Kate Paterson for Council to Homeless Persons – Homelessness and the National Disability Insurance Scheme – Challenges and Solutions
1. About this Project

This project was commissioned by the Council to Homeless Persons (CHP) to gain a better understanding of the interface between Specialist Homelessness Services (SHS) and the National Disability Insurance Scheme (NDIS). Additionally, the project considers the opportunities the NDIS presents for people who both have a disability and experience homelessness as well as for the SHS sector itself and how to maximise these opportunities.

The project comprised mainly desk top research, relying on published information emanating from the trial sites, service and peak body newsletters and information from the NDIA/ State and Commonwealth Governments – as well as the consultant’s experience and knowledge of the mental health and homelessness sectors.

This was supplemented with interviews with key informants in the SHSS sector to provide an up to date perspective on implementation.
2. Understanding the NDIS

2.1 Introduction
The National Disability Insurance Scheme is a new way of thinking about, providing and funding disability support. It replaces a plethora of different State and Commonwealth programs, described as underfunded, inefficient and unfair, with a single equitable client focussed system.\(^1\)

For the 460,000 people across Australia who will be eligible for individual funded packages it potentially offers life changing opportunities for a more independent, more connected and more contributing life. For people who are homeless and have complex needs, the provision of support potentially removes a significant barrier to their capacity to maintain stable accommodation.

The National Disability Insurance Act 2013 provides the governance and rules for the scheme. The scheme is built around three key principles or “pillars”, which are critical for understanding how it works. They are:

1. An insurance approach – it must be delivered in a financially sustainable way and interventions must reduce long term costs.
2. Choice and control – about what supports are received, how they are received and who receives them
3. Harnessing the power of the mainstream - people have a right and need to be full participants of the community. NDIS will not replicate mainstream services, regardless of availability or accessibility.

2.2 The NDIS components
There are three main components to the NDIS:

1. Individualised funded packages (IFPS) – this is the most talked about part of the scheme, with eligible people receiving an individual plan which includes both funded and unfunded (mainstream) supports, available over a life time if necessary. This caters for 2.2% of the population or 460,000 people.
2. Information, linkage and capacity building (ILC) – a suite of services to raise awareness about the NDIS and disability, support the mainstream environment to be more accessible and support people to access the NDIS – including local area coordination and support to exercise choice and control. (This is for the 4 million Australians with a disability and their 800,000 primary carers).
3. Information and referral – for people who are not eligible for an individualised package.

The Local Area Coordinator is a new function which commenced with the roll out of the NDIS and will deliver most of the ILC and information and referral functions. This includes:

- Supporting people with a disability to access community and mainstream services and resources.
- Supporting people who meet the NDIS access requirements to navigate and engage effectively with the NDIS.
- Providing information on assisting mainstream and community services to be more inclusive and supportive of people with disability.
- Promote opportunities for people with disability.

2.3 What are the big changes?
The NDIS brings significant change for people with a disability and the service system. These include:

\(^1\)Productivity Commission (2011) Report on the National Disability Insurance Scheme
Roll over of Mental Health Community Support Service funding into the NDIS

Unlike other states Victoria has committed to roll all MHCSS funding into the NDIS (starting in North Eastern Victoria from May 2017). As a consequence, there will no longer be any community mental health support services providing community based psychosocial rehabilitation programs. This will significantly reduce specialist support options available to people who do not meet the NDIS access requirements.

Separation of Assessment and Planning from Service Delivery

Most Victorian services – including homelessness and MHCSS see assessment and planning as an ongoing and fluid process with a client, which aids engagement and relationship building. The NDIS undertakes this as a separate function, providing a finished plan to the participant. Only those activities funded in the plan can be delivered.

Market approach

Participants choose their provider or providers of services and enter into signed agreements. This customer driven, deregulated and competitive market place has significant implications for the way community services conduct their businesses, including the need to adapt to receiving payment after service delivery. Over time it is expected that many organisations will either merge or exit service provision in this field².

Workforce

The workforce as compared to the current MHCSS (and for many SHS) will be very different. pricing for the most common support items is likely to mean that many people currently working in MHCSS will receive lower wages under the NDIS. The scheme operates as a 95 per cent direct service provision model with little margin for non-direct service work. The pricing structure makes little or no allowance for induction, training, development, collaboration, innovation, debriefing and routine administration. A high degree of casualisation is likely³. Concerns are already being raised about whether these changes will impact on safety for participants.

2.4 NDIS implementation progress

The scheme has been trialled in various locations around Australia. Full scheme roll-out started in July 2016, and in Victoria, this is in North Eastern Melbourne. Transition arrangements for those already receiving support differ depending on what service they receive – for example existing Mental Health Community Support Service clients will not transfer across to the NDIS until May 2017, while Day 2 Day Living clients commenced transition in July.

However, the NDIS is still in its early days – the scheme is not expected to be fully mature until 2025 – and the NDIA recognises that there is still much to be done. There is a commitment to a learning and development approach to system development and this is noted in reports from both the Hunter and the Barwon trial sites. They report that a number of significant issues encountered early on have been addressed, and that the initial experiences of confusion and frustration have lessened.⁴

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² Australian Strategic Services (2016), The Journey to a customer driven, competitive marketplace... re-engineer your business model, transform your culture, reinvent your organisation (mental health/disability), Presentation by Michael Goldsworthy to PIR/ CEO Forum, May 2016.


⁴ VICSERV (2015) Learn and Build in Barwon
The learning and development approach is also evident through a number of relevant projects and reviews, including some that were instigated in response to issues being identified for people with a psychosocial disability. Some of these are still in progress and/or are yet to report. They include:

- Operational access review (initial project completed, but work is ongoing), which responds to early indications from the Barwon and Hunter trial sites that people with psychosocial disability who would have been expected to be eligible for participation in the scheme are being found ineligible or are declining to participate.
- Design of psychosocial supports – expected to be completed mid 2016; recommendations being developed.
- Measuring outcomes
- NDIS mental health workforce
- Information, Linkages and Capacity Building Framework (a draft was released, consultation completed, consultation report released and draft guidelines are available – expected to be finalised this year)

However, it also means that there is still a lot of uncertainty and a lot of issues still to be acknowledged and addressed.

2.5 How does it work?

2.5.1 Access requirements

The NDIS has strict access requirements for the individual support packages. In broad terms, to be eligible a person must:

- Be less than 65 years of age.
- Be an Australian citizen or permanent resident and be living in Australia.
- Have a disability which is attributable to an impairment or a condition which:
  - is, or is likely to be permanent
  - reduces ability to participate in activities or perform tasks unless assistance is received from others on most days or assistive technology is accessed, and
  - affects capacity for social and economic participation.
- Is likely to require support under the NDIS (and not another service system such as the health system) for a life time.

It is also possible to qualify under early intervention requirements. The eligibility criteria are similar to above but there must also be evidence that getting immediate support will help by:

- reducing how much help is needed to do things because of the disability in the future
- mitigating, alleviating, or preventing deterioration of functional capacity or improving such functional capacity, or
- helping family and carers to keep helping.

This includes early intervention for people with a mental illness, however, the operational guidelines for mental health suggest that the NDIS will generally consider that the health system is best placed to intervene for many people in early stages of mental illness. It would be expected that services such as Headspace, Child and Youth clinical mental health services and early intervention centres will be considered to be more appropriate.

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6 For more detail see NDIS, operational guideline – access- early intervention requirements (v2.1), May 2014 @ http://www.ndis.gov.au/about-us/operational-guidelines/access-early-intervention-requirements; and Operational Guideline –
2.5.2 The process
Participating in the NDIS can be summarised into five key stages:

1. **Making an application** – potential participants apply to the NDIA (current participants will be invited to apply). The application requires proof of condition or impairment, permanency and proof that it is limiting functional ability. This is largely a paper based exercise.
   Contact with the NDIA can be made by phone, email or mail, or in North Eastern Melbourne by visiting one of the LAC offices. Initial contact needs to be initiated (or agreed to) by the client.

2. **Planning** – once accepted as eligible, the planning process involves meeting with the Local Area Coordinator or NDIA to discuss needs, goals and current supports around eight life domains.

3. **Individual Plan** – this document is prepared by the LAC (or NDIA) and sent out to the participant. It will be outcome focussed, identify funded supports, may have short and/or long term supports; identify mainstream supports, can include items for support coordination and plan management.

4. **Choosing a provider** – once the participant has received their plan they must choose the providers who will deliver their funded support and initiate contact with them. The participant enters into a signed agreement with the provider/s.

5. **Review** – the plan should be reviewed annually or when circumstances change (although there is some flexibility within the support categories to negotiate changes directly with the provider).

2.5.3 What does an individual package look like?
Individual funded packages are organised around life domains and support categories according to the goals and needs of the participant. Table 1 shows this framework and provides examples of the types of support that could be available².

