Disability Rights Advocacy Service Inc

Safeguarding and promoting the rights and interests of people with disability, their families

SUBMISSION TO THE NDIS REVIEW

ADELAIDE OFFICE

411 Henley Beach Rd Brooklyn Park SA 5032
PO Box 411 Brooklyn Park SA 5032
Phone: 08 8351 9500
Email: administration@dras.com.au

RIVERLAND

2a Ahern Street Berri SA 5343
PO Box 868 Berri SA 5343
Phone: 08 8351 9500
Email: administration@dras.com.au

SOUTH EAST

44 Gray Street Mount Gambier SA 5290
PO Box 1210 Mount Gambier SA 5290
Phone: 08 8351 9500
Email: administration@dras.com.au

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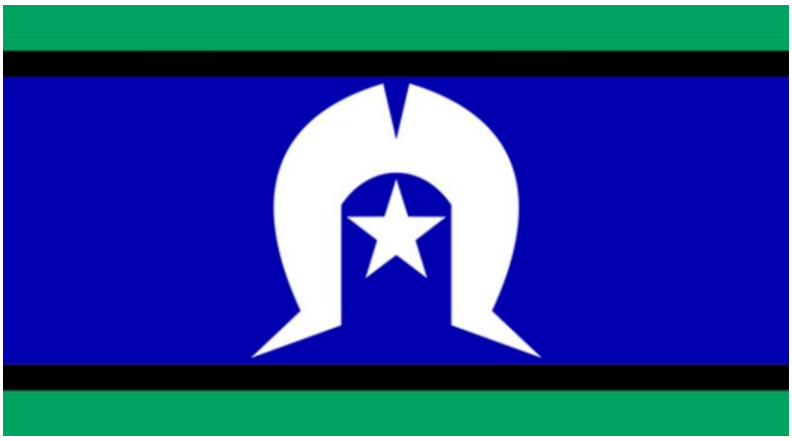

The Disability Rights Advocacy Service Inc acknowledges that this submission was completed on Kaurna Land. We pay our respects to Elders past, present and emerging. We recognise the continuing relationship with the lands and seas and connection to culture.

Kaurna Miyurna yaitya yarta-mathanya Wama Tarntanyaku, parnaku yailtya, parnaku tapa puru purruna. Kaurna Miyurna ithu yailtya purruna, yarta kuma puru martinthi, puru warri-apinthi, puru tangka martulayinthi.

Background

Disability Rights Advocacy Service (DRAS) is a community organisation that is run by our members and our Board, which is made up of people with a disability. DRAS is part of a national network of disability advocacy organisations funded by the Australian Government Department of Social Services to provide individual advocacy and NDIS appeals support, individual capacity-building and systemic advocacy for persons with disability.

What we do

Our advocates listen to people with a disability and learn from them, so that we can work alongside them to promote and defend their human rights. It means helping people with disability to get a fair go. It means helping people with a disability to enjoy all the things they are entitled to – all the things a person who doesn't have a disability can access.

Our locations

Disability Rights Advocacy Service has three office locations in South Australia:

- Our Brooklyn Park office represents people who reside within greater metropolitan Adelaide, Mount Barker, Adelaide Hills and Murray Bridge.
- Based in Mount Gambier, our South-East service assists people throughout the South-East and Coorong region.
- People living within the Riverland region can access our Riverland office, which is based in the township of Berri.

Our Mission

Safeguarding and promoting the rights and interests of people with a disability, their families and carers. We do this through our four governing principles:

1. People with disabilities have the same rights as other members of the Australian community.
2. People with a disability should be able to maintain and develop their culture without prejudice or disadvantage and should be encouraged to understand and embrace other cultures.
3. People with a disability should be able to receive services necessary to enable them to achieve their maximum potential as members of the community.
4. People with a disability are entitled to participate in decisions that affect their lives and to receive services in a manner that results in the least restriction of their rights and opportunities.

Applying and getting a plan

NDIS Access

1. We have heard that the National Disability Insurance Scheme (NDIS) Access Request process can be confusing, onerous, and stressful for applicants and their supporting medical professionals. Much of the work of advocates is centred on trying to breakdown what the Access Criteria is and what it means in plain language. Applicants need help to understand what the 'disability requirements' are, such as:
    a. What a 'permanent' disability is defined as by the National Disability Insurance Agency (NDIA);
    b. How the NDIA assesses whether an 'impairment' or impairments result in a substantially reduced functional capacity to undertake activities relating to communication, social interaction, learning, mobility, self-care and self-management;
    c. How relevant past, current, and possible future treatment is to their NDIS application.
2. The term 'impairment' is not defined under the *National Disability Insurance Scheme Act 2013* (NDIS Act) even though the term is used to describe the reduction in functioning which is considered when NDIS access is requested. This term should be more clearly defined under the legislation.
3. The strict access criteria under the NDIS Act to get onto the scheme is a barrier for people with disability who have not been able to access or afford healthcare. For example, the NDIA permanency rules require that an applicant has exhausted reasonable treatment and that such treatment will not lead to an improvement in the person's functional capacity. However, our clients have told us that this position impacts on people with disability because:
    a. There are financial and logistical barriers to accessing some types of specialists. For example, people with mental health conditions are only eligible for 10 subsidised psychology sessions per year through a Medicare Mental Healthcare Plan, with many unable to afford the gap payment that is required. This is insufficient both as a substantial treatment option and in that the NDIA will not consider that their Access requirements have been met.
    b. For people with physical disability or chronic pain there are limited treatment options available that are affordable and accessible, however, the NDIA requires that these treatment options are met. For example, Medicare will only fund 5 sessions per year for a GP Healthcare Plan, which is expected to cover physiotherapy, exercise physiology *and* occupational therapy (among other allied health services).[1]
    c. Waitlists to see specialists, such as pain clinicians or getting appointments for surgical assessments, are often excessive for people under the public healthcare system.

[1] Use of chronic disease management and allied health Medicare services, Overview of Medicare-subsidised allied health services - Australian Institute of Health and Welfare (aihw.gov.au)

d. Primary healthcare is becoming less affordable and accessible, particularly for people living in regional and remote areas.

e. Getting reports for assessments are not always covered under Medicare and can be expensive. For example, people with disability may pay upwards of $3,000 for an Occupational Therapy Functional Capacity Assessment that does not guarantee access to NDIS supports.

4. Furthermore, the NDIA and the government must adequately train medical practitioners and allied health professionals on the NDIS criteria and what their patient needs to be eligible for the NDIS, as these are the frontline workers that people with disability depend on to provide supporting medical evidence for their NDIS Access Request. This could include Compulsory Professional Development (CPD) training, workshops run by the NDIA, NDIA representatives presenting at peak body medical conferences, or inviting medical and allied health professionals to NDIA-run conferences, for example.

5. The NDIA should have the power to compel medical practitioners and/or allied health professionals to provide the documented medical evidence they have on file, rather than expecting an applicant to navigate a complex process in obtaining past medical evidence, which sometimes leads to needing a Freedom of Information (FOI) request to obtain medical documentation. FOI requests can be costly and time-consuming, while individuals wait for much-needed medical documentation, often without formal supports. For example, this can be the case specifically for people with disability who have not had regular or continuous access to a GP, require evidence from hospital records, or had a formal diagnosis several years ago.

