

Scheme Costs:

- *Why are utilisation rates for plans so low? Are the supports not available for participants to purchase (or are there local or systemic gaps in markets)? Do participants not require all the support in their plans? Are they having difficulty implementing their plans? Are there other reasons for the low utilisation rates?*
- *Why are more participants entering the scheme from the trial sites than expected? Why are lower than expected participants exiting the scheme?*
- *What factors are contributing to increasing package costs?*
- *Why is there a mismatch between benchmark package costs and actual package costs?*

Supports are not available, service providers are full. Many plans have wrong line items in them, so while people need the supports the NDIA has approved the wrong ones. People have immense difficulty in knowing where to access supports from. In theory the NDIA is allocating support coordination (historically referred to as case management) in plans, but that assumes the support coordinator has any idea of what they are doing. In the NDIA's words of wanting to open up choice and control there are no regulations on who can provide support coordination, and there are many questionable providers out there. In order to be able to compare services, a person has to have some idea of what they should be doing and what different people do. If you have not experienced different things, you can hardly know if what someone is doing is good or not. No one questions what a support coordinator is doing; it is the persons fault for not changing to a new one. Equally how can someone with a severe cognitive impairment possibly have the ability to even exercise this choice? How can families of someone newly diagnosed know what they should be looking for? Outcomes are often very different when people have access to a support coordinator that has expertise in their condition. Equally the ability to find the supports in the plan is going to be much higher, when the support coordinator has a high level of expertise in the area. A person could need an occupational therapist, finding one who specialises in the condition is going to be much more beneficial than simply going through the phone book, and hoping for anyone at all, equally the usefulness of the support will be much higher.

The ideas behind who would enter the scheme and who is actually getting support are very different. People with very mild disabilities are getting support, including kids in which a diagnosis of autism has been given by someone, but no one can see it. Kids with mild ADHD, who have no functional limitations, mild arthritis, etc. Equally the NDIA themselves are not exiting anyone from the scheme. A child was given access to early intervention on the basis of developmental delays caused by the first years of life being spent with massive health issues, and spent much of that time at the children's hospital. The health issues are now resolved, with 12 months of early intervention therapists, being in preschool, etc, the child has now caught up. Therapists recommended exiting the child, they remain in the scheme. Many of these children should be reviewed very closely every few years, but are not being. The NDIA seems to expect people to exit themselves, why would they, parents get a few hours of respite care, - free child care from it!! The NDIA was supposed to replace state government disability services, people with mild and moderate disability were previously supported by HACC services, which still exist and funding for that is not being transferred to the NDIA, yet they are largely not servicing anyone, because the NDIA is picking them all up. Equally the community themselves is expecting the NDIA to cover

anyone, even those with the mildest of disabilities. People are expecting the NDIA to cure every social problem that has ever existed and it was never supposed to do that and never will.

Increased package costs exist because no one ever assessed what the real needs were. Figures were largely plucked out of mid-air. Equally people have very little idea on how to assess people or how to lower costs. Because of planners having such little understanding of anything to do with the person's disability, they are not knowing what to put in and what not to. People with very profound intellectual disabilities, who despite now being adults and despite the assistance of numerous of the top speech therapists have never developed any form of communication, who we know understand very little of what is said, who are not toilet trained, cannot feed themselves, cannot dress themselves, have had plans written for thousands of hours of therapy and employment support, with the goal for them to be exited from the scheme, working full time, living independently within 2 years!! This was not what the parents wanted, it was planners believing it was possible.

There are also costs being put onto plans by the NDIA. They require at times up to 5 hours of OT assessments for a \$50 item of equipment. 5 hours of OT costs close to \$900. One case a plan had one item in it which was a specialist epilepsy item and all the parent needed was the phone number of the state epilepsy service, the plan had 10 hours, \$550 of support connection, to help her to make that one phone call!! The parent was university educated!