Individual funded supports must also meet the following criteria. They must:

- address a functional limitation
- be reasonable and necessary, and
- not be provided in the mainstream environment.

This means that the NDIS can provide supports to obtain and maintain accommodation but only when the need arises from the person’s functional limitations as a result of their disability. Similarly supports around activities of daily living or community participation will be provided but only when the need arises from the person’s functional limitations as a result of their disability – not because they do not have access to cooking facilities or because of income limitations.

According to the March 2016 NDIA quarterly report, around 70% of packages have a value of under $30,000 (20% are below $10,000 and 50% are between $10,000 and $30,000). People with a psychosocial disability (who are overrepresented among people who are experiencing homelessness) are most likely to have support allocated for the following life domains.

- Daily living – 97%
- Independence – 89%
- Community, social and civic participation – 30%
- Relationships – 25%
- Employment – 15%

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² NDIA 2015/16 guide to prices in Victoria.
• Home living – 12%
• Health and wellbeing – 8%
• Education – 0%

In relation to purpose:
• 96% of plans included capacity building support (this is often time limited and focuses on building skills and abilities to do the activity themselves or with less support),
• 72% core supports (this is usually for an ongoing need) and
• 12% capital (such as house modifications or aids and equipment).
<table>
<thead>
<tr>
<th>Support purpose</th>
<th>Outcomes framework domain</th>
<th>Support category (plan budgets)</th>
<th>What does this mean?</th>
</tr>
</thead>
</table>
| Core            | Daily Living              | 1. Assistance with Daily Life   | Help with personal care, cooking and preparing meals, household tasks etc.  
|                 |                           |                                 | Eg: $42.70 standard needs, weekdays to $92.53 weekends |
|                 | Daily Living              | 2. Transport                    | Transport costs such as taxis where person cannot use public transport because of their disability |
|                 | Daily Living              | 3. Consumables                  | Support to engage independently in community, social and recreational activities (individual and in a small group)  
|                 |                           |                                 | Eg: $42.79 standard needs, weekday $14.27 if in a group of 3; $19.37 for centre based activity.  
|                 |                           |                                 | Community and social activity costs can also be supported – eg: camps, particularly where person is very isolated.  
|                 |                           |                                 | Social and recreational participation costs are capped at $500 per annum |
| Capital         | Daily Living Home         | 5. Assistive Technology         | Support connection: assistance to strengthen ability of person to connect with informal, mainstream and funded supports. $55.61 per hour  
|                 |                           | 6. Home Modifications           | Coordination of supports: as above but includes supporting coordination of the supports. $92.27 - $175.57 per hour |
| Capacity building | Choice & Control       | 7. Coordination of Supports    | Assistance with accommodation and tenancy obligations (eg: help with obtaining and maintaining accommodation, apply for rentals, and assist with meeting tenancy obligations).  
|                 |                           |                                 | $56.61 per hour |
|                 | Home                      | 8. Improved Living Arrangements | Life transition planning including mentoring, peer support and individual skill development. $56.61 per hour  
|                 |                           |                                 | Skill development (transport, social and recreational participation) – individual or in a group setting.  
<p>|                 |                           |                                 | $56.07 individual/ $27.54 for group |
|                 |                           |                                 | Also, social skills development with an individual ($55.07 per hour) |
| Work            | 10. Finding and Keeping a Job |                                 | Eg: Employment related assessment and counselling; on the job support; employment preparation and support in a group |
| Relationships    | 11. Improved Relationships |                                 | Dietician consultation; exercise physiology consultation and in a group; also personal training. |
| Health &amp; Wellbeing | 12. Improved Health and Wellbeing |                                 | Focused on strengthening tasks associated with management of supports – eg: financial intermediary |
| Lifelong Learning | 13. Improved Learning |                                 | Choice and Control                             |
| Choice and Control | 14. Improved Life Choices |                                 |</p>
<table>
<thead>
<tr>
<th>Support purpose</th>
<th>Outcomes framework domain</th>
<th>Support category (plan budgets)</th>
<th>What does this mean?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily Living</td>
<td>15. Improved Daily Living</td>
<td>Wide range of activities – from assistance with decision making, daily planning and budgeting, individual skill development such as in maintaining home, using public transport. $42.79 per hour. Also, therapeutic support to assist in meeting goals, counselling, OT assessments.</td>
<td></td>
</tr>
</tbody>
</table>
3. Homelessness and disability - who might be eligible.

The purpose of this analysis was to estimate how many SHS clients are likely to be eligible for the NDIS. While there is likely to be a strong relationship between the number of SHS clients and those who are homeless (particularly in Victoria where the level of penetration by services is seen as high⁸) it is not a measure of homelessness per se.

The analysis seeks to identify a range which is likely to include the actual number of eligible NDIS participants within the SHS client group. At the lower estimate we have applied Productivity Commission modelling of prevalence across the general population to the SHS population. It is assumed that those experiencing homelessness have a higher rate of disability than the general population⁹, and as such this is likely to be an underestimate.

At the upper estimate we equate the SHS ‘need for core assistance’ indicator with NDIS eligibility, and add an additional provision modelled on the prevalence of homelessness amongst those with psychosis. As it is unlikely that all Victorians experiencing homelessness and psychosis will participate in the SHS, and likely that ‘need for assistance with core activities’ will not translate to NDIS eligibility in every instance, this is likely to be an overestimate, and forms the upper estimate in our range.

The 2014-15 SHS data collection identifies 102,793 individuals in Victoria who accessed SHS during that year. NDIS participants must be aged 64 years or under to access the NDIS individual funded packages. There were 98,527 SHS clients in this age range in 2014-15.

To estimate how many of these 98,527 people may be potentially meet the access requirements (be eligible) a range of data and methods were considered, and are described below.

3.1.1 NDIS/ Productivity Commission modelling

The NDIS has been planned around modelling undertaken by the Productivity Commission¹⁰ to determine what proportion of the population would be NDIS eligible. Productivity Commission modelling found that 2.2 per cent of the population under the age of 65 were likely to be eligible for NDIS individual support packages.

As such, applying the Productivity Commission’s rate of eligibility for the general population to the Victorian SHS population provides a minimum estimate in which there can be a high degree of confidence. This estimate will form the lower value for our estimate range. Applying this modelling to the 98,527 people under age 65 who accessed SHS in 2014-15 would indicate 2,167 people were eligible.

It is unlikely that the SHS population mirrors the general population in many regards, for example:

- The eligibility criteria for many housing or accommodation support programs exclude people with personal care needs and it is unlikely for people with quite severe disabilities who require support in all areas of life to experience homelessness (although they may be marginalised or receiving inappropriate care or support in other ways). On this basis it would be expected that almost no people would be in the first and largest category of “requiring daily assistance with core activities”.

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⁸ The Age, 31/7/16
¹⁰ Productivity Commission 2011, Disability Care and Support, Report no. 54, Canberra.
• The proportion of people with significant and enduring psychiatric disability may be higher as people who have psychotic disorders experience homelessness at a rate at least 10 times greater than the general population\(^1\).

### 3.1.2 Need for core assistance

The SHS data collection identifies people who need core assistance in the areas of self-care, mobility and communication. The question is conceptually comparable with “severe and profound core activity limitation” in the ABS Survey of Disability, Ageing and Carers (SDAC)\(^2\) and on this basis potentially provides a reasonable proxy for identifying potential eligibility for the NDIS.

A comparison of indicators (see Table 2) that are likely to indicate higher support needs between those that need core assistance, and those that do not, shows that there are differences between the groups, with those with a need for assistance with core activities achieving on average poorer outcomes that those without.

**Table 2: Indicators of need by assistance needed for core activities and diagnosed mental health issue (SHS 2014-15)**

<table>
<thead>
<tr>
<th></th>
<th>Need assistance with core activities</th>
<th>Does not need assistance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of people</td>
<td>3,360</td>
<td>75,533</td>
</tr>
<tr>
<td>Diagnosed mental health issue</td>
<td>40%</td>
<td>27%</td>
</tr>
<tr>
<td>Homeless: At risk of homelessness</td>
<td>39%: 49%</td>
<td>35%: 51%</td>
</tr>
<tr>
<td>Repeat homelessness</td>
<td>6%</td>
<td>3%</td>
</tr>
<tr>
<td>Top 3 reasons for seeking assistance</td>
<td>Housing crisis (21%)</td>
<td>Domestic violence (23%)</td>
</tr>
<tr>
<td></td>
<td>Inadequate or inappropriate housing conditions (14%)</td>
<td>Housing crisis (21%)</td>
</tr>
<tr>
<td></td>
<td>Domestic violence (14%)</td>
<td>Financial difficulties (16%)</td>
</tr>
<tr>
<td>Support period length over 6 weeks</td>
<td>60%</td>
<td>42%</td>
</tr>
<tr>
<td>Accommodation provided over 6 weeks</td>
<td>23%</td>
<td>12%</td>
</tr>
</tbody>
</table>

A total of 3,360 people are identified as needing assistance with core activities (see table 3). The proportion of young people – 8% of those aged under 10 years – identified as needing assistance is particularly high. It is unclear whether this an overstatement of disability (due to people confusing age appropriate need for assistance with that needed as a result of disability), or an accurate reflection of the level of disability amongst children in the SHS population. If accurate, a number of these children could be eligible under the early intervention requirements (as could the 307 people aged between 15 – 24 years with a mental health issue – although it is possible that the NDIA would identify that mental health services may be a more appropriate support provider).