6. People with disability who identify as Culturally and Linguistically Diverse (CALD) face increased barriers in accessing the NDIS, particularly if they do not speak English as their primary language. The NDIA should provide translated materials and interpreters for free. As an advocacy service we can book free interpreters. However, all CALD individuals should have access to free interpreting services if they require them, regardless of whether they have an advocate.

7. The NDIS Access Criteria should be translated into an Easy Read Guide that is provided to all individuals who apply for the NDIS. Such a Guide should be presented in simple language, with audio and visual options, as well as translated into a wide variety of languages.

8. DRAS has been involved in consultations related to the Cultural and Linguistic Diversity Strategy | NDIS and endorses the strategy thus far, with the caveat that additional support should be provided as per the above issues and recommendations.

NDIS Planning

The Planning Process

9. Accessing supports should be made simpler, with longer term NDIS Plans, with the caveat that the process to change an NDIS Plan should be less bureaucratic.
10. For example, there should be a way for NDIS participants to ask for their NDIS Plan to be reviewed in smaller segments – such as when their goals change but they do not wish to review the entire NDIS Plan.
11. There should be a simpler process of replacing NDIS funded Assistive Technology if items that have been purchased break down due to wear and tear for example. Our clients have told us that as NDIS participants they have to go through a complex process of re-proving that they need a particular item or support that they were already previously funded for. Often NDIS participants are getting inconsistent advice from NDIA staff, Local Area Coordinators (LACs) or Support Coordinators (for example) which makes it difficult to plan around what they can or cannot access, particularly if a guideline or practice has changed within the NDIA that means that something that they were previously funded for, is no longer eligible to be funded under the NDIS. Participants also report long delays in getting answers to their questions about whether something can be funded, or a lack of communication if their NDIS Plan was changed without their consent or if it was changed without sufficient notice or explanation by the NDIA.
12. For example:

> *A client was transferred from self-managing their NDIS Plan to being plan-managed. The NDIA noted that some of the items the client had purchased under their previous NDIS Plan were not reasonable and necessary.*
>
> *The client reported that there was a lack of open communication from the NDIA as to the reasons why the items bought under their previous self-managed NDIS Plan were not reasonable and necessary. There was a failure to have a discussion between the NDIA and the client to help them understand why the items purchased under the previous NDIS Plan were not considered reasonable and necessary. The client reported that it took too long to receive an explanation about why they had been moved to being plan-managed and why the items purchased were considered not reasonable, as it took several months and multiple requests for information to finally receive a response via a letter, the contents of which the client is still querying a number of items. The client felt that they raised the purchased items ahead of purchasing them with their Support Coordinator and their LAC who advised that they were appropriate for the client to purchase.*

The client feels that there is no human-centred approach with the NDIA and speaking with staff over the phone or via letter correspondence is distant and alienating, particularly as it does not seem as though staff have appropriate training. The client felt that during contact with NDIA staff they were being either interrogated or being dismissed.

While the client was not concerned that they have now been moved to plan management under their NDIS Plan, they are most concerned about the way the process was managed and lack of communication, and little thought as to their well-being. The client feels that having NDIS support has been a positive for their life but they would like NDIA staff to have better training on how to help people with disability understand the NDIS process and how supports can be implemented under their NDIS Plan.

NDIS Appeals process

13. DRAS has seen some improvements in the Review of a Reviewable Decision (RORD) process, in which NDIA decisions are reviewed internally by the NDIA, wherein as advocates we have more direct contact with the NDIA, and the internal review decision letters are becoming more detailed. However, we remain concerned about NDIS participants who do not have access to an advocate to help them navigate the internal review process. The internal review process could be improved by giving NDIS participants the chance to have scheduled meetings with NDIA staff to explain why they disagree with the initial decision from the NDIA and elaborate further on why they may be requesting a specific support.

14. An issue that has been identified by our NDIS Appeals team is a lack of communication internally within the NDIA particularly when matters are at the Administrative Appeals Tribunal (AAT). For example, during the trial of the Independent Expert Review (IER) one of our clients experienced the following.

A young client with Autism Spectrum Disorder had their NDIS funding and hours reduced for various therapies and an AAT review was lodged. The AAT process is well underway. A first conference was held with further material being sought – the NDIA is being represented by an external Solicitor and a Case Manager has been assigned.

Unbeknownst to the advocate the mother was contacted by the NDIA and encouraged to participate in the Independent Expert Review process. The NDIA explained the process to her and she was led to believe it would potentially hasten the process – she agreed to be involved. The advocate spoke to the NDIA's Solicitor who did not know the IER process was happening. The Solicitor contacted the NDIA Case Manager who also knew nothing of it.

The AAT process was put on hold pending the decision from the IER. The decision from the IER was accompanied by comprehensive reasons, of which virtually all

requested supports were found to be reasonable and necessary (including Immersion Therapy as a separate therapy). The advocate needed to file and serve the Reasons as they seemingly were not automatically provided to the Tribunal and/or the NDIA Solicitor.

Nearly six weeks went by as the advocate chased a response from the Statement of Issues from the NDIA, in which the client and their family expected an acceptance of the IER decision but the advocate was constantly told "The Agency is still considering their position". The NDIA eventually advised that most of the requested supports were agreed but Immersion Therapy was "not best practise" (it was previously rejected on basis of "duplicity" with other therapies). This matter remains unresolved.

15. We have seen that the NDIA's AAT Early Resolution Team has been more proactive in seeking to resolve cases, and this has been a welcome step in supporting NDIS participants and their families. It has been positive to have more open communication between our NDIS Appeals Advocates and the NDIA to resolve matters quicker.

16. For example, our NDIS Appeals Advocates have observed that previously there were 2-month timeframes between the time of lodging an AAT application and a first Case Conference. Our advocates are now seeing that the NDIA's AAT Case Management Team are getting more proactive in the first month by better engaging in communication and negotiation. This includes confirming the Supports being sought and the material available, which often appears to be a genuine reconsideration of the matter and is resulting in some offer of resolution on at least some of the matters in the dispute.

17. However, we note that there are ongoing issues with potential lack of communication between the NDIA's AAT Case Management Team and the NDIA Solicitors/Case Managers. For example:

In at least two recent Case Conferences with two different clients, the contents of the Solicitor's Statement of Issues made it clear that they had been unaware of the previous communication between the client (and their advocate) and the NDIA's AAT Case Management Team. In both cases the one arm of the NDIA had made an offer to resolve the matter and the other arm was unaware of the offer.

18. We acknowledge that the current Government has been working to reduce matters at the AAT with their Early Resolution Team. We note however that there should be more emphasis placed on supporting participants during the earlier planning stages and the internal review stage by communicating more openly and transparently with NDIS participants.

Improved processes needed in the initial Planning Stage

19. A clearer way to help NDIS participants to understand what the NDIS may or may not fund from the beginning could include providing an 'induction pack' or 'orientation' to new NDIS participants in plain language, or in audio or visual format, in a variety of languages.

20. Some NDIS participants have told us that they find the initial Planning Meeting, after they have been approved for the NDIS, to be overwhelming and daunting. They have told us that they feel that terms and acronyms aren't explained, they feel that they cannot always speak up in meetings, or that they may be shut down, or have a feeling of being 'interrogated' or that they must again 'prove' their disability and why a support need relates to their disability. They are also often not given a chance to consider what support needs they would like under an initial NDIS Plan, or in a subsequent Plan meeting, and feel that it is rushed in that they are pressured to sign off on supports 'on-the-spot'.

