - It's always cap in hand when you're trying to live off that type of funding arrangement, never having any surety.

Ms KITTO - The short-term funding is really difficult because so much time goes into preparing for those grants. We're able to put on a couple of additional staff to cover the north-west but by the time you go through the application process, put people on, train them, you're a quarter of the way down the track and then you've got to deliver these really big outcomes, which we're excited to do. Then you've got to do the evaluation process and start lobbying again. It's nearly over before it starts. So, those 12-month grants are really difficult.

CHAIR - And what's the impact on you and on staff and on the board members? It's a whole lot of extra work and pressure to keep things going. There's potentially impact on the participants but there is also significant stress and mental health issues as well as the workload on the organisation itself as well. Is that the case?

Ms ARMITAGE - And certainty of employment for staff.

CHAIR - Yes.

Ms KITTO - Yes. No one on our staff has certainty past this grant. So, it's really hard to put that in place and reassure staff of what's happening. As it is for the members. We've had lots of meltdowns with our members because of that insecurity. As you said, routine security is so important. One of our very loyal amazing staff members resigned. Fortunately, we've got them back for a few hours. They were one of the people who was helping with the grant writing and they really had to pull back. We've lost two board members as well. They were fantastic board members. Because of all the stress that came along with it it's really difficult.

Ms NICHOLLS - Yes, speaking from the board's perspective, we've spent many hours in the last couple of years since I've been a board member - I can't account for the endless hours that had been spent before I arrived on the board - exploring ways of how we're going to strengthen and solidify the financial sustainability of the board with the loss of the core funding back in 2018-19. We are very cognisant of the impact that stress is having, not only on the other board members but certainly Belinda and her very capable staff who give their all to everything, trying to overcome some of the inequities that people with disabilities face. So, it's been a very stressful time.

I come back to my introductory comments about trying to apply for the short-term and project-based grants and the challenge of doing that with a very small staff. New Horizons is putting all of its funding out there to help people, rather than expand beyond what's needed of their staff resources. All the effort is going out in delivering services. Some block core funding is the answer towards sustainability so we're not in this cycle every couple of years.

Ms RATTRAY - Belinda, can you help me understand, out of around 60 per cent of your membership who do have access to the NDIS funding, how is your organisation funded through their funding? Do you send an account? How do you get funding?

Ms KITTO - We don't get a cent of any of that. The biggest thing that comes from it is that we don't employ support workers. The majority of our coaching staff or activity leaders are volunteers. We have people who do access our programs. A participant will come in; some don't need support workers, some do. They bring in their own support worker so they receive that funding but not New Horizons, even though they're accessing our program.

Ms RATTRAY - That seems very unfair. If this funding is attached to the client, then why doesn't your organisation attract some of the funding as well?

CHAIR - Is it because it's a free program?

Ms KITTO - No, they pay a small fee. Most of them are $5; there're a few that are $10 and they pay a $40 membership every year but sport and recreation fees don't come out of their plans either.

CHAIR - If it was it their plan it might be a different story.

Ms KITTO - There's always been that juggle with sport and recreation fees being eligible in plans. If a participant came along to New Horizons and needed a special piece of aid equipment to participate in that program, they could get that in their plan - if they needed a ball with a bell in it to play cricket, that sort of thing. But obviously that goes directly to the participant, it doesn't come through New Horizons. We did look at ways that we could change our structure and employ support workers but it really changes the special culture of New Horizons.

CHAIR - Even though it's a sport and recreation organisation but the purpose is for people living with disabilities, it is still not eligible? It seems to not make sense.

Ms RATTRAY - What conversations have you had with someone in the NDIS structure? New Horizons is unique; that's the long and the short of it from what I've seen. Is there no flexibility in their delivery?

Ms KITTO - The NDIS have adapted over time with different things -

Ms RATTRAY - They've had eight years, Belinda.

Ms KITTO - Yes. Initially, there was absolutely nothing in sport and recreation other than those adapted pieces of equipment or support. To get transport and so forth was part of that. Now sport and recreation can be pool therapy or that type of thing, which can be put in plans. The state government did give us a bit of funding when we were going through these challenges to be able to do more investigation to see if there were different models that we could use that could make us sustainable.

Ms RATTRAY - You had plenty of support in this parliament, I can assure you.

Ms KITTO - We got a consultant who came in and looked at all of that and the ways that we could run a few programs under the NDIS. There are a few programs but they all came out that they would run at a loss.

Ms RATTRAY - I'm quite amazed really but I was amazed before Belinda and Penny came today that this wonderful organisation is not valued to the extent it should be.

Ms ARMITAGE - I think it is valued but unfortunately it is underfunded.

Ms RATTRAY - Okay, valued and underfunded. Thank you.

CHAIR - Is there anything in particular that you wanted to make as a final closing remark, or is there something you'd like to draw our attention to specifically?

Ms KITTO - We've covered most of it but for those who don't know New Horizons, what is special and unique is its family culture. For the people who attend New Horizons, it's not just a place to turn up to do an activity, it's a second home for some. Some don't have that support and they come to us to do a variety of things. Sport and recreation is nearly on the side. The feelings and what they get from New Horizons is so special.

Ms NICHOLLS - It is life-changing. Nothing is more incredible than to go along to some of these programs and seeing people with disabilities just grow over a period of time as we are running programs. What New Horizons is doing is providing life-changing opportunities for people.

CHAIR - Thank you so much for coming in and providing evidence and for the submission that you took the time to put in. We will stop the broadcast for the moment.

THE WITNESSES WITHDREW

Mr DARREN MATTHEWSON, CEO, LI-VE TASMANIA, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Welcome to the public hearings of the Legislative Council Government Administration B subcommittee inquiry into Disability Services in Tasmania. All evidence taken at this hearing is protected by parliamentary privilege. I remind you that any comments you make outside the hearing may not be afforded such privilege. A copy of the information for witnesses is available if you've not read it or not aware of the process. The evidence you present is being recorded and the *Hansard* version will be published on the subcommittee website when it becomes available.

By way of introduction, the procedure that we would like to follow today is that we will provide you with the opportunity to speak to your submission and give us an overview and following on from that we will address some questions to you. We are seeking information specifically relating to the terms of reference. Darren, I will hand it over to you to introduce yourself and the work of the organisation.

Mr MATTHEWSON - Thank you. Before I start I would like to make an apology for Nicole Cummine, our operations manager who has to deal with a sick child, which is a fair call. Nicole was hoping to make it. If there is anything from an operational sense I can't answer today I am going to have to take it on notice and utilise her greater expertise than mine in service delivery.

CHAIR - Thank you.

Mr MATTHEWSON - The submission we made was relatively short, so I won't go over it in great detail other than to say we specifically focused on a group of participants we support who reside at one of our sites called Oakdale Lodge in Warrane. That group, when the NDIS commenced, were not eligible for the NDIS because they were over 65, a decision I can't say I agree with. However, it was put into place and since that time they have been subject to Department of Health funding through the continuity of support that has recently changed to Disability Support for Older Australians.

One of the challenges with the way they are funded and the way they are treated, is that whilst they get funding for their support and care and to a lesser extent their community programs, they don't get specific funding that is not available in the NDIS for accommodation. We are caught in this situation at the moment where this group who are not eligible for the NDIS need to transition out of a model that government policy in the NDIA, which is seen as not appropriate moving forward, is a congregate model of care and we are struggling to find appropriate accommodation for these people of whom there are 12 at Oakdale Lodge.

The issue we face is we could transition those people out but it would mean essentially to residential aged care or to inappropriate housing. We have decided, as an organisation, not to do that. What it means for us is we continue to run a model that the market may not see as attractive, so if vacancies come up we may not fill them, but that is a risk we will bear to ensure that we get the best possible outcome for these residents.

The current situation is we have had to place these older people on a waiting list for community housing. We have not considered residential aged care as an option. We simply haven't because they are currently in a facility that provides for both aged care and disability and simply dislocating people from what is a site to a same site, for the purposes of policy really, we don't think is ideal.

Federal government policy does not obligate us to close the site so we will continue to operate it but obviously the Department of Health is in contact in terms of when are we transitioning these people out.

CHAIR - Can you give us an idea of the cohort, so there are some people that have been there a long time, that sort of thing?

Mr MATTHEWSON - Yes. As I said they are over 65, into their 70s. For some of those people that has been their home for 50 years. We have two residents who were there from the opening of the site right through to people who have been there for 30 years.

CHAIR - Their home.

Mr MATTHEWSON - It is absolutely their home and it is a home-like environment and that is what we are focused on. We have taken a decision that we will continue to operate the site. We obviously now have a growing cohort of NDIS participants who have come to live in that place and, interestingly, despite the fact that it is out of vogue, we continue to be full and we continue to have a waiting list.

CHAIR - That is interesting.

Mr MATTHEWSON - What we are always acutely aware of is that government policy can change overnight, including that there can be legislative encouragement and we do have to have that in mind in continuing to operate.

Ms RATTRAY - Interestingly, Darren, we heard this morning that exactly your model, separate bedroom and shared common area, is what is seen to be so needed in our state, so to me it is not marrying up.

CHAIR - They are talking about three or four people and the Lodge is much bigger which comes with other -

Mr MATTHEWSON - I can give some context about that particularly from the NDIS perspective. The NDIS was set up as a human rights model and it's underpinned by the principles of choice and control. What they try to encourage - and accommodation is no different - is that people have an element of choice and control over where they choose to live.