Benchmarks are not based on real people; the tools used to assess people against benchmark are stupid. Without proper assessments being done by people who understand the disability not much is going to change. The NDIA has been designed for the wheelchair well, i.e. people who have good arm control, can toilet themselves and need assistance with basic household tasks, perhaps showering and the like. Yet those people represent a tiny number of people in the scheme. No one was prepared for the level of autism and nor were they prepared for the numbers of people with autism with challenging behaviours. The plans for these people are massive, but with very high quality positive behaviour support, good quality training and ongoing mentoring and reflective practise for staff, amazing things are possible. In the short term this would cost more, but the ongoing flow on would be much more reduced costs, higher quality of life and more integration into the community. Research has shown for more than 20 years, that with increased costs in the short term for good quality positive behavioural support, the costs over the longer term are massively reduced, yet we still ignore it and focus on controlling the behaviour¹. Very few people get this. No one would need 2 on 1 support for life, although many families and service providers believe it. At present people focus purely on symptoms without considering the person, positive behaviour support is focused on much more than the function of the behaviour and starts from what is happening when the behaviour isn't happening. People rarely if ever gain from 2 on 1, because it is always focused on protecting staff, rather than working on the underlying issues. We do have brilliant positive behaviour support specialists in Australia. Anyone that says we need board certified behavioural analysts does not understand positive behaviour support, or that we need to do more than look at the function of the behaviour and

¹ Hudson, A., Jauernig, R., Wilken, P., and Radler, G. (1995) Behavioural Treatment of challenging behaviour: A cost benefit analysis of a service delivery model. *Behaviour Change*, 12(4), 216-226

how to stop it, which is all they do. The NDIA needs to be doing more to ensure that people really are making gains and not funding 2 on 1 support without ensuring incredibly high quality positive behavioural support is in place and that it is done properly, which does not mean having workers acting as security guards around the person!!

Scheme Boundaries:

Eligibility

- *To what extent have the differences in the eligibility criteria in the NDIS and what was proposed by the Productivity Commission affected participant numbers and/or costs in the NDIS?*
- *Are there other aspects of the eligibility criteria of the NDIS that are affecting participation in the scheme (to a greater or lesser extent than what was expected)? If so, what changes could be made to improve the eligibility criteria?*
- *To what extent is the speed of the NDIS rollout affecting eligibility assessment processes?*

No one considered what was really going on, they spoke to the wheelchair well, which do not represent the vast majority of people entering the scheme. People are more severe than they expected. There is more ASD among children especially, but whether that is truly ASD is questionable. Children with mild ADHD are getting plans, people with health conditions getting plans. There are huge numbers of people with very mild to no disability getting plans. They are so focused on getting people in, that they are paying a cursory glance at them. It is all done on paper without understanding the person. The NDIA is so focused on getting plans done and people listed as participants, that they are not doing proper assessments, not reviewing those in the scheme, not doing proper planning, etc.

Early Intervention

- *Is the ECEI approach an effective way to ensure that those children with the highest need enter into the NDIS, while still providing appropriate information and referral services to families with children who have lesser needs?*
- *What impact will the ECEI approach have on the number of children entering the scheme and the long-term costs of the NDIS?*
- *Are there other early intervention programs that could reduce long-term scheme costs while still meeting the needs of participants?*

The ECEI approach has not rolled out to my area of an existing trial site. What I have read sounds better in theory than what has been happening with the NDIA for young children in the first few years of the trial. In terms of young children, difficulty getting parents to engage with the NDIA, parents must initiate it themselves, within the Victorian Early Childhood Intervention Services, anyone could refer a child to the service and then they would contact the parents to talk about what they could offer. Many children were referred by child health nurses, GP's, child care centres, preschools, etc. That has not been able to happen with the NDIA, at most they can give them a brochure about it. Equally if parents are in denial about the child having a disability, hardly going to access a disability service. The previous federal

government schemes of early childhood intervention, Helping Children with Autism and Betterstart, had much less red tape, much easier for families to navigate. While it is true the NDIA is generally offering more funding, sometimes that comes at the expense of the difficulties involved in trying to access, use and make sense of it.