21. DRAS believes that these issues could be resolved by considering whether the initial Planning Meeting, after a new participant has gotten onto the NDIS, could be broken up into different stages. For example:

    a. A pre-planning meeting, where a new NDIS participant is given a terminology guide, is given information on how the Planning Meeting will work, what role each party in the meeting may play, how supports are approved, and what possible supports a new participant could ask for. This would form an 'orientation' into becoming a new NDIS participant and would give participants a chance to ask questions before supports are 'locked in'.
    b. The Planning Meeting itself where the main review is completed and the bulk of the decisions are made.
    c. A post-planning debrief meeting where the participant has been able to have time to consider how the Planning Meeting went, whether they have any other questions, or whether there is anything they might have missed, forgotten to raise, or anything they are confused about. This could potentially come with a 'cooling off period' where the participant may get a draft copy of their NDIS Plan to consider before 'signing off', including potentially a budget breakdown if this is what a participant feels they would benefit from.

22. While this approach as above may not work for everyone, it could be an option particularly for new NDIS participants, and a starting point on working through the process more collaboratively.

23. DRAS is concerned about the 'attribution' issue that current NDIS participants are facing, in that the NDIA argues that the impairment/s that a participant gained access to the NDIS for should determine the supports they get under their NDIS Plan.
24. In the Federal Court decision *Mulligan v National Disability Insurance Agency* [2015] FCA 544 the Federal Court was clear that the Access and Planning stages are separate and distinct decision-making processes.
25. However, the approach taken by the NDIA to determine supports based on the impairment a participant gained access to the NDIS for fails participants because:
    a. Once an individual becomes an NDIS participant because of one 'impairment' the NDIA often does not consider other conditions even with supporting medical evidence;
    b. There is no way to formally add impairments as being 'accepted' after NDIS Access has been granted, and limited appeal rights;
    c. The NDIA is often not transparent about their decision to limit access to a specific impairment and the NDIA has only recently provided participants information about what impairment was 'accepted' as meeting the Access Criteria.
26. Many people with disability often have multiple disabilities, health conditions or comorbidities that are not easily separated into 'impairments' that may or may not qualify for NDIS Access.
27. Another issue is that the NDIA staff (who make the assessment about whether the support requested during the planning stage is sufficiently linked to the impairment that qualified the participant for the NDIS) may not be adequately trained in the relevant medical field to make such an assessment. This often results in time-consuming and stressful appeals processes, which could have been avoided if there were adequate planning processes in place from the beginning, with trained staff who understand disability and its complexities.
28. The 'attribution' issue and poor initial planning process can be seen in the following case study developed by a client's carer:

> *The client is a young person who has a brain injury following a brain haemorrhage 4 years ago. This has left them with poor balance, double vision, brain injury related fatigue, and cognitive issues including poor memory, poor concentration and increased irritability.*
>
> *The client applied for single resident SDA housing in a complex with an on-call support service for unforeseen support needs. The application included a personal statement detailing how their already poor concentration deteriorated, when overwhelmed by the multiple distractions of a shared household. The result of this was an inability to perform the tasks that they had worked extremely hard to relearn, a loss of confidence and self-esteem, and irritability with those around them.*

In addition, a detailed Occupational Therapist report highlighted these issues and asserted that giving the client time and space in an environment without multiple distractions would allow the client to achieve their NDIS stated goal of returning to independent living.

All of this evidence regarding their disability related needs was completely disregarded in the SDA application, the S100 Internal Review and the initial AAT communications.

Despite repeated requests for clarification as to why the provided evidence was not sufficient, no specific issues were identified by the NDIA.

During the conference process at the Administrative Appeals Tribunal (AAT) the client retained legal representation. The representative pointed to how the evidence demonstrated the disability related need, and indeed, exactly where it could be found in the Tribunal documents.

The NDIA did not elaborate fully on the reasons why they found the evidence insufficient, only pointing generally to the legal guidelines and the cost of the SDA model being sourced, without explaining how they applied to the client's particular situation.

Responses from the NDIA provided blanket and generalised statements that seemed to be "cut and paste" from previous rejections.

Included in the client's participant statement and the OT report was an explanation of how the Community Cooperative model would be cost effective given that the costs of some supports would be shared with the other 9 residents of the Cooperative. This information was also disregarded by the NDIA right up until after the first AAT conference.

At times the NDIA argument wavered between an absence of disability related behaviours of concern or disability related health conditions that would preclude him from sharing, and the issue of the cost of the funding being sourced. It would have been impossible for the client and their family to have negotiated the AAT process without legal representation.

This matter was resolved in the client's favour prior to an AAT hearing, without any further evidence being submitted. The process was stressful and exhausting for the client and their family. The client's family believe that legal fees were incurred and taxpayer funds used, on an unnecessary AAT case.

A complete and joined up ecosystem of support

29. DRAS agrees that there is not enough support for people with disability outside of the NDIS. Our position is that state-funded disability support services should be re-instated, such as Disability SA, for people with disability who do not meet the NDIS Access Criteria.

30. As discussed above, services covered by Medicare also need to be extended particularly for people with complex and lifelong mental illness. This could include a multidisciplinary team that is bulk-billed with access to psychology, social workers, mental health nurses and counselling for example. At this current point in time, there are massive service gaps for people with psychosocial disability attempting to access support. For example, in South Australia alone, there are at least 19,000 people not receiving adequate mental health services.[2] The report notes that 'the funding shortfall could be as high as $125 million per annum' and that service gaps could be closed by the Federal and State Health Departments, as well as non-government agencies, working together to adequately resource the mental health sector.[3]

31. For people with physical disability under 65 years of age there are almost no non-NDIS in-home supports that individuals can access. For example, for people with chronic spinal conditions, or upper and lower limb injuries, there is incredibly limited support services that individuals can receive. Often people with physical disability are going without formal support in terms of help with cleaning, gardening, clothes washing and cooking among other domestic tasks, which can sometimes put their tenancy at risk, if they are in private or public rental accommodation, and their landlord is concerned about their 'property condition'. People with physical disability also require support getting to appointments, such as transportation, or assistance with shopping for essentials.

32. There are also limited services in regional and remote areas, with community transport options and in-home meal supports not always available. Oftentimes people do not have informal supports to rely upon. For example, please see the below case study from a client:

> *The client has physical disabilities of bulging discs with severe back pain, a right leg injury from domestic violence, a shoulder replacement, as well as chronic conditions of COPD, asthma, asbestosis and a skin condition. The client is struggling to access affordable healthcare. For example, a CPAP machine costs $300 every 3 months or $600 if it breaks down or needs maintenance. There are limited Medicare-funded services that the client can access for support for their physical disabilities and chronic health conditions. The client has limited informal support they can rely on. Their son is a carer who also has a disability, which makes carer support difficult. The client requires assistance with self-care, cooking,*

[2] https://s3-ap-southeast-2.amazonaws.com/sahealth-ocp-assets/general-downloads/Unmet-Mental-Health-Service-need-in-South-Australia-that-could-be-met-by-the-NGO-sector.pdf p 4
[3] Ibid

mobility, help getting to appointments and community participation. However, there are limited services outside of the NDIS and they have previously been rejected for the NDIS. They are seeking support from DRAS to re-apply, as they are finding the application process extremely onerous and confusing. The client also lives in a regional area where services are limited.