As part of working through the design of what people's plans look like, including their living arrangements, they take the approach of treating people with disability as ordinary people who should have the choice about where they live and who they live with.

As ordinary citizens, we don't necessarily choose to live in 35-bed arrangements. We live in smaller arrangements. With people who are new entrants to the scheme we are seeing that their preference is to be very independent and live in everything from single bedroom with overnight support arrangements through to the smaller two-bedroom co-joined facilities with shared support in the middle.

We have 16 or 17 other sites around the state which are the group home model which have everything from two-bedroom units through to the four-bedroom house which is probably the preferred model in a policy sense.

Under the NDIS act, they don't want more than, I think, around 15 people on a single title which automatically puts the issue of a lodge in a precarious situation. On top of that, it's very difficult to fund an individualised model, which the NDIS is in a congregative environment.

Ms RATTRAY - That is all fine if you have those new facilities ready to go but if you don't have those new facilities, or alternate facilities ready to go then this is -

Mr MATTHEWSON - The biggest challenge in Tasmania is that we're not a big market. Some of the replacement accommodation is called specialist disability accommodation where you are dependent on developers and STA providers to come into the state and invest in that level of housing so you can transition people into that.

CHAIR - So they're not just on the wait list? They're actually waiting for accommodation to be built in a lot of instances.

Mr MATTHEWSON - Yes.

CHAIR - When I visited and spoke with the former CEO a little while ago he was explaining to me and if this is the case with the 12 that you have left, that it wasn't just the attachment to the lodge. It was also things like the area and finding family members may have moved closer to the lodge so they could see people regularly. How many factors are you considering when you're trying to house a person? It's not just where housing is available. You have said that's one issue but there must be a whole range of things that you have to do?

Mr MATTHEWSON - There are individual preferences through to who they would like to live with. We have gone through the process with the residents at Oakdale; family preferences and then there are location and geographical preferences.

The Lodge is a fantastic place and if you ever visit there you get the feel of what it's like when you walk in the door, it has a vibe. You certainly can feel that. But there are people there now who would be very happy to move out. They want their own space and they usually are waiting in the carpark for me to arrive to ask me when they're getting their house.

The issue we've got is a number of them want a house in Lindisfarne. Now, you know that's not easy to find let alone one that is actually built specifically for these purposes and because it's an ageing cohort we know that their needs will change as well. So that's a challenge in itself.

We've recently taken a decision that we will keep the site so we will not only support people for as long as we possibly can, within reason, and not putting the rest of our business at risk, but we will keep the site itself. Our view is it's a community asset and it provides us an opportunity to look at the model for the next 50 years. We think we've led the way in terms of people ageing with a disability in the last 50 years. We want to look at how we utilise and capitalise on this site for the next 50 years.

CHAIR - Do you also have other things on that site as well?

Mr MATTHEWSON - Yes, we have a day centre. There's the Oak Possability workshop up the back as well. It's beautifully placed. It's actually next to the TAFE as well. We have the Lutheran Eastside School. It's a great position. It's flat, it's close to everything.

CHAIR - Do you have people at the Lodge who have been employed at Possability?

Mr MATTHEWSON - Yes. We have people who work out the back and we have people of the older cohort who now go to their Moonah site. It was originally built for accommodation for all the people who worked at the workshop. It has an interesting history.

We’ve just started a process and we had a workshop with some community leaders and experts and engineers last week to reimagine how we develop this site further into the future. It will have the capacity to accommodate people with disability but we're going to take an inclusive approach. What else can we bring to the site and how can we actually bring others to the site? It's an integrated, inclusive community that has people with disability but other people at that site, that has a range of functions and services at the site, including being carbon neutral and gardening and a whole range of things that really leverages off the whole precinct.

We're starting big and we're starting with ideas. We haven't thought about how we will get the money yet because if you're worried about if you have the money, you'd never start something.

CHAIR - Do you see some benefit in that you're a reasonable sized organisation or business so you have some of that flexibility to take risk? If more effort needs to be put in one space there you can, whereas if you're looking at a very small provider they wouldn't be able to tackle some of these. They wouldn't have the energy, the input, or the manpower as other smaller ones, in a place where you can problem solve perhaps a bit more.

Mr MATTHEWSON - Yes and the ability to take on a bit of risk. That's true, it always comes with a bit of scale, although we're a little bit restricted, even though we've grown as an organisation. We're not unlike many disability providers. In the last five years we've doubled in size but that's got its challenges as well.

I talked about workforce in our submission. We take a view that one of the biggest challenges ahead of disability is the delivery of quality, particularly once the scheme stops growing. It's actually going to be a market share. You're going to have to prove that you're better than others and I think that comes down to quality.

Your biggest determinant in disability services is the quality of your workforce. They're the people who determine the high-quality supports. So, that's our big investment piece. Although we've been growing quite fast, we've actually stabilised that for the specific reason of making sure we get our settings right for workforce planning and development and delivery of quality services. We've also taken a decision that we just won't grow at any cost. We talk about the concept of being at the right size and having some level of diversification so that we can cater for both people in the NDIS and those outside the NDIS as well.

We don't know what that looks like yet but we know that's something we need to be aware of because the problem with being overly dependent on the NDIS and a part of the NDIS that we've very involved in, is supported independent living. As we specialise very much in those high intensity complex clients, we're at the whim of government policy, which can change overnight. It has very recently and we've lost funding, significant funding, quite quickly via people's plans. It's not our funding; it's those people's plans.

Ms RATTRAY - How much more growth capacity do you have at your site? I don't know the Oakdale site.

CHAIR - You'll have to come and visit.

Ms RATTRAY - Yes.

Mr MATTHEWSON - Yes, I'm happy to take anyone around and show them the site. Our buildings take up around two-and-a-half acres of what is about just over four acres. So, we've got -

Ms RATTRAY - Bit of growth opportunity.

Mr MATTHEWSON - We've had engineers to look at the ability to build up and in the oldest part of the building we can. Everything is on the table from our perspective. The issue with simply taking an approach of sort of transitioning people out - the challenge, and I think you spoke about it, Jo - is that the people who can fund the specialist disability accommodation have not moved into Tasmania to the extent they have on the eastern seaboard. Those with the funds and the scale to do it have looked at Tasmania as a small market, which is not uncommon. It's actually what happens to us.

We've struggled to find those partners because even though we own Oakdale Lodge we're not property developers. Our view is we want to specialise in delivery of services and then partner with those in property. That's not our game. I think our game's the care and support. So, we're looking for partners but we're having to encourage those bigger players on the mainland to come over. We're trying to get their attention so they'll build the houses. The issue in the south is that you can't get the land and then you've got to encourage them to go up north. What we have found is there is interest in the north-west but the north is a flat spot.

Mr WILLIE - You can't get the land, you can't get the tradespeople or the materials either.

Mr MATHEWSON - We had a development on the go that we were hoping we would be moving residents into at the end of this year and it looks like the end of next year.

Ms ARMITAGE - Is that the QV building?

Mr MATHEWSON - No.

CHAIR - There is a lot to navigate, even if you are with the NDIS plans there is a lot in terms of managing the different needs and the services that you provide. You are not property developers, but you are looking in that field to make things work.

Ms RATTRAY - Can you talk about your relationship with the NDIS system itself? We are interested in how good that is, or how many challenges there are with that for organisations such as yours.

Mr MATHEWSON - I come from an aged care background so I come into disability with a particular view and my own bias. I have to say I have been really encouraged by the general approach across disability. Because it's a human rights model, it has a different approach from aged care. Aged care was not set up as a human rights model. It's really a service delivery model that used to be focused around providers. Often the person receiving the service would come in second.

In disability because it is a more progressive system set up more recently with a human rights focus, there is a very positive intention to have the people in the scheme and the families and the people surrounding it who drive that. It gives people genuine choice and control to change the culture of how we engage and include people with disability in our communities and have them become part of our society, being far more embedded. That has been a positive experience.

The regulation is relatively new to disabilities so I was used to that coming from aged care where we had a high amount of regulation and we are getting used to that. Unfortunately, what I see in disability at the moment is potentially the increase in regulation in a similar way to aged care, potentially making the same mistakes that aged care has made where it becomes regulation for the sake of regulation, rather than regulation for the development of best practice and a world-leading model, which is where we started and where we should continue. There are some dangers but overall -

CHAIR - It is a fine balance.

Mr MATHEWSON - It is a fine balance but I have come in with a view that quality and regulation is part of the system. You can fight or you can find the best way of resourcing your organisation to ensure that you can deliver on it. We have had to do that and we have had to make a significant investment in creating a portfolio in our organisation around quality and to make a significant investment in the workforce because we think to get ahead of regulation and be in the best practice zone it is investment in your workforce that takes you there. That is why getting the education and training system is such a crucial part of getting that right. That is what we talk about here.

We have recently taken a policy decision in our organisation where we will aim to get mandatory qualifications to work as a support worker, which means we have to support our current workers to receive those qualifications as well as future ones. We think that should be an absolute aim for us but it is not just those funded qualifications.

CHAIR - What level for a support worker?

Mr MATHEWSON - Certificate III as the mandatory minimum and then we would want to build on that. Our view is that it is a specialised area like aged care. For too long these areas have not been taken seriously.

CHAIR - You are looking to do that training yourself? Or are you expecting to go through the TAFE systems?