**Table 3: Need for assistance with core activities by age**

<table>
<thead>
<tr>
<th>Needs assistance with core activities</th>
<th>0-9</th>
<th>10-14</th>
<th>15-17</th>
<th>18-19</th>
<th>20-24</th>
<th>25-29</th>
<th>30-34</th>
<th>35-39</th>
<th>40-44</th>
<th>45-49</th>
<th>50-54</th>
<th>55-59</th>
<th>60-64</th>
<th>total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of people</td>
<td>988</td>
<td>128</td>
<td>85</td>
<td>127</td>
<td>295</td>
<td>202</td>
<td>229</td>
<td>208</td>
<td>256</td>
<td>287</td>
<td>225</td>
<td>179</td>
<td>149</td>
<td>3,360</td>
</tr>
<tr>
<td>Does not need assistance with core activities</td>
<td>9,224</td>
<td>3,588</td>
<td>3,162</td>
<td>3,776</td>
<td>9,108</td>
<td>8,181</td>
<td>8,438</td>
<td>8,219</td>
<td>7,861</td>
<td>5,752</td>
<td>3,980</td>
<td>2,521</td>
<td>1,721</td>
<td>75,533</td>
</tr>
<tr>
<td>Don’t know</td>
<td>2,787</td>
<td>1,142</td>
<td>618</td>
<td>641</td>
<td>1,951</td>
<td>2,025</td>
<td>2,161</td>
<td>2,122</td>
<td>2,101</td>
<td>1,774</td>
<td>1,108</td>
<td>733</td>
<td>472</td>
<td>19,634</td>
</tr>
<tr>
<td>Total</td>
<td>13,000</td>
<td>4,857</td>
<td>3,865</td>
<td>4,544</td>
<td>11,35</td>
<td>10,40</td>
<td>10,82</td>
<td>10,54</td>
<td>10,21</td>
<td>7,814</td>
<td>5,314</td>
<td>3,433</td>
<td>2,343</td>
<td>98,527</td>
</tr>
</tbody>
</table>


Issues with relying on the need for core assistance as an estimate include:

- It excludes how disability restricts everyday activities in the life domain for self-management – that is control of one’s behaviour, insight, memory and decision making (e.g., ability to make decisions, including decisions with medium to long term implications or make long term plans which impacts on capacity to participate in the community). This is the life area in which people with a psychiatric disability are likely to experience the most limitation and need for assistance. It is also associated with conditions such as acquired brain injury and intellectual disability.

- The disability items were introduced for the first time in 2013-14, which means that they are yet to be well tested (for example, one question would be whether the recording of disability for children aged under 10 is accurate); and the data is incomplete with data collected for 80% of people in 2014-15. However, this is an increase from 68% in 2013-14 and the AHIW reports that over 2013-14 the response rates generally increased for those who did not have a disability, which tends to indicate that the actual numbers of people with a disability is reasonably stable and the incomplete data is not of concern.

- People whose need for support with core activities is due to a health condition (which may improve with access to appropriate treatment and hence they would not be eligible for the NDIS) may be inappropriately included.

The first two reasons would lead to an underestimate of eligibility, while the last reason could lead to an overestimate.

3.1.3 Need for assistance

Requiring support for a life time is one of the NDIS eligibility criteria. The SHS data provides insight into the need for disability and mental health support but is limited in that it does not provide any insight into the nature of the support required, for example – a need for mental health assistance might mean for health (such as from a health service or psychiatrist), or for rehabilitation and community support (such as from a community mental health support service). However, the data potentially provides a useful reference point for understanding overall demand for specialist assistance.

While 22,154 people are identified as having a diagnosed mental health issue, less than a third (8,253 people) are identified as needing mental health and/or disability assistance. The data shows that SHS are providing assistance to 4,395 (53%) people around their disability and mental health support needs. No referrals were made for 2,789 of this group indicating that the SHS may be fully (or adequately) meeting their needs (however, this is possibly optimistic as non-referrals also include if a client does not want a referral and/or specialist service providers will not accept a referral).

Current demand for specialist disability or mental health assistance (that cannot or is not being met by the SHS provider) is indicated for at least 5,440 people, comprising:

- 3,047 people who were referred for mental health and/or disability assistance
- 2,393 people who have needs but were not provided with assistance and for whom a referral was not made
Table 4: Assistance needed, referrals made and assistance provided

<table>
<thead>
<tr>
<th></th>
<th>Only disability assistance needed</th>
<th>Only mental health assistance needed</th>
<th>Disability &amp; mental health assistance needed</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assistance needed</td>
<td>365</td>
<td>7324</td>
<td>564</td>
<td>8253</td>
</tr>
<tr>
<td>Referred</td>
<td>202</td>
<td>2718</td>
<td>127</td>
<td>3047</td>
</tr>
<tr>
<td>Disability assistance only provided</td>
<td>153</td>
<td>0</td>
<td>48</td>
<td>201</td>
</tr>
<tr>
<td>Mental health assistance only provided</td>
<td>0</td>
<td>3871</td>
<td>97</td>
<td>3968</td>
</tr>
<tr>
<td>Mental health and disability assistance provided</td>
<td>0</td>
<td>0</td>
<td>226</td>
<td>226</td>
</tr>
<tr>
<td>Total</td>
<td>153</td>
<td>3871</td>
<td>371</td>
<td>4395</td>
</tr>
<tr>
<td>Referred and provided with assistance</td>
<td>57</td>
<td>1459</td>
<td>90</td>
<td>1606</td>
</tr>
<tr>
<td>% referred who need assistance</td>
<td>55%</td>
<td>37%</td>
<td>23%</td>
<td>37%</td>
</tr>
<tr>
<td>% service providing assistance</td>
<td>42%</td>
<td>53%</td>
<td>66%</td>
<td>53%</td>
</tr>
<tr>
<td>% who were not referred or provided with assistance</td>
<td>18%</td>
<td>30%</td>
<td>28%</td>
<td>29%</td>
</tr>
</tbody>
</table>

3.1.4 Eligibility for people with a mental illness

In its modelling for the NDIS, the Productivity Commission identified that the SDAC questions around disability did not adequately identify the psychosocial disability experienced by people with a mental illness.

Using accepted prevalence rates of mental illness and disability in the community, it defined people with a psychiatric disability who are likely to meet the NDIS eligibility criteria as having severe, persistent and complex psychiatric needs, equating to 0.4% of the adult population or 12 per cent of those adults with severe mental disorders (in Victoria this would be 15,840 people). These are people who:

- have a severe and enduring mental illness (usually psychosis),
- have significant impairments in social, personal and occupational functioning that require intensive, ongoing support.
- require extensive health and community supports to maintain their lives outside of institutional care.

Applying this to the SHS population, around 394 people with a psychosocial disability would be expected to be eligible. However, there is evidence that suggests higher rates of homelessness among people who have a serious mental illness\(^{13}\) and that while the prevalence rate of any mental health disorder is similar for people who are homeless and those who are not, people who are homeless are more likely to have a serious mental illness\(^{14}\).

The 2010 Second National Survey of people living with psychosis identifies that 5.2% of people with psychosis (and who are public mental health clients) were homeless at the time of the survey, and 12.8% had been homeless in the past year. Further to this:

- 5.1% reported primary homelessness (rough sleeping on the streets, in parks etc)
- 6.8% reported secondary homelessness – living in temporary shelters such as refuges, emergency accommodation or sleeping on a friend’s couch; and
- 0.9% had lived in marginal accommodation.

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This means that the experience of homelessness for people with psychotic disorders (nationally) is at least 10 times higher than the general population.

Applying these understandings of likely eligibility and homelessness provides an indication of how many people with a mental illness are likely to be eligible for individual packages (see table 5).