33. As per the above, accessing information about getting support under Medicare for medical devices (such as Continuous Positive Airway Pressure (CPAP) devices) can also be convoluted, particularly as the cost can depend on personal circumstances, the area that the patient lives in, insurance, GP charges, length of therapy required, among other things.[4] While this may be outside of the scope of the current NDIS review, it is important to note because an ongoing issue is people with disability applying for the NDIS due to no or limited supports outside of this scheme that are affordable or accessible. Medicare services can vary and services can either be bulk-billed or be somewhat subsidised, or alternatively medical services are not covered by Medicare at all.

34. DRAS acknowledges the current NDIS review panel's reflection that the NDIS is an 'oasis in the desert'. We note that however services, therapies and practical supports are funded, and whichever government department or program these resources come from, people with disability and chronic health conditions cannot continue being left behind and essentially neglected by the current inadequate systems in place.

Aged Care versus NDIS supports

35. A trend that we have noticed in our NDIS Appeals program is NDIS participants – who were granted NDIS access *before* turning 65 in line with the requirements – losing access to their Plan funding *after* turning 65-years-old. This is despite an element of the NDIS Access Criteria being that the participant will need lifelong support.[5] Often this will be due to the NDIA arguing that their support needs are now age-related rather than disability-related. However, this is not easily distinguishable and there are often overlaps on what is 'disability-related' and what is 'age-related'.

36. The argument from the NDIA is that a person's care needs are better met in the 'mainstream' or Aged Care system. However, once a person enters an Aged Care facility they lose access to the NDIS unless it is Aged Care Respite. Our clients and their families have reported that Aged Care services are insufficient and ill-equipped to support people with complex needs and disabilities.

[4] CPAP Coverage (medicare.gov)
[5] Do you meet the disability requirements? | NDIS

37. We are also seeing a lack of coordination and communication on the ground between SA Health, the NDIA and Aged Care services with participants and their families. In some cases, people with disabilities are becoming institutionalised or detained in Aged Care or Mental Health facilities rather than being provided the support that they need to live independently at home or with loved ones. For example, see the below case study:

> *Elderly Caucasian lady has a confirmed diagnosis of cerebral palsy and intellectual disability, is an NDIS participant and lives independently in a Housing SA property. A new NDIS plan was provided which has inadequate funding for supports to help her live independently in her home. The NDIA requested that she explore age care supports. A review of reviewable decision application led to the NDIA rejecting funding for Supported Individual Living because the NDIA determined that support is more appropriately provided by the aged care system, which goes against the legislation that says that the NDIS is for the rest of a participant's life. She is currently fighting this decision at the Administrative Appeals Tribunal.*

38. On the other hand, other people are becoming at risk of homelessness due to losing their NDIS supports – whether this is because they have exhausted the 14 days of respite/short term accommodation options,[6] they have nowhere to go after being discharged from hospital, or because of their high care needs an individual's family or carers are not able to support them without the NDIS funding that they have now lost. For example:

> *The client is a current NDIS participant. After being admitted to hospital they had their NDIS Plan supports cut after an unscheduled Plan Reassessment that occurred without adequate communication or consent from the Plan Nominee. Both the hospital and the NDIA were pressuring the client and their NDIS Plan nominee and carer that the client should go into Aged Care due to being over 65 years of age, however, this would have meant that they lost access to their NDIS Plan and supports. The client trialed Aged Care respite, however, the Aged Care facility could not accommodate for the client's disability-related needs. The client would not have been able to return to the family home either due to their disability-related behaviours of concern and support needs. The client accessed NDIS respite however the 14 days were exhausted and the client was at risk of homelessness. The client and their nominee are getting support from DRAS to appeal the NDIA's decision to reject an application for Supported Independent Living at the Administrative Appeals Tribunal. This is after extensive evidence, along with complaints, were submitted to the NDIS Internal Reviews and Complaints Branch asking the NDIA to review their initial decision and raising complaints about the way the matter has been handled by the NDIA. The NDIA are alleging that the client has a dementia diagnosis and would be better supported in 'mainstream services' or Aged Care, however, the client has never had a formal assessment for this condition.*

39. DRAS is concerned about the position of the NDIA and does not believe that people with disability should lose access to their NDIS supports after they turn 65-years-old.

[6] Short Term Accommodation or Respite | NDIS

Early intervention and childhood supports

40. Services both in childcare centres and schools must be accessible and have established allied health workers to support children. This includes social workers, psychologists, occupational therapists, among others.

41. As part of previous systemic work DRAS has submitted to the *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability* and the South Australian Government our *Report on the Disability Standards for Education and their Operation in South Australia*. Our key take-aways from speaking with families, workers, union representatives and advocates include:
    a. A lack of awareness, understanding and implementation of the Disability Standards for Education across the education sector.
    b. Minimal training and professional development for teachers and support staff.
    c. Minimal funding for schools and families to access support services, reasonable adjustments and facilities they need.
    d. The use of restrictive practices such as use of restraints, isolation and
    e. exclusion.
    f. The onus on students and their parents or carers to self-educate and self-advocate when navigating a complex system.
    g. The intersectional needs of students not being catered for leading to greater marginalisation.
    h. A lack of transition-planning within school year-levels and between primary
    i. school, secondary school and onto higher education or the workforce.
    j. Minimal accountability under the complaints-based mechanism.

42. Systemic patterns of concern that DRAS sees are a ‘hand-balling’ between Federal and State Government services. For example, an education provider stating that they cannot meet the necessary supports required by a student and arguing that it should be met by the NDIS; while the NDIS argues that they are not able to provide funding for supports that from the NDIA’s perspective should be covered by an education provider. Meanwhile, students with disability and their families and carers are left without support.

43. Our service is also hearing from students and carers that often the needs of children with disabilities are dismissed or ignored until there is a crisis point, which could have been avoided if earlier supports were put in place. We are seeing ongoing issues of schools, for example, not following or adequately implementing ‘One Plans’ that form the basis for reasonable accommodations in schools.

44. Families and carers have also told us that they are concerned about a poor transition from Early Intervention childhood supports to the NDIS or other supports.

Recommendations to improve services for supporting children with disability include:

45. School leadership, staff and the greater school community should proactively foster an inclusive environment for all students that enriches the educational experience.
46. Schools to mandate induction training and ongoing professional development for school leadership and staff to include what the Standards are, the rights and obligations for schools, students and families, and general disability awareness and sensitivity training.
47. Explicit references to the Standards should be included in teaching degrees, including the provision of reasonable adjustments.
48. Increase funding for discretionary grants that schools can access to apply for funding for students with disabilities to fund reasonable adjustments and accessible facilities.
49. Assisting schools in enabling them to hire increased numbers of student support officers, teachers, on-site social workers, psychologists, general practitioners, culturally appropriate supports for Aboriginal and Torres Strait Islander students, and safe spaces or well-being hubs.
50. Amend the *Disability Discrimination Act 1992* (Cth) and its subordinate legislation the Standards to clarify and include:
    a. Accountability and compliance standards that schools must meet – rather than the current complaint-based mechanisms that rely on schools and families making individual complaints to enforce their rights.
    b. Requirements for education providers to provide training and professional development to their staff on the DDA and the Standards.
    c. Stand-alone provisions on reasonable adjustments.
    d. Appropriate comparator pools for direct and indirect discrimination.
    e. Mandated transition planning within school year levels and in the transition from school to higher education.
    f. Defining what a ‘restrictive practice’ or ‘prohibited practice’ is in line with the UNCRPD, outlining what it includes, and specifically prohibiting its use on children under section 22 of the Act. This includes practices that are prohibited for use on children under the CROC such as use of restraints, isolation or segregation, and exclusion. At current these practices are not explicitly referred to under the Act and would likely only fall under s 22(1)(c) ‘other detriment’.
51. Expand the NDIS Safeguard Standards to education or develop an equivalent.