Mr MATHEWSON - We will partner with RTOs. We think there is a strong enough RTO system. We have started to go through a process at the moment, which we just recently finalised in taking our first qualifications cohort through. We look at the RTOs and grade them and see who has the best capacity to deliver for us and then we go with that RTO. That does not assume we will go to them forever. There is a responsibility on the employer to drive that market but that is one of these things that you have to be as a disability provider; you have to be able to deal with regulation, housing, service delivery. You have to try to understand the VET system which is a 'kingdom' in its own right.

We have recently employed someone. Again, we have taken a decision to self-fund this decision. We brought someone on who knows the VET system very well, knows how we can achieve subsidies and incentives to ensure that we can build some size in how we develop our employees. That is what you have to do. We did not have that resource. Other providers have to try to navigate it. I think the amount of unspent dollars for incentives and subsidies in the training system is just tragic.

Ms RATTRAY - But again, it is navigating through that. You hear a lot of employees say that it is just too hard, I will just pay them and I will be done with it. You are right, there is so much unspent potential there that people need to be using because then you will get the right qualifications.

Mr MATTHEWSON - I have spoken in a submission even before that; it is about getting the right people.

Ms RATTRAY - The right fit people to the right skills and knowledge.

Mr MATTHEWSON - Some of that is in the qualification, which they fund but some of that is outside that so there needs to be a bit of flexibility. I have talked about some of those other skill sets that we need; work readiness and that whole concept of right fit we bring from aged care. Not everyone is the right fit. In the past disability service providers would go to the market to get people to fill rosters. We have said, 'We can't do that, we are a specialist field; we have regulatory obligations'. We also want to develop a highly skilled workforce. We want to set people up for success. If you bring in the wrong people to aged care and disability and expose them to the challenges of that work, you can set people back in their own lives, which we should not aim to do. We have a responsibility to set them up properly.

Ms ARMITAGE - I was looking at the independent living units in the shared housing. You have 16 other shared housing. How many people would be in each shared housing area, is it seven?

Mr MATTHEWSON - It depends on the house. Our largest site is the Lodge.

Ms ARMITAGE - That is 35, isn't it?

Mr MATTHEWSON - Yes. Other than the Lodge our next larger single site would be around four people maximum in a four-bedroom house with some shared services.

Ms ARMITAGE - And they are all fully occupied?

Mr MATTHEWSON - Yes, most of our houses are fully occupied.

Ms ARMITAGE - We had a site in Newnham that was a shared house. I think it took about 10 people and they could not fill it and it had to be sold, unfortunately. Have you bought the QV building?

Mr MATTHEWSON - No, it is not us.

Ms ARMITAGE - I had a look at Live Eat.

Mr MATTHEWSON - We are a tenant on one of those floors.

Ms ARMITAGE - Right, you're a tenant. I thought it would have been really good for these 35 people.

Mr MATTHEWSON - No, the Lodge is based south. We are not going to get any of those.

Ms ARMITAGE - How many have you around the state?

Mr MATTHEWSON - I think we have an even split. We have probably about six homes in the north and the remainder would be in the south of the state.

Ms ARMITAGE - And the north-west, as you have mentioned, has not come on.

Mr MATTHEWSON - We do not have sites. We are looking at sites. I have slowed that down because the importance of moving to the north-west is to have the ready-made workforce. I am not going to move to a site before the workforce is ready to go.

Ms ARMITAGE - I think the QV building is something you should look at though. When I saw that I thought that is good, they have all got their own bedroom.

CHAIR - I think your fundraising group would have to fundraise quite heavily for that.

Mr MATTHEWSON - We do have a development that we are commencing in the north. We will hopefully have some news in the next six months that I think will be pretty exciting for the delivery of disability accommodation in the north of the state.

Ms RATTRAY - The workforce is what you consider right fit in the north?

Mr MATTHEWSON - In Launceston, most of our accommodation, other than the Lodge and two other sites we own, is former Housing Department property that we lease. In NDIA language it is called 'in kind' stock. It is not necessarily specialist disability housing compliant, it is just older stock. What we would do, as we develop newer sites, is look to transition people out of that older - and probably not purpose-built - stock into the newer more appropriate stock. Then we would utilise our previous older stock for people who are more independent, whose needs are starting to increase, so they can go through there, and then -

Ms ARMITAGE - It's a transition arrangement.

Mr MATTHEWSON - Yes, to create some pathway for people.

Mr WILLIE - It isn't part of your submission, Darren, but we heard some evidence this morning from the NDS around the interface with the NDIS and state government services, whether it is health or child safety or the education system, and there was a need expressed for greater policy capacity within state government. Do you have any comment on where the NDIS stops with some of these services, and the problems that can be incurred for your organisation, whether it is care arrangements in the health service, or wherever it may be?

Mr MATTHEWSON - I will start at a high level and work my way down. It is fairly clear from the comments from the new minister, and through the agency as well, that there are some budget pressures on the scheme. One of the things we have seen develop is that, through choice and control when it comes to the ideal accommodation for people with a disability, everyone has said they are going to choose to live on their own, in one-bedroom units with another bedroom where their overnight support might stay. It has become very clear that this is a very expensive way to go. The projections of the scheme will start to be very large and out of budget, so there is actually a move back to shared accommodation and shared arrangements - not quite back to the 35-resident model, but there is an understanding that there are some economies of scale in that.

The other thing I will say is that there was some commentary when the minister recently met with various state ministers. The minister came to speak at one of the NDS conferences and she talked about the importance of the second tier and the relationship with state governments; that the NDIS was set up as a specific type of scheme, but there is still a responsibility of state governments to be active in the disability space. It is not for them to hand over their responsibilities. It is for them to work with the federal government and to be prepared to continue to deliver the tier-two service level - and in all the other areas, whether it be health, mental health, education, justice, transport.

Having only been in disability for a while, I get a sense that at state level there is a bit of an approach of, 'thanks, you can take it, that is a big responsibility' - and not having to continue to reinvest in the critical role of state governments.

For example, take housing. The state government, like the other state governments, they all threw a lot of money, millions of dollars, into SDA - Specialist Disability Accommodation. That then sat with the NDIS and could be funnelled out to developers as they built that stock. But if you talk to the government and the bureaucracy now about how those players are not coming into the market here - for all the money you have put in, we are not getting the stock built; all the other states are going well, but we're not getting our share back, what are we doing about it here?, the response is, 'We have our properties which we lease to you, and then we have paid our money'.

The problem I see is - if I was government, I would be saying we need to get out of holding that stock, which is old stock anyway. It is only going to cost money for the government in the future because it is old, it will need maintenance. In a small state like this where you need to encourage the market, I'd argue you need to say that this is going to be a tripartite arrangement between the housing development and the Specialist Disability Accommodation (SDA) provider section, the government's going to play a role in this and those care and support providers.

The government can't step back because Tasmania is the size it is and it will take a while for the market to develop. They actually need to step in because the more property they can assist in developing, including using some of our own funds - and I know there will be criticism where they have already put money in - but ultimately, it's going to cost them if they don't. They can actually then move people out of that old stock, move that older stock, maybe regenerate it in some way into community housing stock for those other people in the community who can utilise it as well as families. That's an example from my perspective where the state government particularly needs to think a little bit outside the square. They also need to make a conscious decision that it's not an area where they are handing over responsibility but they see themselves as a partner in this.

Mr WILLIE - We need to see a greater capacity within the government for disability policy for all government services. I think we heard there were only two or three people working in the area.

Ms RATTRAY - Three people left in the department.

Mr WILLIE - Whether it's disability provisions in the health service or education or wherever, it seems like there is a -

Mr MATHEWSON - I think that's right. There are some real resource pressures on the people who are trying to deal with the disability portfolio at state level, particularly at a time where we're also dealing with COVID-19 and they're trying to assist the sector with COVID-19 as well. That's going to take up all their time, let alone everything else that they need to keep an eye on so I would agree with that. They probably need to have a look at how they can resource that because having a partnership with the sector in Tasmania and dealing with the federal government and the agency could only advance disability support and services in this state.

Ms RATTRAY - Are there any parcels of land available that we could advocate for? That's one of the issues, isn't it, finding the locations where there are support services?

Mr MATHEWSON - If we had the parcels we'd tell you and we'd be starting work on them straight away. As I say, we're specialising more and more in support and services, even though we have some property. We're working with partners whose expertise sits in finding land and then building the buildings and then managing them as specialist disability providers. Then we come in as what's called the 'support and service providers' because the reality is, we can't be everything to everyone.

As an organisation, we're choosing to specialise rather than trying to do everything but we do have current partnerships that are actively trying to find the land and if only we could get the roads out to Sorell fixed more quickly that would become an obvious area straight away.

CHAIR - Is there anything further that you either want to draw our attention to or do you want to make a parting message?

Mr MATHEWSON - The only thing that I probably have not talked about is about the workforce and the ability and the role of state government in providing careers in the social care sector. We think it's the next big employment opportunity.

CHAIR - Are you talking about TasTAFE and training or are you talking about career promotion in that field? What do you see the roles being?

Mr MATHEWSON - I'm talking about the whole system. When we talk about delivery we just don't talk about TasTAFE because there are other registered training organisations. We see TasTAFE as an RTO, just like other RTOs, to build the capability of RTOs including TasTAFE to be able to provide the specialised services and support; to be flexible; to be responsive in terms of price; to work with the sector, not only on qualification-based training but a whole range of training that we need as well. There is no point in giving us qualification-based training for support workers if we actually haven't got the middle management leadership expertise that allows us to get there as well.