Mainstream services

- *Is the current split between the services agreed to be provided by the NDIS and those provided by mainstream services efficient and sufficiently clear? If not, how can arrangements be improved?*
- *Is there any evidence of cost-shifting, duplication of services or service gaps between the NDIS and mainstream services or scope creep in relation to services provided within the NDIS? If so, how should these be resolved?*
- *How has the interface between the NDIS and mainstream services been working? Can the way the NDIS interacts with mainstream services be improved?*
- *How will the full rollout of the NDIS affect how mental health services are provided, both for those who qualify for support under the scheme and those who do not?*
- *What, if anything, needs to be done to ensure the intersection between the NDIS and mental health services outside the scheme remains effective?*

Child protection/NDIA interface is awful and not working. As soon as child protection finds out a child has funding they refuse to even investigate, serious child abuse reports. Equally even when children have been removed by child protection on court orders they are trying to get NDIA to pay for the accommodation costs for the child living in out of home care.

While child protection is the worst, there is evidence of all mainstream services trying to push things onto the NDIA, including health services, schools, etc. Schools do not understand the NDIA, and that includes special schools where every student in the school has a plan. They all have very unrealistic expectations. The NDIA really needs to appoint a school liaison.

The same is also true of the general community. Parents are not angry at the education department for not funding an aide for their child in school, they are angry with the NDIA, because the education department does not have the funding for it. Equally people expect the NDIA to pick up health system costs, etc. The NDIA was never designed or expected to make up for failures of every other service system, although everyone expects it to.

People have a complete misunderstanding of what the health system is required to provide in terms of mental health and the role of the NDIA. Huge numbers of people experience mental health issues, but for most of those people they are effectively managed by the health system. Only a very small number is actually disabled by their condition, or even if you do not want to use the word disabled, require community based rehabilitation supports in order to participate in the community.

I know a person with epilepsy. As a result of that, they take one tablet a day, never have seizures, except once when they forgot to take it, and because of that have a license and can drive a car. I also know of people who despite taking more than 10 tablets a day have uncontrolled seizures multiple times a day, they are not able to toilet themselves, cannot walk without assistance, can never be left alone. Clearly the first is not disabled, the later is

very disabled. Obviously there will be people in between. The same is true in mental health. Most people are not disabled by their mental illness and the community based supports on offer through the NDIA would largely be completely useless for them.

The NDIA is not designed and never has been designed to pay for mental health treatment needs, that remains the responsibility of the health system, the same as the health system will be responsible for the medical management of epilepsy, and other conditions.

Planning Processes

- *Is the planning process valid, cost effective, reliable, clear and accessible? If not, how could it be improved?*
- *How should the performance of planners be monitored and evaluated?*

The planning process is a joke at best and anyone should understand that. There is nothing valid, cost effective, reliable, clear or accessible about it. Most plans are wrong and so more time is spent fixing them, which only costs more than spending time getting it right in the first place.

There is no performance management of planners at all. Even when they have hundreds of complaints about them, they do nothing. In extreme cases they might move them to special projects, but they never get rid of them, although some really should never be in the job to begin with. They need to assess them on what they do in relation to different types of plans, might be ok for some disabilities, might be ok for simple plans, but not complex ones, might work well with carers, but not with the person with a disability, etc. They are not being given adequate training, mentoring, supervision, etc.

Assessment Tools:

- *Do NDIA assessment tools meet these criteria? What measures or evidence are available for evaluating the performance of assessment tools used by the NDIA?*
- *What are the likely challenges for monitoring and refining the assessment process and tools over time? What implications do these have for scheme costs?*

The assessment tools are pathetic and do not assess a person's needs or allow them to be compared to other people. Equally any assessment tool is going to be completely useless unless the person understands the person's disability and how those problems might be present, but slightly differently. You could ask can the person dress themselves and many think of it in relation to the physical task of dressing yourself. Yet for someone with an acquired brain injury or autism, they might be able to physically put the clothes on, but have no concept of how to choose clothes, how to dress for the weather, etc. Hence they might put on some summer pyjama's in the middle of winter, and not understand that they should be wearing day clothes or clothes that will keep them warm. That doesn't even begin to take into account dressing for the circumstances of where you are going to be going. People have been accused of lying when they try to explain these things in relation to saying the person has difficulty with dressing, because the person doing the assessment, was only interested in whether they could physically put the clothes on, then they wonder why the person has

higher support needs, because someone needs to be there to help them to pick out the clothes and make sure they are put on properly.