The support and service marketplace

52. Our clients have told us that more telehealth services would help if services are not available in their region. In particular, some clients have noted that some medical practitioners will not allow patients to get a prescription medication if they do not assess them in-person for example. This means that a person with a disability will need to travel miles to the next regional centre or to the city to access basic healthcare needs – or otherwise go without the medication they need.

53. Another option is better public infrastructure to link people with disability and NDIS participants to regional centres or the city. For example, investing in better access to regional and remote public transport services.

54. Attracting and keeping workers in regional or remote areas could include incentivising allied health or medical practitioners to move to regional or remote areas or encouraging Fly-In Fly-Out or pop-up services. It could also include ensuring good workplace conditions, secure wages of workers, and protecting workers from being overworked or experiencing burnout by providing balanced workloads and support services for workers.

Help accessing supports

55. The NDIA needs to improve training for Local Area Coordinators (LACs) so they can better support people with disability and their families and carers in accessing the NDIS, linking to NDIS support services, or referring out to other support services if the LAC believes that a person with a disability is not eligible for the NDIS. This should include mandatory disability awareness training for example.

56. Our clients have told us that LACs often do not have the resources or training to adequately link them into services in their area, particularly mainstream services for people with disability who are not eligible for the NDIS. From our perspective as Disability Advocates working on the ground, we believe that LACs are an under-valued service and that LACs should be provided with increased resources and support to be able to support people with disability. While we understand and share a concern that services outside of the NDIS for people with disability are limited, we note that LACs should be able to meet their role of connecting people with disability with alternative services.

57. If an NDIS participant is unhappy with the service provided by an LAC there are limited options in transferring to another provider. This is because LACs are based on the area that an NDIS lives in and it is not the usual practice for a participant to attend an LAC office outside of their area. From our experience even changing to a different LAC worker in the same office can prove difficult and has generally needed to go through the NDIS complaints process.

58. Increased training, resources and flexibility in choosing an LAC will improve the experiences of people with disability.

Supported living and housing

59. DRAS is currently seeing a surge of clients presenting at our disability advocacy service who are either homeless or at risk of homelessness due to the cost of living and housing crisis. Our National Disability Advocacy Program (NDAP) is seeing that housing/homelessness cases are now becoming one of the biggest issues that people with disability are seeking our advocacy services for, along with claiming for related Centrelink payments. While we can advocate and assist clients to get onto public and community housing waitlists, connect clients to homelessness or crisis accommodation services, and work with legal aid agencies to support clients facing eviction or non-renewal of private rental leases, there is limited further support we can provide when there is insufficient housing access and inadequate protections for tenants. We are concerned at the prospect of a potential risk of frontline workers across the sector burning out and experiencing vicarious trauma due to the scale of the current crisis.
60. DRAS has previously provided multiple government submissions regarding access to stable, secure and accessible housing for people with disability, as it is a common issue that individuals are seeking support for. We have previously provided submissions to the Disability Royal Commission, the South Australian Government, and the Federal Housing Minister. Please see our most recent report on Housing Availability and Access as an addendum to this submission.
61. Our organisation has now signed onto support the 'Make Renting Fair' campaign, which is calling for access to affordable housing by capping rents at CPI, banning no-grounds evictions, healthy homes that meet accessibility needs and efficiency standards, and allowing renters to have pets to make their houses feel like homes. Please also find this attached as an addendum to this submission.
62. We are particularly concerned about the lack of affordable and accessible housing supply, the growing number of individuals and families with disability experiencing homelessness, as well as housing/homelessness service providers being at capacity and not being able to assist people. There are also limited specialised homelessness service providers specifically designed to support people with disability, as our cohort of clients often need more intensive support than generalised homelessness services can offer.
63. Due to the limited housing supply, our clients have told us that they are feeling forced to accept housing even if it is not suitable for their disability-related needs. This is causing significant stress, trauma and risk to well-being of clients who are feeling 'stuck' or 'trapped' in inadequate accommodation.
64. NDIS-funded accommodation services, such as Supported Independent Living (SIL) or Specialist Disability Accommodation (SDA) are often not an option as there is strict criteria to be able to access this type of accommodation, such as needing 24/7 support. People with disability who have families are also not able to live in shared accommodation. People with

disability who are homeless are often not able to engage in drawn-out appeals with the NDIA so they can obtain a safe roof over their head.

65. Housing should be a right and we are particularly concerned that the current housing crisis appears to be disproportionately impacting on people with disability.

Measuring outcomes and performance; participant safeguards

66. As advocacy services we are required to report Data Exchange (DEX) to the Department of Social Services (DSS) that provides de-identified and confidential data on our client cohort and the issues that drove them to seek our services.

67. We note that the NDIA should consult with statisticians and professionals to establish a system of ethical data collection, particularly recording any systemic patterns of complaints that the NDIA receives through their feedback mechanism.

68. Participants should be better protected from service providers providing dubious advice. For example, service providers encouraging NDIS participants to overspend their NDIS Plan funding and asking for a "top-up" if it runs out before the Plan Review date. This puts NDIS participants at significant risk of having no supports, with no guarantee that the NDIA will approve additional funding, as the NDIS Plan has been budgeted to last annually or in some cases for two years.

69. The NDIS Quality and Safeguards Commission could also become more accessible and have broader powers. This includes:
    a. Allowing NDIS participants to be more involved in the complaints process, by ensuring that Complaints Officer are more communicative and follow up with complainants throughout the process;
    b. Providing the Commission greater ability to de-register service providers who are not following safety standards;
    c. Implementing translated materials and making interpreters more accessible in the complaints process for CALD individuals and carers;
    d. Implementing an advocates phone line for the Commission, similar to the advocacy line established for contacting the NDIA generally.

DRAS thanks the NDIS Review Panel for taking the time to review our submission in response to the 'What We Have Heard' Report. We would welcome the opportunity to engage in ongoing consultation to make the NDIS and mainstream services more accessible, affordable and available for people with disability, their families and carers.