There needs to be a broad approach and also to assist in encouraging a pipeline of people to seriously consider it and making it clear that it's a specialised area. For too long, and it's not necessarily been something we've struggled with state governments but with other levels of government, encouraging people to move into aged care and disability almost as a last resort rather than a first resort.

Mr WILLIE - There are some good learning packages for 9-12, but whether there's an opportunity there in different sectors -

CHAIR - Organisations like Young Leaders are fostering that connection with the school in Bellerive. A lot of young people have then shown interest in following that career.

Mr MATTHEWSON - Yes, and we've started those connections again. Previously in aged care, we did a lot of work with the pathway planners, and we had our model right. We were actually dealing directly with the pathway planners, educating them, giving them all the information around a career in aged care, which they had their own bias about. We had them all developed and all geared up. We were starting to get some runs on the board - and pathway planners disappeared.

Ms RATTRAY - They took them out of school.

Mr WILLIE - It is very hard, isn't it? Career education is being done off the side of teachers' desks.

CHAIR - If it's done.

Mr WILLIE - If it's done at all.

Mr MATTHEWSON - There has recently been more engagement. There seems to be a move back to some presence that we think offers some opportunity, so we'll be pursuing that because we think that's part of the way we have to go.

CHAIR - Thank you, Darren. This has been really helpful.

THE WITNESS WITHDREW.

The committee suspended from 3.11 p.m. to 3.30 p.m.

Rev Dr CHRIS JONES, CEO, ANGLICARE TASMANIA AND **Dr LISA STAFFORD**, SOCIAL RESEARCHER, ANGLICARE'S SOCIAL ACTION AND RESEARCH CENTRE, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Welcome to the public hearings of the Legislative Council Government Administration B subcommittee inquiry into Disability Services in Tasmania. All evidence taken at this hearing is protected by parliamentary privilege. I remind you that any comments you make outside the hearing may not be afforded such privilege. A copy of the information for witnesses is available if you have not read it or are not aware of the process. The evidence you present is being recorded and the *Hansard* version will be published on the subcommittee website when it becomes available.

As I am sure you are familiar from other committees, we like to start with an overview if you would like to speak to your submission first, and then the committee will direct some questions to you. We are seeking information specifically related to the terms of reference. I will hand it over to you to introduce yourselves and your work more fully and to speak to the submission.

Rev. Dr JONES - Thank you, Madam Chair, and I thank all of you for your interest in the difference you can make for people living with disability. My name is Chris Jones and I am the chief executive at Anglicare.

Dr STAFFORD - I am Dr Lisa Stafford and I am a social researcher with the Social Action Research Centre at Anglicare Tas.

Rev Dr JONES - I might just say a little bit about Anglicare, although I am looking at people who probably know all about Anglicare anyway. I will start there just to set some of the scene for what we have to say.

It was about 30 years ago when we were asked at Anglicare to see if we could help people live well in the community and to move away from what was really a medical model that existed. We agreed to look after people, not so much in a hospital setting but in a home. That was a bit of a challenge for us because we hadn't done work with disability. We did lots of work with people who were homeless and people in financial difficulty, so it was quite a challenge. What appealed was the sense that we could actually create homes for people, so as opposed to it being a little mini institution, we could actually do some work about creating homes.

We had one young guy whose home was the Royal. He had significant disabilities, but there was not a capacity for him to be able to live in the community because you needed certain supports that others weren't prepared to give and we were able to say let's give this a try. Now 30 years later that guy is still living well in the community and his biggest disability now is that he barracks for Collingwood.

Ms ARMITAGE - I barrack for Collingwood.

Rev. Dr JONES - Yes, I can see the problem, Rosemary - I'm sorry. No, I make light of it because that's how he describes it, do you know what I mean? He has profound disabilities but he makes that joke and I think that is so good because we have been able to do lots of other things so that it is a home and he can have people to visit and stay, although that creates another dilemma as it often does with younger people. That was a big shift for us and that concern to make sure we can give homes to people is why we're still involved in looking after - they're still the phrases we use - and still supporting people with disabilities today.

The reason we are here is that we are concerned there are going to be people who are going to miss out. We have established what we think is quite a good home at Curraghmore in Devonport and that is the example we have to talk to you about. I had been at Anglicare six months when we had an election and it was the Bacon turnaround and we had this new government coming in. Peter McKay had just finished as Health minister and they had almost opened a facility in Devonport. We had an opening and the new minister, who was Judy Jackson at the time, said, 'I want to go and visit this site'. It was a site that had 18 beds but only 12 residents.

Do you remember the *Yes, Minister* episode with the hospital that works really well without patients? We had a facility that wasn't full. That is the facility we're talking about today that 23 years later, we are still working on making that place a home, continuing for that to be a home. Some of the guys there, because of what is happening with the NDIS, are having to move because they're not eligible for the NDIS so they're going to miss out.

What we've ended up with is a commitment to create homes for people to have a safe place to live, so we've got that need and we can respond to that, and what we've got is a system that now says you have to be eligible for the NDIS in a particular way otherwise there is not going to be a home for you. That is the gap we've been identifying, that there are people who don't meet that criteria under the NDIS and the state Government is saying, 'Not our problem, they should be there', and they're falling through the gaps.

I am using that by real example. The policy issue is what you guys can look at, isn't it? What we are concerned about is making sure that as you look at the policy you have the people in Curraghmore and other places in mind because currently they will miss out.

Ms RATTRAY - Because the policy affects the people and the purpose is supporting the people who are living with a disability, whatever that might look like.

Rev. Dr JONES - Yes. I know the NDIS is a good scheme. We want the NDIS.

Ms RATTRAY - If it was for everyone.

Rev Dr JONES - But it has to be bigger. It has to be more generous than it is now. That sense of generosity is what I think needs to be behind the scheme.

CHAIR - Can you give a little description of the cohort that you’re talking about? If they’re not eligible, what mixture of disability are we talking about - age, et cetera?

Rev Dr JONES - The particular group of people who live with a mental illness. That’s what is used as a definition within the NDIS scheme -

CHAIR - In the permanency.

Rev Dr JONES - Yes. Then you have people who are aged from just under 30 through to 67. We have a spread of people. Some of them won't be eligible for a whole range of different reasons, and if they're not going to be eligible -

CHAIR - Can you roll off a few of the reasons?

Rev Dr JONES - Well, some of it is episodic. There are other people who - actually, I have to be a bit careful, because I know them.

CHAIR - Yes, of course. Broadly speaking.

Rev Dr JONES - If I talk more generally, for some people, the idea that you have to go to the assessment - so, you have to go to the GP; then the psychiatrist; then the OT - you have all these and it's just too much. For some people it's overwhelming. Other people, they have good days. It is genuinely episodic.

CHAIR - We heard that it was the severity and the permanency, so with mental health issues -

Rev Dr JONES - It's the same thing: how severe it is, and over what period of time.

CHAIR - And for many in that category, a lot of mental illnesses fluctuate radically.

Rev Dr JONES - Yes. An underlying diagnosis is present; however, its impact can vary.

CHAIR - Yes.

Rev Dr JONES - I could keep going, but we're here because we have the concern and passion about that. I can get carried away with some of the individual stories, because of the people we support. Lisa and the team at SARC are very good at putting it together in a way that says, this is what we've found. Did you want to add anything, Lisa? These guys will have questions.

Dr STAFFORD - Yes. In addition to mental health, we have to think also about chronic illness and where the intersection lies. One of the biggest barriers around disability is how people identify. If you don't identify as having a disability, then how are you going to access the NDIS? That's one barrier.

The other problem is severity, as you said. With the NDIS - and you look at the Productivity Commission - it has only ever been that about 10 per cent of the population of people living with disabilities will be eligible. And that's based on determining severity of impact.

CHAIR - But there could be people that just miss the mark?

Dr STAFFORD - Absolutely. I personally know plenty of people - myself included - who don't fit within a certain ideal of what that looks like, and many people living with mental illness also have coexisting conditions. About 68 per cent of people with a mental illness have a co-existing mental illness - there's also sensory, autism.

The other thing is when it actually occurs. The one unique thing about disability is that it can occur any time in the person’s life. For me it was in my first year of university, at 17. I got a virus. It can happen anywhere, and this is the problem as well; it’s how we define it. How we define and determine the impact on people’s lives.

It’s also the intersection of low income. From Anglicare’s perspective, we've always been really passionate about promotion for people who are on low income with the intersecting issue. About 50 per cent of people with disabilities are on low income. That’s what we know, and that’s not including chronic illness, which doesn’t get picked up into that stat. So, they can be anyone living with chronic inflammatory disabilities, lung problems, or maybe an acquired brain injury that isn’t formally diagnosed. There are so many, it’s complex.

CHAIR - And all of those can have a really big impact on your ability to -

Dr STAFFORD - A profound impact. And it might be little things combined. You might only have mild mobility, but then you also might have a learning impairment. You see numeracy’s huge impacts here.

So, if you haven’t had the opportunities - and this is what it comes back to. A lot of people do not have those basic fundamental opportunities for education, work, social interactions and basic healthcare. If you don’t have those impacts, you’re actually going to have a prevalence, or it could get worse. We see that with stress onset, but also how people can have more episodic illnesses. It actually starts combining, and the intensities and the triggers for those things becomes complex.