Ideally you would have them per disability, but the NDIA continues to say they are not disability specific. If you ask very broad questions and have specialist assessors, with a very in-depth understanding of the disability it might be possible, that is done in the UK and appears to work well. Within the UK the person is assessed by a specialist assessor in their primary disability and if they have other disabilities, a person expert in that must be consulted as well. They are broad open ended questions designed to allow them to get to know a person's needs. <https://www.sheffield.gov.uk/dms/scc/management/corporate-communications/documents/social-care-health/social-care/factsheets/Assessment-questionnaire/Care%20Assessment%20Questionnaire.pdf>

The UK does utilise specialist assessments to assist them in completely the standard assessment, and specialist ones for brain injury have been developed to assist with that task. I am sure others exist as well. <http://www.thedtgroup.org/brain-injury/for-professionals/resources/the-brain-injury-needs-indicator-bini/>

But as detailed in the first paragraph, unless they understand the disability in depth they do not know how to dig into what it might mean for the person, how it might manifest, etc. Equally cannot work out supports if you cannot understand it.

The UK also does a completely separate assessment of care needs for carers. <https://www.sheffield.gov.uk/dms/scc/management/corporate-communications/documents/social-care-health/social-care/factsheets/Carers-Assessment-form/Carers%20Assessment%20form.pdf>

Creating Support Packages:

- *Are the criteria for participant supports clear and effective? Is there sufficient guidance for assessors about how these criteria should be applied? Are there any improvements that can be made, including where modifications to plans are required?*
- *To what extent does the NDIA's budget-based approach to planning create clear and effective criteria for determining participant supports? To what extent does it lead to equitable outcomes for participants? What improvements could be made?*
- *What implications do the criteria and processes for determining supports have for the sustainability of scheme costs?*
- *Are the avenues for resolving disagreements about participant supports appropriate? How could they be improved?*

They have got no capacity to assess risk, support structures around a person, etc. You can have a parent with an intellectual disability and mental health issues, with no family support, they are in supposedly to prepare a plan for their child with a severe disability. The NDIA does not understand why that person might need slightly more support, than a married couple, both with university degrees and close family nearby. The NDIA's solution is to refer them to the local community, so they can join a group and make a friend, but no one considers if the person even understands what a friend is, because they could be raped by

someone, with the person saying I am your friend, they could have things stolen by someone, but they are their friend, etc. Who is protecting people from abuse and exploitation, that occurs just as much in the real world as in the disability world.

Before we consider anything else we need to consider consistency across plans, and at present that simply does not exist. Reality is the more a person can advocate for themselves the more they get, whether they really need it or not. Equally even if we refer people to disability advocacy services they need to be able to tell the advocacy services what supports they need. Those with the most complex needs are not supported by disability advocates, because they do not have the capacity to assess or understand their own needs.

There is limited guidance for planners and assessors on anything at all. The system is not designed for those who need the most help and the only option is to tell them to try harder, to make a friend, etc.

Scheme costs are going to keep spiralling out of control, because the most complex needs are not being met, so they end up costing more money, as they do not know what to ask for or how to find it, equally the most vocal advocates simply keep getting everything they want, regardless of need, because no one knows how to assess needs and simply gives them everything they want.

Disagreements about plans can only be done by those who have the means to navigate through the complex system of complaints and who have the capacity to interact competently with advocates and even have an understanding of what could be done differently.

Without highly skilled planners who understand the disability, not much is going to change.

Market readiness

Will the workforce be ready?