Table 5: Estimating homelessness in the population of people with severe and enduring mental illness in Victoria

| Estimated Victorian population 15 - 64 years (2015) | 3,960,019 |
| People with a severe and enduring mental illness (likely to be psychosis) (0.4%) | 15,840 |
| Homeless in any one year (12%) | 1,900 |
| Homeless at any point in time (5%) | 792 |

As the SHS data already identifies 1,340 people with a mental health diagnosis and needing assistance in core activities (1,258 who are over 15 years of age), this will be a subset of the estimated 1,900 people. Therefore, adding another 642 people to the potential eligible group.

Issues with this approach include:

- It is possible that applying national survey figures to Victorian data overestimates the level of homelessness within this population. Victoria’s homelessness rate is slightly lower than the national rate (0.42% cf 0.49%),\(^\text{15}\) and Victoria also has some dedicated clinical resources to work with people who are homeless and have a severe mental disorder (through its Homeless Outreach Psychiatric Service teams).
- The SHS population does not represent all homeless people, and as a further analysis of the National Survey data showed, this client group was less likely to be accessing any community support services.

3.2 Results

Table 6 provides three different methods to considering the potential eligibility for the NDIS. All are based around the categories used by the Productivity Commission in its estimation of eligibility.

Method 1 assumes the SHS population has the same distribution of disability as the general population. This is flawed due to the SHS population not mirroring the general population (see discussion at 2.1.1).

Method 2 is based on those identified in the SHS data collection as needing assistance with core activities. While this provide a conservative estimate, this item does not capture people who have self-management issues — such as those which may arise from a psychosocial disability or an acquired brain injury. All children aged under 10 years and needing core assistance are recorded in the early intervention category.

Method 3 adjusts the proportion of people in the significant and enduring psychiatric category based on population estimates of people likely to be eligible and their experience of homelessness.

\(^{15}\) National rate of homelessness 48.9 per 10,000; Victoria 42.6 per 10,000. Source: Australian Bureau of Statistics (2012): 2049.0 - Census of Population and Housing: Estimating homelessness, 2011
Table 6: Summary of estimates for eligibility for the SHS population 2014/15

<table>
<thead>
<tr>
<th>Category</th>
<th>Method 1</th>
<th>Method 2</th>
<th>Method 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Victorian population</td>
<td>Applied to 2% of the SHS population 0-65 years</td>
<td>People needing assistance with core activities</td>
</tr>
<tr>
<td>Require daily assistance with core activities (54%)</td>
<td>60,000 (54%)</td>
<td>1170 (54%)</td>
<td>1,091 (32%)</td>
</tr>
<tr>
<td>Self-management limitations - but not daily support for core activities (12%)</td>
<td>13,000 (12%)</td>
<td>260 (12%)</td>
<td></td>
</tr>
<tr>
<td>Significant and enduring psychiatric disability (14%)</td>
<td>15,500 (14%)</td>
<td>303 (14%)</td>
<td>1,281 comprising: -951 (over 24 years) -330 (aged 10 – 24) who might qualify for early intervention or not at all (38%)</td>
</tr>
<tr>
<td>Early intervention (20%)</td>
<td>22,000 (20%)</td>
<td>433 (20%)</td>
<td>988 (29%)</td>
</tr>
<tr>
<td>Total</td>
<td>110,992</td>
<td>2,167</td>
<td>3,360</td>
</tr>
</tbody>
</table>

In line with the expectation that the SHS client group would be different in its characteristics and needs to the general population with respect to the criteria used by the Productivity Commission in its modelling, the proportion of people requiring daily assistance with core activity, or who have self-management limitations but not daily support for core activities is lower and the level of significant and enduring psychiatric disability is higher.

That it appears that there may be more people (particularly young people) who may be eligible for early intervention amongst the SHS population than the general population is interesting – and requires further examination.

In addition to the issues and concerns with various parts of these estimates, it is also likely that people with an acquired brain injury have not been adequately identified due to not having a mental illness or needing assistance with core activities.
4. Accessing and participating in the NDIS – opportunities and issues

There is very little information about people who are homeless and who are accessing the NDIS. At this stage of roll out, at the time of writing this report, very few people have transitioned across in Melbourne. Both the Barwon and the Hunter trial sites have produced reports with regards to the experiences of people with psychosocial disability and the agencies which have been working with them. These provide the most insight into what some of the opportunities and issues might be for people who are also homeless. SalvoConnect in Barwon – which provides a ranges of services including SHS intake and assessment – has also identified issues for their clients through a range of submissions, and senior staff were interviewed about their experiences for this project.

4.1 The opportunities

*From the Hunter trial…*

A homeless man with numerous physical health problems and also mental health and substance misuse issues approaches a local emergency services program for housing assistance. He is deemed ineligible for transitional housing as his support needs are too high, and is referred to NDIA where he is assessed as eligible for Tier 3 funded services. While the Agency is unable to assist with permanent housing as this is a housing sector responsibility, he is helped to access the emergency service provider’s transitional housing program with four hours a day of additional support funded by the NDIA. Because the support chosen by the man is 7-9 am and 5-7 pm, and the service is traditionally staffed 9 am to 5 pm, they successfully explore options for flexibly expanding their operating hours. (Mental Health Coordinating Council, 2015)

Reports from the Barwon and Hunter trials both identify success stories for people who are homeless and/or at risk of homelessness – and as this example from the Hunter region shows, it will and can make a significant difference for people who have a disability and experience homelessness. The Barwon report identifies that participants have benefitted from the flexibility and choice and have changed providers and/or are receiving a very different suite of services to which they had previously.

The person centred approach means that supports can be tailored to the individual’s needs – thus enabling the provision of support that may not have been previously available. One notable example, is practical and ongoing support for hoarding behaviours allowing people to maintain their accommodation.

The NDIS operational guideline in relation to the interface with housing and community infrastructure, identifies that the NDIS is likely to fund:

- personal and domestic assistance that is provided to assist participants with ongoing functional impairments and allows the participant to live independently in the community; and/or
- supports which build a participant’s capacity to live independently in the community where these needs arise from a participant’s functional impairment including; and/or
- supports which assist a participant to obtain and maintain accommodation and/or tenancies where these needs arise from a participant’s functional impairment.

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16 VICSERV (2015). *Learn and Build in Barwon*. Psychiatric Disability Services of Victoria
The NDIS will also fund the additional cost of accommodation (user costs of capital) in some limited circumstances (however, this is unlikely for most people who are homeless - see later discussion at 5.2 about this).

4.2 Risks and issues

Underpinning the risks and issues for people who have a disability and experience homelessness in accessing and participating in the NDIS is that the NDIS has not been designed for people who are homeless and does not specifically identify or target people who are homeless. It would appear that homelessness as an issue in itself and the impact it may have on accessing the NDIS has not been an active consideration in its current administration. At this stage there is very little discussion or discourse about the interaction of the NDIS with people who are homeless.\(^{17}\)

Table 7 provides a summary of the potential issues and barriers for people who have a disability and experience homelessness at each of the NDIS stages. Key issues are explained in more detail below.

4.2.1 Exercising choice and control

In line with the key pillar of choice and control, participation in the NDIS is also appropriately voluntary. However, how this dimension is reflected in the service model – one which relies on an individual having capacity or willingness to access and participate – inevitably creates a significant barrier for many people who experience homelessness and have a disability.

This capacity and willingness to access and participate (and therefore opportunity to exercise choice and control) is likely to be severely reduced for people who are socially marginalised and resistant to engaging with services, often as consequence of histories of trauma and/or previous poor experiences with health and community services, and for those without the social cultural literacy required to understand and make systems like the NDIS work for them – this lack of capacity contributing to the ongoing perpetuation of their social disadvantage and exclusion.\(^{18}\)

In addition, there is some evidence that people with psychosis and the highest psychosocial needs are less likely (despite their needs) to be accessing community based support. The authors surmise that these people, possibly because of their psychosocial disability, are least likely to want to engage with services and less able to engage with services (eg: such as through using the telephone).\(^{19}\)

The impact is compounded through structural issues which make service access reliant on an address, making and turning up to appointments, or making a phone call – all of which are more difficult when homeless and the lack of family or friends who can proactively assist and advocate on the person’s behalf.

Homelessness services use a range of evidence based practices such as assertive outreach, continuity of care, relationship based work, and persistence to engage people who may otherwise choose to be disengaged – to directly address these issues. The lack of specific focus to engage and get people ready,

\(^{17}\) A google search on the terms homelessness and the NDIS identifies very little relevant material, and of which the most relevant is the operational guidelines regarding the interface with housing and homelessness services. When inappropriate accommodation is mentioned it usually refers to a young person in a nursing home, not a crisis shelter or substandard rooming house; complex needs is likely to mean having health and multiple disabilities – not as a result of experience of family violence, homelessness and incarceration.