That's one of the problems if we keep looking at disability through a 'one size fits all' lens - whether that’s employment, whether it's education, whether it's health. We're never going to meet what people's needs truly are. It has always been a holistic model, which is why people were excited about the NDIS - but it's not okay to have this 'who is deserving, who is undeserving' sort of divide. For many people, what does that look like?

The other thing is that the NDIS is not for everything. We have significant housing and transport barriers here in Tasmania, and if you want to talk about triggers for mental health, then what do you think the impacts are going to be with insecure housing? So, they're just going to compound. It could bring on an onset for anyone who doesn’t even have it. We know that already.

With transport, Josh knows my incident, and I had another one this morning. I couldn't get on the bus because of really poor-quality ramp systems. These are fundamental basics. I can't get to work, which is a basic fundamental activity - and that's me in a very highly privileged position where I can ring a cab. There are so many people who don't have a voice, and who are just not getting the day-to-day basics.

As a state government, I think you have a responsibility to keep the NDIS. We just saw that with the independent assessment, and it was so good that Tasmania voted against it, because that alone would cause more problems.

We won't go down the slippery slope of independent assessments today, but again, when you try to fit people into boxes, people will fall out, and in particular those with disability and psychosocial disability - unless you are a classic fit, and there's not a lot of people that do fit. This is something I've been researching for a long time, in terms of inclusion.

CHAIR - Yes, I can see you are very passionate and knowledgeable. So, roughly only 10 per cent were ever intended for the NDIS. That leaves 90 per cent of our people living with disabilities in Tasmania.

Dr STAFFORD - I think it's about 130,000 people.

CHAIR - That means they rely on state government services. How effective are these existing services and programs at actually meeting the needs of those 90 per cent, in your view?

Rev Dr JONES - I think the concern that we have is really back in the 10-12 per cent, if that makes sense. Those people who are on the edge. That's the cohort example - people who have not traditionally received a lot of state support through disability, but for a whole range of reasons are now needing it. They have ageing parents, or their condition worsens, or something like that. How are they going to get picked up? What is then going to happen for them, because of the eligibility criteria? That's where we get concerned. Are those criteria going to be broad enough to be able to pick up people who will actually need that level?

CHAIR - Focusing on state responsibility, what can the state do? Is it advocacy?

Rev Dr JONES - Particularly for a facility like Curraghmore where people aren't going to be eligible, that has been someone's home for a long time. That's where the state government can help. They can say, 'Well this is not going to fit there. We're not going to have people fall through the gap. We’re going to pick them up, and we're going to continue to fund a home for those people.'

The state can continue to do that. Lisa has already referred to another example, where some of the policy settings around the NDIS are set by the states as well as the Commonwealth, so that's where we need to stake them. We've been very clear. We don't want independent assessments. We actually are interested in independent living options. We do need to have supported independent living. We need something further about housing. That's where the state can actually exercise some of its policy capacity to influence them.

CHAIR - We have heard that there are only two or three people in the department who are focused in this space, which must make it challenging.

Dr STAFFORD - We will confirm that.

Rev Dr JONES - What's needed, then, is the policy grant, because these are big issues. We need good people who can then argue the case, because that's where the state does have a role. It's one thing to make sure there's not the gap, another thing is to make sure that they are influencing where they can. That's what needs to happen.

Dr STAFFORD - Absolutely, and it's all possible. Yes, there is the COAG mechanism that is what the states can do, but also, we can help with good quality policy that looks at whole-of-life responsibility, which is really critical. As soon as we compartmentalise, that is where the gaps fall. And your question about the unmet needs is where the NDIS came about. It was alarming the significant unmet needs existing in every state and territory.

I remember I was in Queensland state government at the time and the amounts of applications. I used to run four weeks of assessments. We used to assess people's applications time and time again pleading for basic levels of support. These unmet needs have always been found. A really good report triggered the Productivity Commission - whose name has slipped my mind - sets the tone and shows the degree of what people have been living with. I can give you the name of the report.

And I remember when you said about ageing population. I will never forget this woman I worked with, she was 92 and had two adult children 56 and 60. She had no support ever, and it was at that point - because of her age, decline and also those adults' lives - they still only got 4 hours of support. I remember meeting their support coordinator at the time and asking, what do we need? And then trying to bring her HACC which is an amazing service, but again, there are all these eligibilities. 'Oh, no, we can do the laundry for her, but not for -' This is the reality for family units. When we have tight eligibilities, it prevents that seamless support for people and family units. This is one of the things as state government you can do to look at that seamlessness of services across people's lives, but also across the age span.

Rev Dr JONES - I have just been to Trinity Hill, the accommodation service in Hobart for younger people, meeting with the CEO of TAFE. One of the things we were able to do at Trinity is accommodate people with disability because the state government said there are going to be five units for people with disabilities. It is a way the state government can do some things to plug some of the gaps. When they have housing happening let us make sure houses are accessible, as a priority.

Ms RATTRAY - The same as they do with requirements for age care providers. A facility has so many beds that perhaps somebody is able to pay and others where people do not have the capacity to pay, but they still have them in the one facility.

Rev Dr JONES - There is opportunity for the state government to use some of those other levers around the housing policy. Let's bring it on, we need Huntingfield.

CHAIR - They need to be aware of the gaps and that can be a challenge with only two and a half people.

Rev Dr JONES - Education is another area where you've actually got the capacity. There is the need to respond to all of your constituant issues for families and the childhood education system with disabilities. Again, that is where the state government has responsibility and there is a gap there, so what other things can we be expect them to do here?

Mr WILLIE - There is some confusion too about where the support stops. Under the bilateral agreement equipment can be provided in the school, but there are some schools that allow NDIS providers in the school during school hours to deliver services. Others says no, that stops at the school gate, and we take over with the adjustments. There is a lot of confusion around the interface with government services.

Dr STAFFORD - Absolutely, and it all impacts on the child at the end of the day as they are the ones who can't get to school five days a week, because they can't sort it out.

CHAIR - One of the other areas you responded to was workforce development. I wonder if you could speak about the recommendations you made there about retention of the workforce and whether recruitment is an issue and those sorts of things?

Rev Dr JONES - One of our challenges is actually getting people who can do the individual support work across the state. We do not have enough people who have the qualification, which is why we are meeting with TAFE today and again tomorrow.

CHAIR - It is a significant shortfall of something like 5000 in the next so many years.

Rev Dr JONES - Yes. One of things for us is what is it you can do to make it possible for people to take up the work. For us, this part is this idea of continuing and building the relationships with training organisations like TAFE. It is pretty crucial.

Some of things back on us are about what we can do to make our work attractive and we are trialling running more rounds. People will start work at 9 a.m. and finish at 3 p.m.

Ms RATTRAY - Fit in with school hours.

Rev Dr JONES - To fit in with the school hours. What this requires is to have people who are prepared then to have their shower a bit later. Then, can we work with you if you want to do your shopping and things after and not before lunch?

In other words, we have to come up with the rounds of work - because everyone wants a shower in the morning or wants to do their shopping - whatever those things. We are trying to come up with what an individual might need and then work that to be attractive for people to do in school hours. Some of those sorts of things.

The other thing is we are trying to attract people for whom this is not a job they have ordinarily seen they would do. You and I have talked about the French pine closure. Part of what we are looking at is people who would have gone into those particular jobs, we are trying to make this attractive to them.

You have a family member and they worked at the pulp mill at Wesley Vale. When the pulp mill closed, what do you do? You have work in disability or as a security guard on the wharf. What? You know? Disability. You have a family member with a disability. You know disability. A boy working in this area would be so good but he took the security guard job.

We are trying to work hard at making this industry attractive.

Ms RATTRAY - And a choice of employment.

Rev Dr JONES - And make sure it is clear that it is worthwhile work and the difference you can make. Those things are important. One, to make the jobs attractive to start with and we have to get the training done. The job has to be attractive, then the retention and what would cause people to stay.

Part of what we are doing is wanting to celebrate - I shouldn't have been rude about Collingwood - what is attractive is the difference you are making with someone over time. You stay and what has happened now is he talks about his disability. You can see it is the difference.

We are trying to make sure we help them see the difference they are making. That has been really important for us. We are now doing some video clips of some of our staff talking about those sorts of moments - longer term staff, see the difference it is making to clients' lives, telling an anecdote de-identified about the difference they can make. Some of those things are so crucial.

I need staff to go to Moltema. We cannot get staff to go. We have a team at Smithton that is running behind in terms of the recruitment. We need four more people at St Helens. It is constant pressure.

CHAIR - We have heard in the regions that the NDIS and services generally have been very under-utilised. You are talking about what you know that you need. There are probably more people who need help that have not even had the opportunity to be identified as needing help or are able to reach out. There may be even greater needs for the workforce in those areas.

Rev Dr JONES - It is interesting the NDIS look at thin markets. I am not quite sure what that language really means but what they have identified is places like the Derwent Valley where they say, hang on, what is happening? The low number of people who are accessing services in the Derwent Valley, is that because there is a low number of people in the Derwent Valley? Craig would say, no, that is not that case, of course not. However, where are the disability support providers? Where is the work? It shouldn't follow that but the NDIS are saying it does, so what are we going to do, how are we going to do it? We also find it difficult to get workers in the valley.