- *What factors affect the supply and demand for disability care and support workers, including allied health professionals? How do these factors vary by type of disability, jurisdiction, and occupation? How will competition from other sectors affect demand (and wages) for carers? What evidence is there from the NDIS trial sites about these issues?*
- *How will an ageing population affect the supply and demand for disability carers (including informal carers)?*
- *Is increasing the NDIS workforce by 60 000-70 000 full time equivalent positions by 2019-20 feasible under present policy settings? If not, what policy settings would be necessary to achieve this goal, and what ramifications would that have for scheme costs?*
- *How might assistance for informal carers affect the need for formal carers supplied by the NDIS and affect scheme costs?*

- *To what extent is the supply of disability care and support services lessened by the perception that caring jobs are poorly valued? If such a perception does exist, how might it best be overcome?*
- *What scope is there to expand the disability care and support workforce by transitioning part-time or casual workers to full-time positions? What scope is there to improve the flexibility of working hours and payments to better provide services when participants may desire them?*
- *What role might technological improvements play in making care provision by the workforce more efficient?*
- *What are the advantages and disadvantages of making greater use of skilled migration to meet workforce targets? Are there particular roles where skilled migration would be more effective than others to meet such targets?*

Aging carers is going to place more pressure on needs for workers. People with intellectual disabilities and autism are over 60% of participants in the scheme. In many cases they have enough trouble understanding what people say at the best of times, trying to understand someone with broken English, ie skilled migration, is going to be impossible for them. When they do not understand they cannot comply, hence they are subjected to restrictive interventions, not because they did anything wrong, but because they could not understand what was being said to them. There is competition with aged care, justice, child protection residential care, and aides working in child care, schools, etc.

We need to look at trying to attract workers to the industry, best done through making it a career option, not done at the moment, allowing people to complete certificate 4 which is considered the entry level qualification for free, and that includes those who already have other qualifications and which would have to pay full fees to complete the course. This has been done in terms of TAFE courses before to allow us to get workers into specific fields. Similarly the Australian government has had a HECS-HELP benefit that allowed people to lower their HECS-HELP loan by working in high needs areas, which could be done for allied health professionals, etc, perhaps even just in regional and remote areas: <http://www.studyassist.gov.au/sites/studyassist/payingbackmyloan/hecs-help-benefit/pages/hecshepbenefit>

If we support families better and recognise the issues they face, it will in the long run reduce costs to the scheme.

It used to be for mums between 9-3, i.e., supporting people in day programs. It is not the case anymore. Need to make it a career.

UK has a scheme to skill up workers. They also have processes in place to attract workers to the industry. People do an initial base level qualification, similar to our certificate 4, to give them the basic skills and understandings needed to work in the industry. They can then go on and do add on certificates at the same level, like a certificate in autism, which involves 4 subjects in autism, and allows people to become more highly skilled in supporting those people. Or a certificate in intellectual disability, which is 3 subjects. It encourages people to skill up in real ways, not through the small half day trainings that service providers might offer as professional development. Equally they have people who speak to high school students about what it is like to work in the industry. Our solution to that has been to put the wheelchair well into schools, as though they can somehow say what it is like to work in the

industry. No one goes to a hospital and talks to a patient to find out what it is like to be a nurse, they would talk to a nurse, the same can be said for any career/occupation. If we want to attract people to the industry, we need to allow them to meet people who work in it and can dispel any myths and concerns they might

up. <http://www.skillsforcare.org.uk/home.aspx>

It is not sustainable at present with the funding issues that exist.

Fixing the portal will at least allow providers to be paid, self-managing participants to claim, etc.

Will Providers be ready?