\(^{19}\) C Harvey, L Brophy, S Parsons, K Moeller-Saxone, M Grigg, D Siskind (2016) People living with psychosocial disability: Rehabilitation and recovery-informed service provision within the second Australian national survey of psychosis. \textit{Aust N Z J Psychiatry} June 2016 50: 534-547
willing and able (including for people who are not homeless) to access the NDIS has been identified as an issue by the Barwon providers\(^\text{20}\).

### 4.2.2 Knowing about and making contact with the scheme

People need to know that the NDIS exists and it is relevant to them. This includes having an awareness that they have a disability (or willingness to acknowledge that they have a disability) and that the NDIS has supports that would be valuable for them.

The Barwon trials identified this as an issue, and contributed to people declining to participate. Potential participants were invited to participate by mail and many chose to ignore the letter, or felt that it was not relevant to them.

The reliance on the mail has continued into the roll out and this has already been identified as an issue for at least one homelessness service with its clients not receiving transition letters due to not having access to a post box or safe delivery of mail, and/or who had changed their address. For this agency, they also noted that some clients did not respond to the letter because it was in English and/or they had poor literacy skills.

The responsibility for engaging and supporting with hard to reach groups sits with the Local Area Coordinator and should be a responsibility under the Information, Linkages and Capacity Building function (for which the framework is still be released, see section 6.3 later for more information). It is unclear what response or planning will occur to engage those who experience homelessness. However, the North Eastern Melbourne roll out supplements telephone contact with a “walk through the door” option which may make finding out about the NDIS easier for some people.

The language of permanency is also identified as an issue for some people, particularly younger people, and results in them not engaging with the scheme.

### 4.2.3 Assessing Eligibility

Assessing eligibility for those with a psychosocial disability was an issue identified early in the trial sites with people who were expected to be eligible for participation in the scheme found to be ineligible or declining to participate\(^\text{21}\). In response, the NDIA undertook an operational access review to look at access, pathways into the scheme and how it relates to the broader service system. The Independent Advisory Council (IAC) for the National Disability Insurance Scheme (NDIS) also noted issues associated with identifying permanency – including that some people may have ongoing functional limitations as a result of their illness (even if the illness is not ongoing), need for mental health related support items (including peer support, life coaches) needs, capacity to respond to quickly changing needs, defining what are reasonable and necessary supports. The review has been completed but the outcomes of the review, apparently under consideration, have not been made available.

At the March 2016 MHRG meeting it was noted that trend of alignment between emerging trial site data and the Productivity Commission’s initial estimates of overall percentages in relation to people with psychosocial disability – suggesting that there has been some changes to the way the scheme is assessing eligibility in this area.

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\(^\text{20}\) Phil Dunn, Presentation at VICSERV NDIS forum 2015

\(^\text{21}\) In December 2014, Barwon mental health services reported that 49 people who were eligible for the NDIS had declined or withdrawn from the service and another 46 people who had received mental health support under the previous system no longer qualified for support under the NDIS (Salvation Army).
However, the experience in Barwon is that while there have been some improvements—there are still some significant issues. The Salvation Army in its 2015-16 Budget submission identified that many of its clients with a mental illness, regardless of whether diagnosed or not, were not getting access as a result of their disability not being considered permanent. Another provider in Barwon has also reported that there is a skill disparity in identifying consumers with episodic disorders, due to varying skill levels of NDIS planners.

4.2.4 Proving permanency and eligibility

While it appears that there have been some issues associated with the NDIA processes and criteria for assessing eligibility and which are under review/ have been reviewed; providing proof of condition, impairment and permanency remains a significant barrier for a number of people with a psychosocial disability and who experience or are at risk of homelessness.

The difficulties are compounded where people don’t have an ongoing (or any) relationship with a health provider (making establishing their condition and permanency difficult in the short term), requiring them to initiate contact, make and get to appointments. Costs may be associated with specialist assessment processes. For some people this is too cumbersome, confronting, expensive and overall difficult.

In addition, where needs are very complex and multifaceted, there appears to be difficulties in attributing functional limitations to a particular condition, and/or there are difficulties in obtaining a diagnosis. While in part some of these issues are supposed to have been dealt with through the operational review, anecdotal reports suggest that people are not being accepted as eligible without a diagnosis.

4.2.5 Getting a plan that meets your needs

There is concern that even if a person gets through the eligibility process that they will be unwilling to participate in the planning and/or will not participate in such a way that ensures that they get a plan that meets their needs.

The reports from Barwon identify that those people who got plans that met their needs attributed it to the role their support worker played in advocating for them and assisting them prepare for their planning meeting. Reports from providers suggest that people need to be able to articulate what their needs are on their worst day and be clear about what support they want and how much they need.

For people who are socially and economically marginalised, specific issues include:

- A lack of trust and/or relationship with the planner which means they may not attend the planning meeting or fully disclose their needs and issues. This can be compounded by a deficit approach to planning, rather than the strengths based approach used by other service systems.

- Being able to prioritise and articulate future life goals and separate out needs related to their disability from other needs in a context where many basic needs – such as housing and safety – may not be being met and/or the planning process is not able to address these basic needs.

It appears that there is an expectation that a person’s needs are relatively easy to define. However, people with a disability who experience homelessness may also have a range of needs which are not necessarily related to their disability and may be complex to understand. The NDIS processes are not set up for such a comprehensive assessment. Anecdotally, providers are reporting that this is resulting in simplistic plans that do not address some core needs (such as accommodation).

The need for support coordination which assists people to link with their providers and reduce impediments to accessing their supports is identified as increasingly important for many people with a psychosocial disability. In the context of supporting people who may be reluctant to engage with new

22 Salvation Army Victorian State Budget Submission 2015/16 (p29)
services inclusion of this support category is likely to be integral to ensuring some resource is directed towards managing the relationship between provider and client.

The community mental health support service providers also remain concerned about the lack of capacity within the scheme to provide support items which will allow for the employment of staff with skills in psychosocial rehabilitation and working with people with complex psychosocial needs.

4.2.6 Finding a service or support that meets your needs

There are no reports that services are not responding to people who are homeless, and in the trial sites most of those who are receiving services have transitioned with many remaining with their existing provider (although not all). The NDIS support system is also designed to be flexible to respond to different needs and while it assumes that much of the support will be delivered in a participant’s home, there is no requirement for it to be so.

However, the capacity and willingness of NDIS providers to provide support to people who are not in stable housing or have no dwelling (or whose needs are complex due their homelessness as well as their disability) is still to be tested.

This raises many issues, including:

- having the service model and flexibility to deliver support to people who are not in stable housing or do not have a dwelling
- being able to work with people whose needs are complex due to their homelessness and other social or economic factors rather than functional limitations due to disability
- ability to manage the financial risks of a service/organisation associated with people potentially not showing up/or being available for appointments.

The expected high level of casualisation in the workforce is likely to make it more difficult to develop a trusting relationship between client and worker, thus reducing the suitability of the service to the participant (and their willingness to enter into an agreement with the provider).

Additionally, if a person is felt to be unreliable at keeping appointments it is possible that providers may choose to not work with them due to the financial risks (participants need to enter into a signed agreement with a provider around what will be delivered and when, and failure to receive the supports as agreed can lead them to be cancelled - eight cancellations will be tolerated).
Table 7: NDIS pathway components and issues and barriers