Disability Rights
Advocacy Service Inc

Safeguarding and promoting the rights and interests of people with disability, their families

SUBMISSION TO THE INQUIRY INTO SOUTH AUSTRALIAN HOUSING AVAILABILITY

ADELAIDE OFFICE

411 Henley Beach Rd Brooklyn Park SA 5032
PO Box 411 Brooklyn Park SA 5032
Phone: 08 8351 9500
Email: administration@dras.com.a

RIVERLAND

2a Ahern Street Berri SA 5343
PO Box 868 Berri SA 5343
Phone: 08 8351 9500
Email: administration@dras.com.au

SOUTH EAST

PO Box 1210 Mount Gambier SA 5290
Phone: 08 8351 9500
Email: administration@dras.com.au

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ADELAIDE OFFICE

411 Henley Beach Rd Brooklyn Park SA 5032
PO Box 411 Brooklyn Park SA 5032
Phone: 08 8351 9500
Email: administration@dras.com.au

RIVERLAND

2a Ahern Street Berri SA 5343
PO Box 868 Berri SA 5343
Phone: 08 8351 9500
Email: administration@dras.com.au

SOUTH EAST

PO Box 1210 Mount Gambier SA 5290
Phone: 08 8351 9500
Email: administration@dras.com.au

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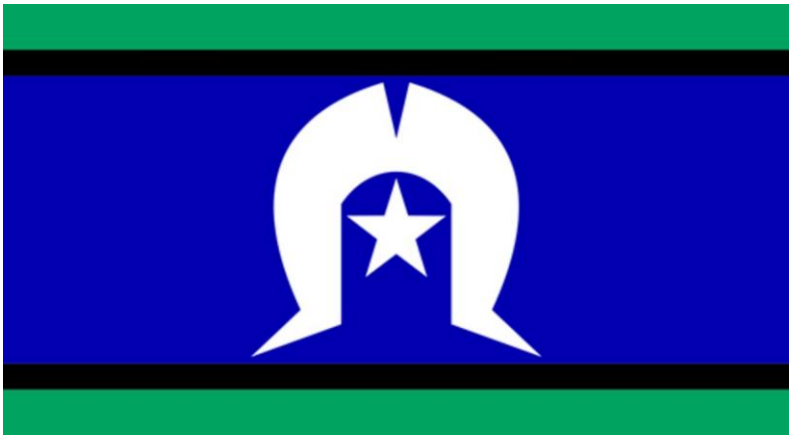
Acknowledgement of Country



The Disability Rights Advocacy Service Inc acknowledges that this submission was completed on Kaurna Land. We pay our respects to Elders past, present and emerging. We recognise the continuing relationship with the lands and seas and connection to culture.

Kaurna Miyurna yaitya yarta-mathanya Wama Tarntanyaku, parnaku yailtya, parnaku tapa puru purruna. Kaurna Miyurna ithu yailtya purruna, yarta kuma puru martinthi, puru warri-apinthi, puru tangka martulayinthi.

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411 Henley Beach Rd Brooklyn Park SA 5032
PO Box 411 Brooklyn Park SA 5032
Phone: 08 8351 9500
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RIVERLAND

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PO Box 868 Berri SA 5343
Phone: 08 8351 9500
Email: administration@dras.com.au

SOUTH EAST

PO Box 1210 Mount Gambier SA 5290
Phone: 08 8351 9500
Email: administration@dras.com.au

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Disability Rights Advocacy Service Inc

Safeguarding and promoting the rights and interests of people with disability, their families

Background

Disability Rights Advocacy Service (DRAS) is a community organisation that is run by our members and our Board, which is made up of people with a disability. DRAS is part of a national network of disability advocacy organisations funded by the Australian Government Department of Social Services to provide individual advocacy, individual capacity-building and systemic advocacy for persons with disability.

What we do

Our advocates listen to people with a disability and learn from them, so that we can work alongside them to promote and defend their human rights. It means helping people with disability to get a fair go. It means helping people with a disability to enjoy all the things they are entitled to – all the things a person who doesn't have a disability can access.

Our locations

Disability Rights Advocacy Service has three office locations in South Australia:

- Our Brooklyn Park office represents people who reside within greater metropolitan Adelaide, Mount Barker, Adelaide Hills and Murray Bridge.
- Based in Mount Gambier, our South-East service assists people throughout the South-East and Coorong region.
- People living within the Riverland region can access our Riverland office, which is based in the township of Berri.

Our Mission

Safeguarding and promoting the rights and interests of people with a disability, their families and carers. We do this through our four governing principles:

1. People with disabilities have the same rights as other members of the Australian community.
2. People with a disability should be able to maintain and develop their culture without prejudice or disadvantage and should be encouraged to understand and embrace other cultures.
3. People with a disability should be able to receive services necessary to enable them to achieve their maximum potential as members of the community.
4. People with a disability are entitled to participate in decisions that affect their lives and to receive services in a manner that results in the least restriction of their rights and opportunities.

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Disability Rights
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Safeguarding and promoting the rights and
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Submission to the Inquiry into South Australian Housing Availability

As part of our work our advocates frequently liaise with clients who are homeless, facing homelessness, or trying to access housing. In putting together this submission we have reviewed key research and interviewed advocates, surveyed and interviewed persons with disability and their carers, reviewed our DEX data, spoken to housing organisations and government officials.

In the July to December 2022 period, we had 306 clients who sought disability advocacy related to housing. The issues that our clients sought assistance with included:

- Access to secure housing because they were homeless, including sleeping rough and/or couch-surfing;
- Access to secure housing because they were facing homelessness after being served an eviction notice or due to a housing provider not renewing their lease for a public, community or private rental;
- Support at the South Australian Civil and Administrative Tribunal (SACAT) related to appealing an eviction notice or requesting an extension of time to find a new property;
- Liaising with or making complaints to the South Australian Housing Authority (SAHA), a Community Housing Provider or a private real estate agent relating to maintenance issues or disability modifications. These matters have included:
    - Poor insulation or ventilation, black mould or asbestos in the property;
    - Pest infestations;
    - Disability or medical-related modifications (such as grabrails, handrails or adjustable shower-heads);
    - Advocating for essential heating and cooling items to be provided in the property (such as air-conditioners and heaters);
    - Long delays with SAHA maintenance requests needing to be escalated to the DHS Minister.
- Support to lodge a housing transfer application, particularly with SAHA. Reasons for requesting a transfer have included:
    - The property is not accessible or suitable due to the client's disability;
    - The client feels unsafe or is being harassed in their current residence due to neighbours exhibiting anti-social behaviours, such as substance abuse, theft, domestic violence, vandalism, assault or risk of violence;
    - The property is not nearby support networks, including informal and/or professional supports.

ADELAIDE OFFICE

411 Henley Beach Rd Brooklyn Park SA 5032
PO Box 411 Brooklyn Park SA 5032
Phone: 08 8351 9500
Email: administration@dras.com.au

RIVERLAND

2a Ahern Street Berri SA 5343
PO Box 868 Berri SA 5343
Phone: 08 8351 9500
Email: administration@dras.com.au

SOUTH EAST

PO Box 1210 Mount Gambier SA 5290
Phone: 08 8351 9500
Email: administration@dras.com.au

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Disability Rights Advocacy Service Inc

Safeguarding and promoting the rights and interests of people with disability, their families

Affordability and access to housing for people with disability leading to risk of homelessness

1. From a housing and homelessness perspective, in the past 12 months we have been seeing an influx of people with disability accessing our services to get assistance due to them experiencing homelessness, facing eviction, or living in unsuitable housing. DRAS currently has 55 open individual advocacy cases related to housing/homelessness for our Adelaide, Berri and Mount Gambier offices.