- *Are prices set by the NDIA at an efficient level? How ready is the disability sector for market prices?*
- *How do 'in-kind' services affect the transition to the full scheme and ultimately scheme costs?*
- *What is the capacity of providers to move to the full scheme? Does provider readiness and the quality of services vary across disabilities, jurisdictions, areas, participant age and types/range of supports?*
- *How ready are providers for the shift from block-funding to fee-for-service?*
- *What are the barriers to entry for new providers, how significant are they, and what can be done about them?*
- *What are the best mechanisms for supplying thin markets, particularly rural/ remote areas and scheme participants with costly, complex, specialised or high intensity needs? Will providers also be able to deliver supports that meet the culturally and linguistically diverse needs of scheme participants, and Aboriginal and Torres Strait Islander Australians?*
- *How will the changed market design affect the degree of collaboration or co-operation between providers? How will the full scheme rollout affect their fundraising and volunteering activities? How might this affect the costs of the scheme?*

Prices are not set at an efficient level for one on one supports. HACC services in Victoria currently pay \$46.37 an hour for one on one support. TAC currently pay \$45.20, and will pay more for complex needs. Yet the NDIA only offers \$42.79 for the same support. TAC also offers establishment fees for setting up supports of up to \$1,131.07. They will also pay for training of workers in specific client needs. This includes paying for the professional to deliver the training and the costs of worker hours for them to attend the training. In extreme cases you might get the NDIA to fund the trainer, but they will not pay for workers to attend, which ends up coming out of the persons allocated support hours.

Registration is technical. Issues with the portal and getting paid.

The NDIS cannot support remote communities, it is simply too complex. It is also costing more money. They can fly in a private OT to assess someone when the department of education is flying in another OT to assess the same child in school on the same day. The costs to each system is just stupid and unnecessary. You cannot have choice and control in

those locations. Equally they have no understanding of the communities, and are not looking at what has worked in the past.

Providers are not prepared for the diversity of needs entering the scheme, particularly autism. Even autism service providers have largely only worked with people with intellectual disabilities combined with autism, before and so are struggling to provide or develop supports for those who have normal or above average intelligence, but in many cases still have quite high support needs. Previously providers worked with those with physical disabilities and people with intellectual disabilities in day programs. A whole new world is needing to be established, but many continue to only work with easy clients. They are not interested in working with those with complex needs, and many publically state they will not support them. Many publically state they will not work with anyone with even elementary behaviours of concern, will not work with anyone who is not toileting themselves independently, cannot function well in groups, etc. The question remains then who supports those who have those support needs. Who works with people with communication difficulties, who works with those with challenging behaviours, who works with those who are not toilet trained. Those require more highly trained staff, but the NDIA rates do not fit with those clients. Even the high intensity rate which is not always paid for those people does not reflect their needs. Add in the need for staff to work behaviourists, to have ongoing training, which the NDIA also completely rejects. According to the NDIA the behaviourist can come in and fix the person alone, but it has to be a team effort, or it will never work. It requires ongoing reflective practice to continually talk about what's working, what isn't, what can be done differently, etc. None of those things are factored into costings, of any scheme, so rates for other similar supports in other schemes listed above also do not cost those things into them. If you wanted to cost those things into them, the rates would need to be dramatically higher than what they are, although it is probably more cost effective to pay for what is needed, rather than costing it into the base rate.

There is absolutely no cooperation between providers anymore. They kick out complex clients, saying they do not support clients like that. They do not talk to each other, saying it is not their problem.

Will participants be ready?

- *How well-equipped are NDIS-eligible individuals (and their families and carers) to understand and interact with the scheme, negotiate plans, and find and negotiate supports with providers?*

They are not ready, they are misinformed. Have very unrealistic expectations. People are either picking up fearful stories from the media and believing they will get nothing, or they are believing they will get everything they have ever wanted in life. Telling people they have choice and control, does not give them the skills to find appropriate service providers, which are much harder to find when they are full and simply tell people to go somewhere else if they are not happy with something. There is no information anywhere on how people can choose providers, what to look for in them, the sorts of questions to ask and what sorts of things you might want to consider. Equally when providers are all full, then what options are there.