<table>
<thead>
<tr>
<th>NDIS pathway components</th>
<th>Issues and barriers for people who are homeless</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Access (transition clients)</strong></td>
<td>Assumes that the client is literate and/or literate in English; will understand the intent or purpose of the documentation and is at the same address (or has a forwarding address). In Barwon and in the current roll out, services report that many clients either ignored or threw out the package of information.</td>
</tr>
<tr>
<td>- Invited to participate through mail (package of information sent, including planning workbook). - Information cannot be sent through service or accessed independently</td>
<td></td>
</tr>
<tr>
<td><strong>Access (new clients)</strong></td>
<td>Participation is completely voluntary. Assumes that potential client knows about the NDIS, understands its value and its relevance to them and will want to contact. The NDIA (or LAC) does not have an assertive, engagement based approach to encourage and support people to make contact. However, the new LAC premises may provide a more welcoming environment for people to consider making first contact</td>
</tr>
<tr>
<td>- Client must initiate contact (or someone else on the client’s behalf with their consent) - Client must check if they meet requirements on web based access checker. - Potential participants call the NDIS and can answer questions over the phone and/or fill out a form. - In North Eastern Melbourne potential clients can also visit a shopfront.</td>
<td></td>
</tr>
<tr>
<td><strong>Making an application</strong></td>
<td>There are specific issues in relation to mental illness and psychiatric disability that are still be worked through by the NDIA – particularly regarding trying to get a consistent definition and understanding of severity and permanency. Issues for people who are homeless include: - not having relationship with health provider in order to get the paperwork complete - knowing who to see to get the correct information, and - potential expense involved in visiting specialists (and additional difficulties re making and getting to appointments) Also, high level of complexity for some people may make it difficult to get a specific diagnosis and therefore to prove “functional limitations” as a result of a permanent condition or impairment (ie: could be complicated by alcohol or drug (AoD) issues, homelessness).</td>
</tr>
<tr>
<td>- Paper based - Requires proof of condition or impairment, permanency and proof that it is limiting functional ability. - Some conditions automatically qualify you for support (eg: some genetic or physical conditions)</td>
<td></td>
</tr>
<tr>
<td><strong>Planning</strong></td>
<td>An expectation that the applicant is able, or willing, to participate in assessment and planning activities with a person with whom they have no established relationship. The planning discussion usually occurs over one meeting (but more can be organised if needed). May be difficult to identify life goals in context of not having basic needs met. Person needs to be able to articulate what their needs would be on their worst day. This deficit focus and language of permanency can create an additional barrier.</td>
</tr>
<tr>
<td>- Once accepted as eligible, participant is invited to a planning meeting - Complete workbook beforehand, bring in any existing plans - LAC can help with pre planning as well as planning (including pre planning capacity building and linkages) - Identifies needs, goals and current supports - Plan submitted to NDIA for approval</td>
<td></td>
</tr>
<tr>
<td><strong>Individual plan</strong></td>
<td>Usually very specific; some but limited flexibility to change supports once completed. Funded supports are only around functional limitations due to disability; however, a person with complex needs may require a more comprehensive assessment and plan.</td>
</tr>
<tr>
<td>- Developed by LAC - Around domains, outcome focussed - Includes funded/unfunded supports</td>
<td></td>
</tr>
<tr>
<td><strong>Choosing a provider</strong></td>
<td>The NDIA send the participant a copy of their plan, and they must then initiate contact with providers. In the Barwon trial some participants did not open this correspondence, or take action on it. Uncertainty as to whether there will be a provider/providers who are willing to work with people who are homeless and can provide</td>
</tr>
<tr>
<td>- Participant chooses who delivers funded support - Most will enter into a signed agreement with provider - LAC can assist with this process</td>
<td></td>
</tr>
</tbody>
</table>
creative options for support around activities of daily living when a person does not have a house/home or cooking/shower facilities etc.

Pricing levels raise issues about whether staff will have the specialised skills necessary to work with people with very complex needs at wages possible within the NDIS

Likely to be a high level of casualization in the workforce making it difficult for there to be consistency of workers.

<table>
<thead>
<tr>
<th>Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Can happen when circumstances change; plan stays static until this time</td>
</tr>
</tbody>
</table>
| Some (but limited) flexibility in the plan to respond to changing needs. 
Eight “no shows” are allowed per annum without financial disadvantage to agency or participant – this includes if a worker turns up as agreed and person refuses to receive the support or is not there, but plan likely to be reviewed and if not being used there is a potential for it to be reduced. |
5.0 Implications for people experiencing homelessness and Specialist Homelessness Services

5.1 Not everyone will meet (or test) the access requirements

The introduction of the NDIS is likely to change demand patterns in homelessness services. Of particular concern is the potential demand from people with a mental illness who are not eligible for the NDIS and/or who choose not to/ are unable to test their eligibility.

People with a mental illness are already a significant component of the SHS population. Currently, 53% receive assistance for their issue from SHS services and 37% are referred. It would appear that around 29% are not having their needs met at all.

Some of these people may only need support from health services (eg: a clinical mental health service). However, there will also be people who may be eligible but choose not to (or are unable to) test their eligibility. Given that within the current system there are 2,393 people for whom the SHS services are unable to respond to their needs and they are not being referred (including because the person does not want to be referred or the referral is not accepted), it would suggest that this latter group could be quite high.

The Information, Linkages and Capacity Building (ILC) function will provide some support for people who have a disability but are not eligible for individualised packages – although at this stage it is unclear what this support will look like, how it will link in with the mainstream system and what support will be available beyond providing information and helping to make mainstream services more accessible. Similarly, given that there will no longer be any community based mental health programs in Victoria, it is unclear what alternative supports will be available for people with a psychosocial disability.

It is likely that the homelessness service sector will be the “last resort” or “catch all” response option for people who have a psychosocial disability who are not receiving services through the NDIS.

5.2 Demand for affordable housing will increase with possible flow on effects into the SHS sector

The NDIS will profoundly affect patterns of housing demand by people with a disability and for housing assistance generally. The provision of ongoing support will remove one of the barriers to independent living – and potentially enable people to move from their parents’ home, or from group homes or institutional accommodation, to independent living in the community. Estimates about how this demand for affordable housing will play out vary but are in the range of 83,000 – 127,000 for Australia (it is unclear what it is in Victoria).

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25 Bruce Bonyhady Chairperson of the National Disability Insurance Agency in August 2014 identified unmet need for affordable housing for 127,000 NDIS participants (ie 198,000 – 14,000 in group homes - 57,000 in social housing = 127,000); The National Affordable Housing Consortium says that the SDA signifies the most transformative growth in housing supply for people with a disability in decades, but that 35 000 to 55 000 NDIS participants will not have their housing needs met in the first decade of the scheme (Disability Housing Futures Working Group, 2016); AHURI identifies that at full rollout of the scheme (2019), there will be an unmet need in affordable housing for 83 000–122 000 participants.
The NDIA funded Specialist Disability Accommodation (SDA) is only intended for housing where specific design elements are required that will not be provided in the mainstream environment, and which meet the needs of people with highly complex physical, intellectual and/or cognitive difficulties. The SDA will provide a total of 27,600 places, however this needs to provide for people already in some type of specialist type of accommodation. The real increase is only around 3,800 places.26

While unmet need for affordable housing is an issue for people who receive NDIS support and will limit their opportunities to live an “ordinary life”, it will also create pressure on waiting lists for social and other low cost housing, and there is a likely flow on effect of increased proportion of people who are likely to experience homelessness (and demand for SHS support).

The issue of a lack of affordable housing is widely recognised, including by the Joint Standing Committee for the NDIS, which undertook a review into housing affordability for NDIS participants in 2015, and the 2015 Senate Economics Reference Committee report on “The Australian Housing Affordability Challenge”. COAG is expected to receive a report on reforms to housing and homelessness, in the context of existing work on housing affordability, at the end of 2016.

The NDIA continues to state that it “will work closely with states and territories, housing authorities, and communities to identify opportunities to address the broader accessible and affordable housing challenges for people with disability”27. However, it is unclear in what capacity this is happening and if and how it links to the broader affordable housing agenda; and there is lack of policy clarity about the roles of Commonwealth and state governments in providing housing assistance for NDIS participants.

5.3 Making it work – opportunities and challenges

Specialist Homelessness Services are designed to be a last resort service option providing short to medium term interventions to assist people to move out of homelessness. Connecting clients to the services and supports they need is integral to this process, and this work must now include supporting them to connect to the NDIS.

The changes to existing pathways and challenges and the upheaval for clients, support workers and partnerships under the NDIS are significant. However, SHS are also well placed to work with the NDIA and NDIS providers to support access and overcome the barriers to participation as outlined in section 3.

Information and awareness

The Initial Assessment and Planning (IAP) workers at homelessness system front doors could inform people about the NDIS and encourage access where appropriate. However, IAP workers lack the time needed to undertake a warm referral or to actively support someone to take the next step in making contact with the NDIS or testing their eligibility.

Co-location of community mental health support workers at homelessness service access points has in the past been shown to be effective at linking people with mental illness and/or psychosocial disability to relevant mental health support.28 A similar arrangement within the NDIS may be required.

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26 In line with the 6% of people requiring SDA, 27,600 places are expected to be available by 2020. This will provide for the 14,000 already in group homes, the 3,000 in institutions and 6,200 in residential aged care, leaving an additional 3,800 places. Based on the figures above it leaves an estimated 117,000 people who will have an unmet need for affordable housing.


28 The value of this function was noted by SalvoConnect (Barwon); and was identified as a loss following the recommissioning of the MHCSS in Victoria (and did result in MHCSS providers and intake providing a presence at homelessness services for this purpose).
Supporting access

Reports from the trial sites have suggested the need for significant practical assistance to support people through NDIS assessment and planning. This has included helping to obtain and collate evidence (including attending appointments to explain to GPs what they needed to do and why), providing copies of existing plans, assisting the participant to understand and articulate goals and attend planning meetings.

Both the Barwon and the Hunter trials note that this can be very time consuming and intensive.

During transition, it would be hoped that the case manager would be working with any existing disability support provider to ensure that their client makes the transition successfully – including ensuring that mail is received and opened, that appointments are kept and that any existing plans are taken into account. Advice from the Barwon providers is that transition is more successful if support to obtain and collate necessary information occurs at the outset.