What we are trying to point to is, yes, that is an issue. We are trying to do what we can and where we need some of the skills funding into TAFE and also this idea about it being seen as a positive job, something that people would find valuable to do. It's worthwhile and makes the difference.

Mr WILLIE - It is also a career structure with decent pay. It is all right to have the skills side of things working well but it also needs to be attractive in terms of conditions.

Rev Dr JONES - The NDIS pricing drives a certain level and so we are very keen for them to do the work about whether we can do a paid-value work that we have in other parts of the community sector. We need that to happen in disability services. If we could get that through - as we did in housing and community services - that will drive the funding. So, that is what we need to do.

Mr WILLIE - Yes, I understand - you are limited by the NDIA.

Rev Dr JONES - Career structures are interesting - but what can you do to create a career structure for someone? What we can guarantee is life-long work. That is not a difficulty. However, the career structure is so flat. What we are looking to do then is whether there is something about the difference you are making in someone's life, and what does that look like, and what is the value around that? We are also saying can we skill you up so you can do some more complex work? So it is not a career trajectory in terms of an organisational hierarchy, it is what skills you have, and whether someone needs the level of skills that you have been trained in. We are trying to do it this way, not that way, in terms of career and talking about the value of the work. We are also being realistic, that sometimes you need a break.

As a support worker sometimes you need a bit of a holiday and so part of what we are looking at is what can we do to give people a holiday, a break from a client?

Ms RATTRAY - In government they call it secondment.

Rev Dr JONES - Yes. If you have been working in disability and you have been doing that for a long period of time, what we are saying is let us be a little bit more flexible, as opposed to having to do that forever - whether it's the Home and Community Care program, or some sort of aged care. For example, one of our jobs is taking kids swimming. We have a number of young mums who have young kids; they do not want to do the swimming. It is a different way that we will try to create jobs that have a mixed economy; that is what we are trying to do, because the need is so huge.

Ms RATTRAY - It is very clear to me that one size does not fit all, and there needs to be some flexibility.

Rev Dr JONES - That is what you were saying outside.

Dr STAFFORD - Absolutely. Sometimes it can get overwhelming because it is so huge, but it is also looking at what is around, what are the strengths? In terms of housing, there have to be some specialised systems but there are also ways you can do that. We can also look at generic systems. We've had the National Construction Code adopt universal access for housing. That alone will start opening up stock. Putting my planner's hat on, when we think about land use and infrastructure, if we don't start interconnecting those two - which currently are treated separately - you will keep having the pockets of inequality and disadvantage that we are seeing. Housing can be tackled, not only in terms of social housing models, but it does not have to be the onus on government. If you have given over land, how do we look at the other mechanisms where developers are held to account in terms of providing stock?

Ms RATTRAY - You have to have a mix, as Chris talked about - that mix of housing.

Dr STAFFORD - Yes. Transport is the same. We are kicking off a project around transport-disadvantaged communities. If you allow housing to go in without infrastructure you keep creating the same problems, such as traffic congestion. There are reasons for that, if we don't govern and put mechanisms in place. It can easily be done, it is sometimes simply where do you start. There are mechanisms in place and funding, such as the City Deal.

CHAIR - Yes, but you are saying the will to act is also needed.

Dr STAFFORD - Absolutely - and the need to keep looking at that whole-of-life approach with disability and mental health particularly. We did not mention recovery. That is a really important program that is sort of outside the NDIA. They have changed recovery but that means you do not have support coordination anymore. That is another classic example where a model is so important, because many people will never be eligible for NDIS but will need recovery and psycho-social support. That is a fundamental service.

CHAIR - We have heard a bit about transport today, and access to transport, and whether it is the scheme itself that is problematic in some cases or whether it is the fact that it falls outside the NDIS. There is also that there are no accessible taxis, or not many available, in the north and north-west.

Given that you are working on a paper and research work, is there anything that we should be particularly aware of that is impacting people with disabilities, in that space?

Dr STAFFORD - Public transport is profoundly problematic here. In Launceston alone, 5 per cent of all households have access to public transport.

CHAIR - 5 per cent?

Dr STAFFORD - 5 per cent. The federal transport infrastructure department has productivity measures around this. Hobart is only about 11 per cent and that's the capital city. So, think about working on the Tasman Peninsula, and those places.

CHAIR - Then you add disability as an overlay and very specific needs sometimes in terms of transport mode.

Dr STAFFORD - It's the whole journey, even if you only want to go up the road. How do you read a timetable? Has anyone tried to read the timetable?

CHAIR - I will admit I do not like those bus timetables at all.

Dr STAFFORD - Literacy, numeracy - these are fundamental. If you can't even access information, that is a barrier straight away. If you can't get out your front door and get down to a bus stop safely, that is a barrier. If you can't wait safely …

CHAIR - I can see a lot of anxiety about public transport too.

Dr STAFFORD - Slopes, trips, hazards - we don't have safe footpaths. Then, if you are at the bus stop, are you feeling safe? Why is there no lighting, from winter to summer, to stay safe? There are multiple factors.

Rev Dr JONES - That was a big question.

Dr STAFFORD - It is just starting now. Josh and I have already had this conversation and welcome anyone to sit on our reference group.

CHAIR - What are your thoughts on the Transport Access Scheme?

Dr STAFFORD - I do not know enough about it from a broader perspective. It provides a really important gap because it is funding huge things. For example, if a taxi costs $126 - as it does for me, to get from home to here - it only subsidises in part and then you have to try and grab all your NDIA package. I don't have it because I have to lose my licence to get it. That is another problem.

CHAIR - If you fluctuate in any way.

Dr STAFFORD - Which I do, absolutely; I fluctuate from morning to night.

There are all these different situations, and I think that is the reality of people's lives. So, there are definitely people who always fit and always require, but there are a lot of people who could if they felt safe and secure. People talk about anxiety just in terms of the whole interaction process.

CHAIR - The main reason why young people never wanted to ever catch a bus was anxiety and fear.

Dr STAFFORD - Predictability, what is going on. Yes, even waiting for the bus. There are multiple things. It's a really key connector to education, as you would have heard from YNOT - people making decisions whether they were going to put food on the table or go to school. That should never be a conversation in a western society like Australia. I know there are multiple barriers but the subsidy is for only a very small portion of the population. So many people that still need access to transport.

CHAIR - Given the people who are at the home and have mental health concerns and are currently being supported, what would happen to that particular cohort without that support?

Rev Dr JONES - We are worried about what will happen to them because where will they go? The public housing waiting list in Devonport, as it is in parts of Launceston - you are waiting a long time.

CHAIR - It is not only public housing - it is making sure it is appropriate housing as well, which may not exist.

Rev Dr JONES - There is a challenge about where will they go next? We are concerned about that because at the moment some of them would exit into homelessness. That is our concern. Some have family and they are returning home at 45 to be with mum, so that is not best for mum or for the person. That is the concern that if we aren't able to provide the home, if the gap isn't plugged, then that is what could happen.

Dr STAFFORD - It comes back to dignity, choice and control. These are fundamental basic rights, that someone has a choice of housing, a home, and are supported to survive.

CHAIR - In closing, is there anything in particular you want to draw our attention to that we might not have touched on or anything you want to leave us with?

Rev. Dr JONES - No, but thank you for the work the committee is doing and having the opportunity to contribute. As I said, there is a gap and the idea of shining a bit of a light on the gap so that it might be plugged - and it can be, we're positive about that.

CHAIR - It's encouraging to think it can be.

Ms RATTRAY - I think it needs a floodlight.

Rev. Dr JONES - Yes, a floodlight would be better, Tanya. Anyway, thank you all.

CHAIR - If you want to send any of those reports that you mentioned to the committee, we can table them as well.

Dr STAFFORD - Definitely - it's the Shout Out report that I remember from 2009.

CHAIR - If you are happy to do that, we'd really appreciate that. Thank you so much for the work you've done in the submission and coming along, but also just generally.

THE WITNESSES WITHDREW.

Ms DEBORAH BYRNE, EXECUTIVE OFFICER, BRAIN INJURY ASSOCIATION OF TASMANIA, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Welcome to the public hearings of the Legislative Council Government Administration B subcommittee inquiry into Disability Services in Tasmania. All evidence taken at this hearing is protected by parliamentary privilege and we remind you that any comments that you make outside the hearing may not be afforded such privilege. A copy of the information sought is available if you've not read it or not aware of the process. The evidence you present is being recorded and the *Hansard* version will be published on the subcommittee website when it becomes available.

By way of introduction, our procedure is that we would like you to speak first to your submission and any issues you want to raise. Following that, the committee will address some questions to you. We are seeking information specifically relating to the terms of reference which I am sure you are well across.

Ms BYRNE - I am Deborah Byrne, executive officer of the Brain Injury Association of Tasmania. I have been in that position for 19 years now, so for quite some time.

Prior to March 2020 the organisation was funded by the Tasmanian government to provide brain injury information and referral services to deliver systemic advocacy, community awareness and professional training opportunities for people working with brain injury. Every year we apply for a grant through the Motor Accidents Insurance Board's Injury Prevention and Management Foundation and get a small amount of funding to provide brain injury education and prevention activities, largely addressed at younger people.

Ms RATTRAY - Is that still available, Deb?