2. We have seen a concerning rise of tenants being told that their lease will not be getting renewed through no fault of their own. For example, a private landlord selling their property, or a public housing tenant being told to move out to 'make way' for others. Tenants have also not had their leases renewed, or had their rent raised, after requesting maintenance in their property. Some are avoiding making maintenance requests or complaints due to fears of retaliatory evictions or rent increases.

3. We surveyed persons with disabilities about their experiences with accessing housing in South Australia. People told us that affordability of housing was a major concern for them:

> *"I feel like if I wanted to move I wouldn't be able to because there is so little private rental accommodation available – certainly for what I can afford to pay"*

> *"There is a gap between homelessness services and public housing for people with disability. Homelessness services are not willing to accommodate autism access needs. NDIS won't fund to support me to find a safe housing and the public waiting lists are years. Private rental is too complicated to access and is unaffordable."*

> *"There are no other options for me to move into affordable housing so I have been forced to stay where I am with an extra rent increase but now I can't afford to feed myself"*

> *"Due to cost and availability in the rental market, it is very hard to relocate anywhere. Currently we are on a periodical lease and hope something else becomes available, but we have been looking for over 6 months now, pet policy for myself, and cost is not good. Options are seldom, and not overly affordable"*

> *"Trying to obtain lower cost housing is unaffordable on benefits"*

> *"I'm in a very vulnerable position my landlords are selling my house, I'm on JobSeeker and stand no chance of obtaining a suitable place to live"*

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SOUTH EAST

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Phone: 08 8351 9500
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> *"It is expensive, and as usual a total rush to find a house before a lease is up, meaning little time to find something better and more affordable… which I guess is irrelevant because so little affordable housing exists!"*

4. People with disability may have a greater exposure to risk factors associated with homelessness than the general population (Beer et al. 2012). Low income, lack of social support, limited engagement with the labour market, compounded by the need for specialised assistance and services, can leave some people with disability increasingly vulnerable to the risk of homelessness and the negative impact of homelessness.

5. Timely access to safe, suitable and long-term housing can be critical to the wellbeing of people with disability, providing independence and the ability to participate in social, economic, sporting and cultural life. Housing that meets accessibility requirements, is nearby to public transport, as well as quality and affordable support services is also vital for those with disability.

6. The Specialist Homelessness Services annual report from the *Australian Institute of Health and Welfare* addresses homelessness and disability from a national perspective, In the latest reporting period (2021–22), roughly 272,700 Specialist Homelessness Service ("SHS") clients received support from specialist homelessness services. **18,030 SHS clients were located in South Australia.**

7. Nationally, 31% (or 85,200) lived with mental illness, 4.9% (or 11,300) were NDIS participants, and 3% (or 7,300) were categorised as clients with disability.[1] The most common reasons for people with disability seeking assistance were due to the housing crisis (28%), family and domestic violence (18%) and inadequate/inappropriate dwelling conditions (14%).[2]

8. **We are concerned that the rising cost of housing is pushing people with disability and those on fixed incomes into unsafe or unsuitable housing options, or into homelessness.** For example, as of March 2023, median rent for houses in Adelaide is $520 (a 4.2% increase on the previous quarter) and $420 for units (a 5% increase).[3]

9. Regional areas are not much better, with rental prices ranging from $300 to $500 per week. Townships have seen sharp increases between March 2022-March 2023, such as 23.3% for the Barossa, 24.6% for Murray Bridge, 20% for Port Pirie, 10.7% for Berri Barmera and 10.3% for Mount Gambier.[4]

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[1] Specialist homelessness services annual report 2021–22, Clients, services and outcomes - Australian Institute of Health and Welfare (aihw.gov.au)
[2] Specialist homelessness services annual report 2021–22, Clients with disability - Australian Institute of Health and Welfare (aihw.gov.au)
[3] Domain Rental Report - March 2023 | Domain
[4] Domain Rental Report - March 2023 | Domain

10. Mean house prices for purchase in South Australia were $644,300 according to the ABS as of December 2022.[5]

11. From our experience these prices are pushing many out of the private housing market, particularly persons with disabilities, people on income support, single parents, new migrants and refugees. We are seeing a lack of access particularly for people with 'hidden' disabilities, such as psychosocial, intellectual, sensory or behavioural disabilities or brain injuries.

12. At the same time as the cost of purchasing a house or renting privately has increased, wages and income support have not kept up. Anglicare found that of the 1,456 private rentals that were advertised on the weekend of Saturday 18 March 2023 in South Australia, **for a single person over 21 on the Disability Support Pension, a single on JobSeeker Payment, or a single aged over 18 on Youth Allowance, 0% of properties were suitable without placing a person in housing stress.** 256 of individual properties (or 18%) were suitable for at least one household type living on the minimum wage without placing them in housing stress. These results are found in the table below.[6]

#	Household Type	Payment Type	Number Affordable & Appropriate	Percentage Affordable & Appropriate
1	Couple, two children (one aged less than 5, one aged less than 10)	Jobseeker Payment (both adults)	2	0%
2	Single, two children (one aged less than 5, one aged less than 10)	Parenting Payment Single	1	0%
3	Couple, no children	Age Pension	8	1%
4	Single, one child (aged less than 5)	Parenting Payment Single	0	0%
5	Single, one child (aged over 8)	Jobseeker Payment	0	0%
6	Single	Age Pension	6	0%
7	Single aged over 21	Disability Support Pension	0	0%
8	Single	Jobseeker Payment	0	0%
9	Single aged over 18	Youth Allowance	0	0%
10	Single in share house	Youth Allowance	0	0%
11	Couple, two children (one aged less than 5, one aged less than 10)	Minimum Wage + FTB A (both adults)	252	17%
12	Single, two children (one aged less than 5, one aged less than 10)	Minimum Wage + FTB A & B	15	1%
13	Single	Minimum Wage	9	1%
14	Couple, two children (one aged less than 5, one aged less than 10)	Minimum Wage + Parenting payment (partnered) + FTB A & B	48	3%
	Total No of Properties	1456		

13. We are particularly concerned that the current rate of the Disability Support Pension (DSP) is not keeping up with the rising cost of private rentals.

[5] Total Value of Dwellings, December Quarter 2022 | Australian Bureau of Statistics (abs.gov.au)
[6] https://www.anglicare.asn.au/wp-content/uploads/2023/04/Rental-Affordability-Snapshot-Regional-Reports.pdf at *Believe Housing Australia – South Australia*, p 150, 1-2

14. Social housing is struggling to keep up with the demand of access requests. The South Australian Housing Authority (SAHA) confirmed in 2022 that there were up to 17,000 people on their waitlist with limited vacancies per year. **People with disability are requesting advocacy support from our service due to waiting several months or *years* on Category 1 – the highest priority to get into social housing.**

15. The current public and community housing stock is therefore not meeting the housing demand and investment has declined over time. Across 2001-2020 the share of public housing in South Australia declined from 50,000 to 30,000 places.[7]

16. We have also heard concerns that affordable housing or social housing is concentrated into particular areas. This means that if persons with disability are facing homelessness, they may also have the added barrier of either having to move away from support services, networks, schools or NDIS funded treating teams, or rejecting a housing offer.

17. Persons with disability told us that access to available and accessible housing in a safe area is an urgent priority that is not being afforded to them overall. We heard a common theme that persons with disability want the State Government to increase access to public housing because it is more affordable.