Support Coordination and Access

A potential role and change for SHS case managers will be working alongside the NDIS support providers. This could take a number of forms and is likely to change depending on whether support coordination is included in the package and whether the homelessness support is identified as a mainstream short-term support within the package.

Case managers may find that the NDIS plan and subsequent supports only address a small proportion of the person’s issues, and that they will undertake service coordination as they do now.

They may also find that they are identified as being part of the support network within the NDIS plan and will be being “coordinated”. In addition, consideration to potential roles could include:

- in assisting in locating a client or advocating for the client with regard to how and when they should receive supports
- supporting the client to receive the services, for example encouraging them to attend appointments – or making timely cancelations, providing warm handovers – supporting continuity of care.

Alternatively, there is a risk that the plan does not include support coordination despite all or most of the supports the person is receiving being through the NDIS. Consideration as to the appropriateness of the case manager remaining involved and/or seeking review of the plan would be needed.

Support around housing access is likely to be key. With access to ongoing and guaranteed support – including tenancy support, it is possible that there are opportunities for stable accommodation which may not have been available before and may require a different approach.

Nomination rights

Some transitional housing places are reserved for people receiving support from particular support service providers (called nomination rights). This link between housing provision and support will no longer be possible for supports, such as mental health community support programs, which are transitioning into the NDIS, as the NDIS enables participants choice of service provider. This means that a person already in housing may change their provider, and means that service providers cannot guarantee that they will continue to provide support.
6.0 Homelessness services delivering the NDIS

6.1 Specialist Homelessness Services as NDIS support providers

The NDIS is a new funding stream and as such provides an opportunity for growth for interested services. Some SHS providers have a history of providing psychiatric disability rehabilitation and support/mental health community support – the NDIS is expected to replace many of these services.

The NDIA has a wealth of information to assist organisations to transition to becoming providers of NDIS funded services, including checklists for readiness. Areas for consideration include accounting, reporting and quality management systems, financial viability and staffing changes. In the Barwon trial site, PDRSS programs were block funded through the trial due to the difficulties in making the transition to the lower per hour funding levels, the output based funding model and staff arrangements. As a result the funding model for working with people with a psychosocial disability is only just being tested now.

Additional and particular issues for homelessness services in considering whether to become a NDIS support provider (for people who are homeless) will be:

**Managing the risk associated with “no shows”**

Clients enter into an agreement with the NDIS service provider to receive agreed supports. A “no show” is when the client does not cancel the service in a timely manner (usually 24 hours) but does not receive the service – including because they are not at the agreed place for the service to be received and/or they refuse to receive the service. The expectation is that the service will work with the individual to minimise this happening and that they will actively follow up with the individual to ensure that they are OK – none of which is funded. The NDIS allows for eight no shows before there is a review.

The risks for the agency include that the funding allocation is cut on review and/or that they spend a lot of time chasing the individual and managing the situation so that they receive the service.

It is possible that the inclusion of “support coordination” in the plan to ensure that support is received may assist in addressing this issue.

**Workforce**

The NDIS workforce is likely to be more casual, involve outside business hours work and, for some workers, a lower hourly rate. It is unclear to what extent the current SHS workforce would be able (or willing) to transfer their skills into the NDIS workforce.

**Separation of housing and support services**

If an SHS is also a housing provider, there must be adequate separation between tenancy and NDIS support functions. It is important that there is no real or perceived conflict of interest between these two roles.

**Separation of NDIS and specialist homelessness support services**

A key principle of the NDIS is that it does not replace existing services or services that should be provided by other parts of the service system, regardless of accessibility or availability. The interface between

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29 Since moving to the full NDIS model in July 2016, one large local provider “Pathways” has announced that it is under administration.

30 MHCSS organisations participating in the trial have identified a change in the nature of work and a need to recruit based on “relationship skills” rather than skills to respond to mental health needs (Community Mental Health Australia (2015).
homelessness and the NDIS is yet to be really tested and there is a risk (at least in the short or medium term) of some pushback from the NDIS to the homelessness service system.

On the other hand, homelessness services bring a particular approach and philosophy of working with people who are homeless and there is perhaps an opportunity to think about delivering some “non-traditional” support models, which fit into the NDIS model. These could include, for example, support for people to use public washing facilities, centre based daily meal preparation programs and/or mentor/peer support programs for people who are homeless.

SHS providers also bring expertise and experience in relation to the coordination of supports and to tenancy support and management, including in relation to private rental, which could assist people with a disability who have complex needs but for whom homelessness is not an issue.

Table 1 provides a summary of the types of support likely to be funded under the NDIS – see also discussion under 2.3 – what does an individual package look like.

6.2 As a Specialist Disability Accommodation Provider

Specialist Disability Accommodation refers to specialist designed housing—including land and built form (user cost of capital)—for NDIS participants requiring integrated housing and supports, due to their significant functional impairment and/or complex needs. It includes both existing specialist accommodation where people are currently living, as well as new and innovative models that are not yet widely available.

It responds specifically to the provision of housing where the housing need is specifically related to the disability, the need will not be met by the market and/or where it responds to support needs for which it would be unreasonable to meet in another way. The focus of much of the SDA housing is on providing for people with physical, sensory, intellectual or cognitive impairment who need significant design features for accessibility. SDA responding to other disability related needs such as ensuring availability of shared support or to meet particular privacy or location needs is not available for new builds (but is for existing stock).

It is expected that most SDA housing will provide for people who need 24 hour support (or access to 24 hour support), and as such will only be suitable for a very small proportion (if any) of the people who are homeless and have a disability.

Funding for new builds is seen as competitive – the NDIA explains that SDA pricing framework is set to provide an incentive to a broad range of potential investors to respond quickly in constructing new properties to provide for unmet SDA demand. The price for existing stock is lower and provides yields more in line with the established rental market to ensure owners have a financial incentive to retain participants for as long as they choose.\(^{31}\)

However, as with all aspects of the NDIS the funding is tied to the individual and therefore occupancy rates. The person’s package needs to reflect that the accommodation is required and that person needs to choose the accommodation setting. While demand is high, reducing the risk of low occupancy rates overall, risk of low occupancy may be increased by too specific targeting (e.g., people who are also homeless).

The NDIA prefers that SDA providers are not also NDIS support providers, although it acknowledges that separation is currently not always possible (for example, many existing disability accommodation services are provided by support providers).

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\(^{31}\) SDA decision paper, June 2016
6.3 Opportunities through Information, Linkages and Capacity Building (ILC)

The Information, Linkages and Capacity Building function will comprise a suite of services to raise awareness about the NDIS and disability, support the mainstream environment to be more accessible and support people to access the NDIS – including exercising choice and control and in planning. Most of the ILC function is expected to be delivered through the Local Area Coordinator (LAC) but grants will also be available for other services to undertake some of this work.

The ILC policy framework was agreed to in 2015 and draft commissioning framework released for consultation in late 2015.

The report on the consultation notes that “Many organisations highlighted the need to make sure that ILC would cater for people with disability who have multiple or complex needs. Many people were concerned that vulnerable or hard-to-reach groups may be overlooked in ILC and said targeted outreach that was connected with other services may be required.” The Salvation Army in its submission noted a concern that “Marginalised individuals with disabilities may end up being excluded because achieving the required outcomes in their case becomes too difficult or too expensive or both.”

The framework identifies “cohort focused delivery” as an investment area. This includes providing tailored information and referral for a number of particular groups including:

- people with a mental illness
- people with high and complex support needs, and
- “hard to reach” populations.

Correspondence from the NDIA to Homelessness Australia suggests that people who experience homelessness would be considered as a “cohort” requiring investment.

Of particular relevance for homelessness services may be in relation to stream four – individual capacity building32.

Individual capacity building is about fostering the principle of choice and control. For people who are eligible for a funding package it is designed to improve outcomes, drive market changes through cost reductions and innovation as participant’s needs and expectations evolve. It is also expected to benefit a range of people with disability, and their families and carers, who are eligible for an IFP or who are just outside of the access criteria for the scheme and would otherwise need to test their eligibility (and therefore support the insurance principles of the NDIS).

The supports under this stream are often one off, low intensity or episodic and are better delivered and managed through funding arrangements outside of IFPs. Effectively delivering this stream can mean that people are more able to communicate their preferences and to make informed and independent decisions.

Examples of things that this funding stream may support include:

- courses, groups and organisations to help build capacity, self-advocacy and decision-making, facilitate mentoring and peer support and help provide people with information that will support choice.