Ms BYRNE - Yes. We have to apply for it each year but we still get that. We target that towards what we call our Brain Injury Community Education Program as well as Brain Injury Awareness Week activities which, in case you haven't been aware in the media, is this week. We've had quite a lot of good coverage around that. That funding is still available.

As you would be aware, in March 2020, with the introduction of the NDIS, funding for organisations such as the Brain Injury Association ceased. The expectation was that we would apply for ILC grants or look for other funding opportunities.

As we've highlighted in our submission, the problem with looking for other funding opportunities is that the organisation doesn't have funding to look at funding opportunities. As we've also said, ILC grants, some of which we have been successful in obtaining, don't provide for you to use that funding to apply for other ILC grants or to look at other areas outside.

For example, the Brain Injury Association has done a lot of work in the area of raising awareness of brain injury as a contributing factor and consequence of family violence, but we don't have the resources because it sits outside our project funding to be able to do any work in that space and if there are project opportunities, technically we don't have the funding to be able to apply for those.

CHAIR - And you may not be eligible for every ILC grant round either.

Ms BYRNE - No. As you saw in the submission, the ILC goalposts continue to move on a regular basis, so you think you're doing one thing and you prepare for that and then something changes and you have to then look at responding in a different way.

Ms RATTRAY - It's for specific programs or projects, isn't it?

Ms BYRNE - Yes. The ILC strategy identified some key areas and grants have been rolled out, focussing on specific projects. Our major issue is the longevity of the ILC strategy, when organisations are required to lurch from project to project.

CHAIR - Without core funding.

Ms BYRNE - Without core funding. The grants are nationally competitive, and so you have to put in a lot of time and effort into a grant, getting it right and being able to compete. As I said, you're not funded to be able to do that. Normally that requires me to go offline for days to work on the grant, with no surety of success.

The other issue is the time limitations around your grant, and we've experienced this. Because we were providing an information and referral service, we had a grant that enabled us to purpose-build a database so that we could capture the people who were contacting the organisation, and also to develop a referral database. So, if you rang up and said, 'I need a neurologist in Launceston', we would be able to go to that database and provide you with that information. We were funded to provide that under a 12-month ILC grant, but we weren't funded to provide the information service.

Technically, we're not funded to provide an information and referral service anymore. A Queensland-based organisation received that big, national information program funding. They don't have anyone on the ground in Tasmania, so we still remain that first point of contact for people and family members, and organisations supporting people with brain injury. Technically, we are supposed to ring the local area coordinator, who doesn't have the brain injury knowledge and expertise that we have built up over 20 years; or we tell them to ring the Queensland-based organisation that is providing a national service, but they also don't have that local expertise and knowledge.

The ILC was about local responses, placed-based responses, but we're not seeing that happening. There is that issue around funding projects that are delivering really good outcomes for people, and building up people's expectations over time, and then it's 'I'm sorry, we can't deliver that program anymore.'

Another really good example is the project I talked about, that also had some funding for brain injury peer support groups. We developed peer support groups around the State. We have one in the north-west, one in Launceston and one in Hobart and people started coming along. The evidence, the benefits of those peer support groups, are really significant to people and then technically - 'Well, that project's finished. We can't continue doing that.' We've had to look at some different ways to try and keep that going because we really value that project, and also that opportunity for people to feed into some of the work that we do.

CHAIR - Deb, with the loss of your core funding, I understand that one of the only options is the ILC grants and looking at other things. With it being a struggle to now provide that core service that is the organisation's intention, can you give us a picture of someone who might be falling through the gaps if they can't get help from you? Once before you gave me an example of a person who wanted help at the bank, and had trouble accessing the service. It's not how I thought about it, so I think it's a good example perhaps for people to hear.

Ms BYRNE - It's really hard to pin down what people want. The NDIS is great for people who have been deemed eligible for it and have that funded package. They've got that choice and control, although I know there's a whole lot of issues around market and service providers et cetera. For someone who doesn't have the NDIS package - the 89 per cent of people who will not be eligible for an NDIS package - that hear about us, or have a family member who sustains a brain injury, what they want to be able to do is either pick up the phone, or come in, or just receive that bit of extra support, or to have someone who can go and give them some understanding.

The example that Jo was talking about related to a gentleman who has some quite challenging behaviours related to his brain injury. He had some problems with MyState and they wanted to terminate him as a costumer, but needed some support to do that. Some of the issues had police involved, and had security involved, and so they had staff on stress leave and it was quite an expensive exercise for them. I was able to come in, work with them, support this person and negotiate him to an alternative banking arrangement, and set up a really good relationship with that new bank. There is quite a significant cost saving.

I highlighted in my submission that I understand that for the Tasmanian government, the funding was signed over under the bilateral to the Commonwealth; but the responsibility to people with disability doesn't stop there. And if we don't have services such as those the Brain Injury Association was providing - those safety net services of being there for people in a whole range of different circumstances - we will see them, as we know, in the criminal justice system, because the research says that potentially up to 60 per cent of your prison population have diagnosed or undiagnosed brain injury. The research says that 65 per cent of detainees in youth detention centres have brain injury. We see that if the carers, or the family members are not supported, we see them in the hospital system, or in mental health services.

Ultimately, the Tasmanian government is going to pick up the bill and the bill is going to be a lot higher than providing for the safety net services that organisations such as ours provided. That was the main concern of our submission, and as I also said, my real concern is around the ILC strategy. At what point do we stop having project after project after project, where you get a really good outcome? Another really good example, and I'm not sure if you have seen the media this week, is the National Assistance Card. If we had not had an ILC grant we would not have been able to roll that out, and I am really grateful for that opportunity.

CHAIR - Others might not be aware of it.

Ms BYRNE - There was an incident where a gentleman with brain injury had a really negative experience with police. Just prior to me joining the association, police …[inaudible 4:22:51] partnered and developed what was called an ABI ID card. The person could apply for a card, it had their photo on it, and listed on the back. 'I have brain injury and may have difficulty due to memory, speech, balance, et cetera'. The card had a nominated contact name on it, and it had the police assistance line, and that information was provided to police. If the contact person could not be contacted, police could say, yes, this person has a brain injury and here is their information.

It was a card that was issued out to people, and they had that card in the community. We started getting a lot of inquiries from people in other states, wanting something similar. We applied for a grant to roll the card out nationally to people living with brain injury, and to pilot the addition of a QR code. It might be fine to say I have memory issues, or I have slurred speech, but what does that mean for you? The QR code means that someone could come up to you in the street and say, look I am really stressed can you have a look at my card, it says I have a brain injury and you can scan it. It may have either written information or a video. As an example, a person going into Centrelink could hand over the card, and they could scan it and it says 'I have memory issues, could you please write the information down for me?' They could hand it to the court, and say 'Could you please write down my next court appearance?' We know people don't turn up, because they don't remember. We are getting a purpose-built online application system built for it, so as part of this project it will be available nationally, for all people living with brain injury. We are going to pilot it in Tasmania for people with epilepsy, autism, and people with intellectual disability, because of the linkages of the project with the justice system. We hope all Australians will, at some stage, have access to the card. But the situation is that once again this is project-funded, so it might mean that if you apply for the card on 31 December, you can have the card but if you apply the next day then sorry, the project is finished and you don't have access to the card.

I understand that with ILC projects part of it is you look at ongoing sustainability, so there will be a cost for the card which will essentially cover what it would cost to physically replace the card but not to have the project officer administering it, who would have to review videos to make sure the information is correct that is provided to police on a regular basis.

It's a fantastic project. We've been taking expressions of interest in the last two days and from where no-one knew about it and we had only about 10 or 15 inquiries, now we're up over 200, and this is only expressions of interest that we've launched. We're hoping that we can get the NDIS minister to launch the card later this year.

CHAIR - Taking into account the limitations of ILC grants, what do you see as the state government's role in fixing this, I guess? Is core funding the answer for you? What is it you would like to see happen?

Ms BYRNE - I think there are a couple of elements. It is around that core funding. I am aware that, for example, they looked at the advocacy services because that funding was also handed to the Commonwealth and they realised that wasn't being funded by the NDIS so the Tasmanian government has funded the advocacy services. I think it is having a look at the value that organisations such as ours can provide and going back to that core funding model, whether that's something the Tasmanian government does or something that it advocates through the NDIS that maybe ILC is framed a bit differently. I think that with the ILC funding, there should still be some of the funding allocated for innovation and projects such as ours, but I think also some of it should be quarantined.

It's almost like your ILC projects are pilots and if you get a really good pilot that demonstrates that the outcome is not sustainable - for example with the card where you're asking people who are already disadvantaged to pay for something that is going to change their lives in ways that are really incredible - to be able to say, 'This is really great, we think the organisation needs core funding to be able to continue this', and also some core funding that allows the organisation to look at other opportunities.

I think they need to have a really good look at the gaps that have been created. For us it is that information and referral gap and I guess to hold some of the ILC projects to account. I'll give the other organisation the benefit of the doubt because it is a three-year project so you have that opportunity to roll out your outcomes over three years, but an outcome of that project was that they would have a physical presence in every state and territory. They talked about having local engagement officers in each of the regions. That hasn't happened in Tasmania, so there's a significant gap there that is having a flow-on impact on people and on the Tasmanian Government.

Having a look at where the gaps are is something that government needs to do. We can tell them where the gaps are. We want to be able to work with government around solutions. We've evidenced that with our justice project that we're working on and we're happy to work with government around coming up with solutions.