Governance and Administration of the NDIS

- *Do existing administrative and governance arrangements affect (or have the potential to affect) the provision of services or scheme costs? What changes, if any, would improve the arrangements?*
- *To what extent do the reporting arrangements help to achieve the financial sustainability of the scheme? Are they too onerous or do they need to be expanded?*
- *Does the way that the NDIA measures its performance affect the delivery of the NDIS?*
- *To what extent do the existing regulations provide the appropriate safeguards and quality controls? Can these arrangements be improved?*
- *Are there appropriate and effective mechanisms for dealing with disputes with the NDIA?*

The NDIA does not measure its performance at all. Satisfaction ratings are a load of crap, not done in any real way. It is 10 questions only asked one week a month of people who go into the office, asked in person, most people are too scared to tell the truth. Equally the questions are around if the planner listened to you, let you speak, etc. Feedback has been given to the NDIA in relation to it, since the first week of July 2013, yet nothing has changed at all. No anonymous survey done of participants or families, carers, ever. In April 2015 they supposedly undertook a Cultural mapping survey, yet the results were never released.

No one is currently taking responsibility for safeguards. While states technically remain responsible, reality is they keep pushing things onto the NDIA, no one cares. There have been cases of agencies going to visit accommodation options, which are NDIA accredited providers for accommodation for a 40 year old and found an 11 year old living there, which goes against any regulations of any agencies, let alone who was funding it. The NDIA said they didn't care, not their problem, take it up the state, the state said since it was NDIA funded it was their problem. All of the adults in the accommodation had challenging behaviours, which made it even more risky for the child.

The NDIA does not wish to resolve disputes and simply blames the person concerned. They have no real dispute resolution process. Anything that is done is at a local level and there is nothing to address systemic issues at a national level. A person was allocated to a planner who did not understand anything to do with their disability or wish to understand their life. By glancing across the room at them, the planner determined that all they needed was to be referred to the local community to make a friend. The person had also requested in writing that all contact be via email, but the planner rang them multiple times. A complaint was lodged, complaining about the planner ringing them and asking for a new planner to be allocated. The NDIA's response was to get the planner the person had complained about ringing them to ring them to talk to them about it! They were further told a new planner would not be allocated, as the first one had done a good plan – cutting all current supports! Phone calls from the planner continued. The person became so scared they ended up hiding in a wardrobe every time the phone rang. They took the complaint to the Australian Human Rights Commission. The NDIA did not ask what on earth have we done to make someone so scared that they feel the need to do this, instead they viewed it as a behavioural problem. Despite having planners with a high level of expertise in the disability they never consulted them. The NDIA initially did not respond to the AHRC request for a response. When they

were pressured further they finally agreed to a conciliation meeting. A few weeks after that they finally reached and signed a conciliation agreement, agreeing to begin the planning process again, to allocate a new planner with a thorough knowledge and understanding of the persons disability. Another 3 months passed and finally the person was allowed to attend a planning meeting, or so they thought. They turned up to meet a planner who handed them a fully funded and approved plan, which was beginning that day, which had been prepared without any communication with the person at all, and which did not even list the persons goals on it. The planer had never met a person with the individual's disability before. The person took the case back to the AHRC, but it was subsequently closed, because the NDIA refused to conciliate. The person became acutely suicidal and was subsequently assisted by the CEO of a not for profit provider who specialised in the persons disability. The person now has a plan worth \$90,000, which is not luxurious in any way, given their support needs. This occurred in 2013; the NDIA has never apologised and still cannot see that they have done anything wrong. It took over 3 years before the persons phone number was removed from the system, because over 20 requests to the NDIA to do it, were never done. It finally occurred because the new portal allowed the person to update the details themselves. The person has PTSD as a result of their interactions with the NDIA and goes into acute panic each time they hear the word and refuses to have any contact with them. They have no family or friends and how have service providers doing all interactions with the NDIA. This case also highlights how the NDIA wonders how benchmarks are wrong. If you did a proper assessment of the person, the benchmark need would be high, but when you have someone who knows nothing doing it you go from a plan with nothing, to a plan of \$90,000. The person could very reasonably ask for more than that.