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32 This also includes information, linkages and referrals (however, this most likely to be with LAC) and Capacity building for mainstream services is also included. Its focus is on ensuring people with a disability have access to mainstream (government and private) services. While people who are homeless and have a disability also experience discrimination (arguably higher levels of discrimination) work in this area would be a departure from areas of expertise – better outcomes likely to be achieved through promoting access to the NDIS (issue is more likely about building capacity within NDIS to work with people who are homeless) ....
• facilitation of local support networks to provide opportunities for people with disability to learn from the experience of others
• peer support groups that lessen isolation (for example for people with a mental illness or an acquired brain injury), or
• training courses and mentor programs to help people to self-advocate and assume increasing levels of choice and control.

The final ILC commissioning framework was released in November 2016.
7.0 Conclusion

The introduction of the National Disability Insurance Scheme brings about a significant change to the delivery of disability support and the service system in Australia. For people who have a disability and experience homelessness, it offers an opportunity to access to life-long support thus addressing a significant barrier to obtaining and maintaining stable accommodation.

It is estimated that around 3,360 to 4,003 people who are currently accessing Specialist Homelessness Services in Victoria could be eligible for the NDIS – representing a significant number of people who could potentially benefit.

However, many people who have a disability and experience homelessness are also likely to be significantly socially and economically marginalised and face considerable barriers to accessing the NDIS. Many will lack the capacity or willingness to access and participate in the self-directed process. Those who do attempt to engage but who do not have the skills or skilled family or friends to assist (and/or encourage them) may not receive a plan that meet their needs. There is a risk that a significant proportion of people who have a disability and experience homelessness may find it too difficult to access the scheme and/or choose not to test their eligibility. It also possible that the scheme offerings – and in particular the service delivery approach – may not suit those who do not have stable accommodation or are otherwise reluctant to engage with services and service providers. With 55% of SHS clients who need disability or mental health assistance already not receiving it or being successfully referred to a service who can provide it, there is a risk that many of these people will miss out.

The NDIS is not a service system that has been designed for people who experience homelessness. While functions such as Information, Linkages and Capacity building are designed to support access for hard to reach cohorts and to improve individual capacity to access and participate in the scheme, awareness of the needs of people who are homeless and considerations of the safeguards and mechanisms needed to ensure access for people who are homeless are not at the forefront of administration. For example, “complex needs” generally refer to having a combination of health, disability or behavioural issues – and not problems with housing, alcohol and drug addiction and social disadvantage, and inappropriate accommodation generally refers to young people residing in nursing homes, not unsafe housing.

For those people who do choose to test their eligibility or participate, the system presents a number of challenges including:

- variability in follow up where a participant does not make contact with the NDIA as expected
- difficulties in obtaining proof of condition, impairment and permanency
- people unwilling to be involved because of the complexities of obtaining documentation and a reluctance to identify that their disability exists or is permanent, and
- getting a plan that meets their needs – particularly for people who did not have a family member, service provider or advocate.

The interface between the SHS system and the NDIA is yet to be fully explored. However, it appears that at this stage SHS will need to take an active role in creating and supporting pathways into the NDIS if their clients are to access the opportunities the NDIS potentially offers. Potential roles include:

- contributing to the information and awareness about the NDIS among clients
- supporting clients to test their eligibility, including assisting them to obtain the necessary documentation
- supporting clients through the planning process to identify goals and needs, and
- working with support coordinators to ensure that clients receive the supports and services they have been funded for.
While some of these roles are consistent with that of the SHS case manager, there is a need for discussion with the NDIA about the interface and how a partnership can be formed. It is also unclear whether the funded service models for intake and assessment, or information and referral, will adequately provide for identification, engagement and referral of people to the NDIS. A dedicated NDIS worker would be invaluable in these services to support linkages to the NDIS as well as provide support for those who are ineligible.

The Local Area Coordinator and Information, Linkages and Capacity functions do have the potential to address some of these issues but as yet the functions and commitment to ensuring access for people who experience homelessness is unclear.

A possible unintended consequence of the NDIS for the SHS sector will also be the flow on effects from the increase on demand for affordable housing, and also potentially demand on the sector to find affordable accommodation for people who may be identified as being at risk of homelessness (but whose risks may have previously been managed by others).

There is also the issue of people who are ineligible for the NDIS. It is estimated that there will be between 1,437 and 2,080 people who are homeless who will not meet the NDIA access requirements but require specialist disability or mental health assistance. In Victoria, this is a potentially a significant issue as the NDIS results in the ceasing of the community mental health program and it is unclear what other supports may be available for people with a mental illness who require community support and/or rehabilitation beyond that provided through clinical services.

It is expected that over time the number and scale of NDIS providers will change, with fewer and larger providers dominating the system. However, there is potentially the opportunity and need for smaller scale niche providers, including ones which can respond to the particular needs and characteristics of people who are in unstable accommodation and/or who do not readily engage with support providers. However, at this point in time the NDIS funding model is not adequately addressing or compensating providers for the complexity of doing this work, including the need for ongoing engagement and flexibility.
8.0 Where to next?

The following are options developed for consideration by SHS:

Develop and test the SHS/ homelessness and NDIA interface
Establish a formal liaison with the NDIA and/or LAC to explore the NDIS/ SHS interface and how a partnership can be formed. Discussions need to focus on roles and responsibilities and the opportunities to work together to provide a pathway out of homelessness.

- SHS may consider a specialist case manager role and/or adapt the existing role. The role could include:
  - contributing to the information and awareness about the NDIS among clients
  - supporting clients to test their eligibility, including assisting them to obtain the necessary documentation
  - supporting clients through the planning process to identify goals and needs, and/or
  - working with support coordinators to ensure that clients receive the supports and services for which they have been funded.

- Develop a linkage role between the NDIA/LAC and SHSs. Key functions would be to take referrals and assertively identify and connect with people who are homeless with a disability and assist them through the application and planning processes; and act as a liaison person between the NDIA/LAC and SHS.

- Support the linkage role with information about the NDIS using language and examples which are relevant for people who are homeless and financial support for medical assessments.

- The NDIA/LAC to consider providing assessments and planning activities in environments that are comfortable for the client and in partnership with SHS case managers (particularly where many support needs may not be related to functional limitations due to disability).

- SHS and NDIA to consider developing standard protocols for NDIS support agencies with regard to working with SHS case managers where there is a shared client; and with the NDIA/LAC with regard to assessment and planning processes – including to ensure that the client is supported through these processes and that assessment is comprehensive and responds to the complexity.

Monitor and contribute to the development of NDIS/ homelessness interface at a systemic level

- SHS to monitor access requests supported through SHS and document outcomes.

- The SHS sector to seek representation in NDIS policy and program discussions – including on relevant working groups.

Support for the changing environment

- This might include orientation and training for case managers, and other SHS workers to the NDIS and its systems and processes.

- More leadership and direction from the NDIA to manage the risks associated with the inevitable and inadvertent consequences from such significant change, including recognition of the broader service system impacts. For example, homelessness agencies could be engaged as active participants in the change process with resources to increase awareness of the NDIS and to support clients through the transition phase (the linkage role as per above would also assist this).

- Develop a “how to refer” guide for SHS.
Support a provider market for people with a disability who experience homelessness

- Review support rules, funding and processes to ensure that they provide adequate incentives to work with and respond to the needs of people who have a disability and experience homelessness. This could include:
  - providing support for engagement purposes, including using assertive outreach approaches (recognising that this may need a different approach to funding hours of support).
  - higher levels of tolerance for “no shows” before funding is reviewed/ceased.
  - recognising the skills, expertise and ongoing relationship needed to engage and support people who have complex needs (arising from issues other than their disability such as alcohol and other drug use, poverty, homelessness etc) within the funding model.
- Identify and describe how support might be need to be provided in order to respond to the particular complexities of experiencing homelessness and/or living in unstable or unsafe accommodation.
- Monitor changes in the market and the existence of services that are sympathetic and responsive to people who may be in unstable accommodation, and who have complex needs due to their social and economic situation (as opposed to health and disability issues).

Respond to the demand for adequate affordable accommodation

- Continue to raise the issue of NDIS generated demand and the need for State and Commonwealth Governments to meet this demand and ensure that it does not lead to increased waiting lists (and flow on issues for people who experience homelessness/homelessness services).
- Monitor any change in demand for accommodation and from where it is coming.

Respond to the needs of people who do not meet/ will not test the access requirements

- Should the SHS sector be seeking support for developing expertise within its service system to specifically respond to the needs of people who do not meet the access requirements (this could build on existing programs such as Breaking the Cycle, Street to Home).
- Monitor the number of people for whom there is no referral option.

Maximise the opportunity through the ILC

- Advocate for “homelessness” to be defined as one of the “hard to reach” and “people with complex and high needs” populations for cohort related service delivery.
- Start a sector wide conversation now about what might be needed and how it could be delivered to improve capacity for people who have a disability and experience homelessness to provide a strong response to the first stage of commissioning which involves looking for relevant ideas.
- Advocacy to the NDIA about the needs of people who are homeless.