The NDIS has created gaps for people who aren't eligible for the NDIS and I think that needs to be addressed. I would hazard a guess that it's not just in Tasmania, it's in the other states as well. The focus needs to not just be on participants. The focus for the Tasmanian Government in investing our taxpayer dollar needs to be also on ensuring an outcome for those Tasmanians who are not eligible for the NDIS.

Ms RATTRAY - Have you been part of the review of the NDIS process?

Ms BYRNE - I'm aware of some of it. I know that DSS has engaged Swinburne to do a review of ILC. Once again, it gets to the issue that with ILC you're funded for a project and they're tight time frames and you have to deliver on that project. Even for me, something like sitting on the NDS State Committee, which is a really valuable opportunity for me to learn what's going on in service provider land and how that might impact, I'm not really funded to do that, so time away from that is time away from the projects and the time frames.

CHAIR - And that is what the core funding would have allowed?

Ms BYRNE - It is that cost to be able to keep your door open, to be able to respond to opportunities that arise, to be able to feed back into areas of interest. For example, last week the police had a forum on police responses to family violence. The state Government nominated me to go to a summit in Canberra - which I don't think is going to happen, it has been delayed once - around women and family violence and particularly women with disability. The latest report they have done around that will inform the new national plan.

There is a 431-page report and brain injury is not mentioned once, despite the fact that a brain injury can increase the likelihood of marital aggressions sixfold. If you think about the mechanisms of family violence and the impacts of strangulation, choking or being knocked unconscious, brain injury is a consequence of family violence but it is not being recognised and considered. Our capacity to be able to feed into that and respond is very limited because we are now only project funded. As I said, they are great projects with really great outcomes. We were lucky enough to be able to leverage off one of the earlier projects we did to get a further grant to trial the methodology and resources to see if that might work with other disability cohorts, which I think is really great. That was an employment project. It has created some opportunities, but I think inherently the ILC is flawed and I don't think in the long term it is sustainable.

It is really hard for me. I have some really great staff at the moment but we know that by March 2023 we may not have any funding whatsoever, so I would be looking about November-December for perhaps other positions. Usually we do not know up until the last minute whether we have been successful or otherwise with a grant, so I won't know whether I'm shutting my doors at the end of next year. There haven't been any other grant opportunities recently. I don't know what the situation is with ILC other than DSS are doing a review, so nothing has come out, no opportunity.

Ms RATTRAY - That is not the first time we have heard that particular scenario today and quite an emotional contribution.

Ms BYRNE - It also compromises our ability to partner with other organisations. A really classic example is that it has been interesting with some of the feedback we have had around the assistance card, such as it would be really great for people with autism. Because we want to trial it in Tasmania for people with autism we have been talking to Autism Tasmania, but one of the problems they have is that they're in a similar situation to ours, so to work with us around this project they don't have the funding to look at those opportunities. We have been approached by the university around a TBI moot they're doing and a project they have some funding for but it's really hard because it's like, 'I'm sorry, it sits outside our project'.

CHAIR - Even with this inquiry there were originally 18 organisations whose funding was at risk for the same reason. We have heard from a couple of them and some of it I put down to COVID-19 and some other reasons, but from speaking to you it is really obvious that in a lot of the cases it would be capacity as well. They just don't have the capacity anymore.

Ms BYRNE - No, we don't have the capacity.

CHAIR - Autism Tasmania think of that because all of them are really engaged.

Ms BYRNE - If you think of the expertise that is built up over time and the intellectual and social capital as well, I know that quite often my organisation looks at me as a risk because a lot of the information -

Ms RATTRAY - As they should.

Ms BYRNE - Yes - and are looking at how we do that and different systems, but you lose those grassroots community organisations and you can't get that back overnight, you can't rebuild. We've lost three brain injury programs and we're the only specific brain injury organisation left.

CHAIR - Even if you were funded for them again tomorrow there has been a gap in that knowledge.

Ms BYRNE - Yes. In terms of the flow-on impact, once again we were lucky we were able to get some funding to address it. We know a lot of people with brain injury are going through the justice system and as you are probably aware, back in 2013 we lobbied the Magistrates Court to have the mental health diversion list expanded to include people with a brain injury, with cognitive impairment.

They had two court liaison officers at that time. We funded a neuropsych to work with them, so people with cognitive impairment could go through the diversion court and stay out of jail. Better outcomes for the person, their families and the justice system, but the success of the diversion depends on having services in the community you can divert people to.

When the three brain injury programs lost their funding, they closed their doors. There were no services to divert people to - a discrimination issue - but we were lucky to be able to get some funding to develop that service. Once again, that funding runs out in March 2023. We set up the service. We get it going. We are hoping the money we can save Justice in setting up this service and keeping people out of prison that we will get a Justice reinvestment principal and they will see the value of the service and fund it. Once again, this is a process we need to go through, whether it is a Treasury submission or a submission to Justice that we then have to write and prepare.

I do not think some of those flow-on impacts have been considered and guess this is what the inquiry is about to look at some of the impacts.

CHAIR - Social and economic.

Ms BYRNE - Yes, most definitely the economic side of it is one thing, but the social side also. As part of Brain Injury Awareness Week, we were doing some tv interviews and the lady you may have seen, talked about how, because of her brain injury, she can just become really overwhelmed. She may be in a shop. She just needs to get out and may walk out not having paid for something not even realising she has something in her hand. She was talking about the value of the card and her daughter saying, 'This gives me the confidence that Mum can go out in the community and people will respond. I can have a normal teenage life.' I actually went up to her, hugged her and said, 'Thank you. It's hearing your story that makes all the blood, the sweat, the tears we are putting in to making this assistance card happen worthwhile.'

You have to sort of say to people, 'I'm sorry, you have the card, but you know, see you.' Can't update it, or -

CHAIR - Do you have any further questions Tania?

Ms RATTRAY - No, I am a tad overwhelmed by what you have been saying.

CHAIR - It is quite a sizeable problem. Do you have any further questions?

Ms RATTRAY - Just very appreciative of the fact people have been so willing.

CHAIR - I am appreciative of the people who are still doing their work even though they are not funded. It seems to be the common theme which is a big ask. I know you could speak forever and you are very knowledgeable and passionate, but is there anything particular you want to make sure our attention is drawn to such as key messages or anything at all you want to leave us with?

Ms BYRNE - Thank you for the opportunity. I am not quite sure what the stages are next. I hope you can get the Tasmanian Government to listen. I hope you can get them to not just put it into the portfolio of disability. One of the issues we really struggle with is that siloing and, if I have time, can I give a brief example?

We had some Tasmanian community funding for a project which had a person working in the hospital. We find for people with brain injury coming out of hospital into the community is where they really struggle. We had a person working in the hospital, liaising with families, supporting them back into the community and linking with services. It was only a 12-month project by the time you get it up and running. We supported 87 families and had some really great outcomes. Obviously, because it was a pilot we provided all the evidence to say look this is a really great project. Went to see the health minister at the time and he said, 'Yep, Deb, really great project but it is brain injury, it is disability, you need to go and talk to the disability minister', even though we are saying, you are getting people not coming back through emergency and better health outcomes for your carers, and went to see the disability minister of the time and she said, 'Yes, really great outcomes, we know this is good - but you are working from the hospital so you need to see the health minister.'

CHAIR - Even in Estimates, I've raised transport, and everyone says, no that is a disability program, or no, it is for Transport. So, you end up - and I am sure you did the same - asking the question of everyone in the hope that you get some answers.

Ms BYRNE - I think disability is a whole-of-government response. It, and the NDIS, needs to recognise that, as you said, people with disability still catch public transport, they still go to prison, they still access our hospitals, they still access education.

I know some work has been done around that mainstream interface, but I don't think enough is being done, particularly in recognising those people who will not be eligible for a NDIS package, and the fact that only 0.06 per cent of the NDIS budget has been allocated. So that is the ILC allocation to addressing the needs of 89 per cent of your disability population.

My key message is that the Tasmanian Government still has responsibility for those people. Even though the funding has been handed over to the Commonwealth, the responsibility is still there.

Ms RATTRAY - We have heard today that the NDIS funding is underutilised in Tasmania by $140 million.

Ms BYRNE - I think some of that is about the markets, and people's access. We have found that people with brain injury, in particular, struggle with the NDIS application process.

Prior to organisations losing their funding, part of the block funding that was provided by government - services such as [Tabbas?? 4.42.14] - would be used to support people through the NDIS process. The Productivity Commission actually talked about disability support organisations - people who were funded to specifically support people through that NDIS process, because a lot of people are falling at that first hurdle, and then not going back into the process.

Ms RATTRAY - Assessments, the cost of assessments, the whole thing.

Ms BYRNE - I know that, quite often, even people with brain injury do not refer to themselves as having a disability, so once again there is a gap around that support through the process. I know it is supposed to be a role of the local area coordinators, but given everything else they have to do, it falls off the side of their desks. LACs are also meant to provide some of that information and referral, but because they don't have the brain injury expertise that we have, we might make a referral to them - because that's what we're supposed to do; we are not funded - they would then ring us and say, we need this information to respond to this referral.

CHAIR - Thank you very much Deb for your submission. In your current organisational capacity, I wish you the best of luck with the funding.

Ms BYRNE - Thank you.

THE WITNESS WITHDREW.

The committee suspended at 4.44 p.m.