18. Persons with disability have told us the affordability and availability of housing could be improved in the following ways:

> *"Bans on rental increases, massive social housing developments, more training to Housing SA staff on how they deal with people, more disability housing access to housing for carers, fixing up of older housing/community houses, increases to payments for rent, options for lower incomes to "purchase" property instead of being stuck on the cycle of renting. More help from services to access property before becoming homeless and being moved into emergency accommodation"*

> *"More social housing with capped rental costs, Social housing that is available to low-income earners and not just people on Centrelink payments"*

> *"Having more access to public housing would help alleviate so much stress for those on waiting lists. Big corporations need to pay their fair share of tax so as the rest of society can have some semblance of a stable life"*

[7] South Australian Council of Social Services, Submission to the Select Committee Inquiry into Privatisation of Public Services in South Australia, 2021 p 2, accessed: SACOSS Supplementary Submission - Housing.pdf

Disability Rights Advocacy Service Inc

Safeguarding and promoting the rights and interests of people with disability, their families

"A massive increase in public housing [is needed] … The price of renting needs regulation and more housing made available"

"More affordable housing for poor people. Availability in a safe area"

"More availability of housing. Stop people hoarding housing for profit. Drastically increase public housing stock"

"More public housing, caps on rental prices, increased rent assistance for people with disability to access safe appropriate private rental"

[Word cloud of responses to the DRAS survey question 'What changes would you like to see to improve the housing sector in South Australia?]

ADELAIDE OFFICE

411 Henley Beach Rd Brooklyn Park SA 5032
PO Box 411 Brooklyn Park SA 5032
Phone: 08 8351 9500
Email: administration@dras.com.au

RIVERLAND

2a Ahern Street Berri SA 5343
PO Box 868 Berri SA 5343
Phone: 08 8351 9500
Email: administration@dras.com.au

SOUTH EAST

PO Box 1210 Mount Gambier SA 5290
Phone: 08 8351 9500
Email: administration@dras.com.au

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Supported Independent Living (SIL) or Specialist Disability Accommodation (SDA) – a limited option

19. Some people with disability may be able to get access to Specialist Disability Accommodation (SDA) or Supported Independent Living (SIL) if this is included in their NDIS Plan. However, many people with disability do not have access to the NDIS. For example, there is an estimated four million people living with disability in Australia and only 500,000 people on the NDIS. As of 30 June 2020, there were only 6% of NDIS participants living in SIL accommodation according to the NDIA.[8]

20. There is also only a limited number of NDIS participants that have been approved to have SDA or SIL included in their NDIS Plan. The cost of SDA or SIL is out of reach for persons with disability unless they can get the cost covered in some other way. This means that many persons with disabilities who may benefit from SIL or SDA do not have access to this type of accommodation due to financial and administrative barriers. Many SIL or SDA providers will not accept residents at all unless they have funding approved under their NDIS Plan.

21. From our experience it is difficult to get SDA or SIL approved in an NDIS Plan because of the requirements for a person with disability, in that they need to have a substantially reduced functional capacity and require 24/7 supports.

22. SIL is funded individually under the NDIS to each person according to their needs. It is a shared living arrangement of 2-7 NDIS participants. Participants get assistance with daily life tasks and have access to 24/7 care. There are three levels of support that can be accessed. However, the cost of funding from the NDIS often does not include rent, board or lodging, day to day living expenses such as food (unless explicitly agreed upon), activities, personal care supports if the person if hospitalised, vehicle costs, household budgeting or bill paying activities, or expenses relating to holidays, including travel costs.[9] Our clients have told us that SIL has financial and administrative barriers, such as the amounts charged to their NDIS Plans, and an onerous process in seeking suitable supports, making complaints, or changing providers.

23. Another housing alternative that has been used, particularly for children or teenagers, is to house persons with disability in Aged Care facilities. This has not been an ideal situation, particularly for younger people who are not able to develop social networks with their peers. This has often led to social isolation of young people with disability.

24. SDA is offered for persons with disability on the NDIS with extreme functional impairment or high needs that require person-to-person support. Homes are specially designed to be more accessible based on disability related support needs. The cost of accommodation itself is funded separately to personal care supports, supported independent living, individualised living options and some assistive technology

[8] *Improving outcomes for participants who require Supported Independent Living (SIL): Supported Independent Living (SIL) – Provider and Sector consultation*, NDIS, September 2020, p 3

[9] Supported Independent Living for participants | NDIS

options. SDA may also involve a shared home with a small number of other people, wherein the NDIS participant has a private bedroom. In some cases, participants may be able to live in SDA by themselves if that meets their support needs and circumstances. Participants pay for rent, bills and other day-to-day expenses.[10]

25. As a result of the limited NDIS Plans including SDA or SIL, or a lack of access to the NDIS, many persons with disability are instead turning to private accommodation or social housing. However, as discussed, these options are often not accessible or affordable.

Inaccessible crisis accommodation and a complex system of accessing homelessness support

26. **We note with concern that crisis accommodation is often inaccessible for persons with disabilities.** For example, we have had clients who are deemed *ineligible* for crisis accommodation because their greater care needs mean that they need 1:1 support and therefore placing them in crisis accommodation would put the client at risk. In this case the crisis accommodation provider does not have access to the necessary staff to provide support a person with disability.

27. In other cases, clients have also not been able to be housed in crisis accommodation because the physical inaccessibility of the accommodation would put them at risk due to their disability. For example, a person with vision impairment was rejected from a crisis accommodation provider because the complex had stairs and this presented a falls risk.

28. In some cases clients have been turned away from accessing short-stay accommodation providers due to long waitlists.

29. Clients have raised with us that they do not feel safe accessing crisis accommodation, such as women's shelters or men's sheds, because of behaviours of concern from other people, or due to their disability-related needs.

30. Clients have also faced barriers in having to get a referral to a homelessness support service, such as through Homeless Connect (former homelessness gateway), rather than being able to directly access a service.

31. Homelessness support services can only be accessed when a person is physically homeless i.e. sleeping rough or couch-surfing. There are no homelessness support services available to help people when they are facing homelessness, such as when their private rental has decided to not renew their lease, they have no legal rights to appeal this, and they have nowhere else to go, for example. **There are no support services specifically designed to assist people who are at risk of homelessness, to prevent them becoming homeless.**

[10] Specialist disability accommodation | NDIS

32. The only options available to a person or a family who are *about to* become homeless are:

    a. To seek an extension of time via SACAT to find another place (which can include a fee unless they can prove financial hardship, which can be an onerous process); or

    b. Submit further support letters to public or community housing to escalate a Category 1 application; or

    c. Seek out a potentially inaccessible boarding house.

33. Only once a person is physically homeless (sleeping rough or couch-surfing) can they call Homeless Connect and get a referral to a homelessness support provider. This situation is putting vulnerable people at risk.

Accessibility and Minimum Housing Standards

34. As an advocacy service we have had clients come to us for help in obtaining housing that is physically and sensory-accessible. Housing often does not meet the needs of persons with disabilities and it can be difficult to get approval for disability housing modifications.

35. SAHA has developed their *Disability Access and Inclusion Plan 2020-2024*, as part of their obligations under the *Disability Inclusion Act 2018* (SA) (*DIA*). We are towards the end of the delivery of this plan in mid-2023. The Plan is also part of the broader 10-year strategy of the South Australian Government, *Our Housing Future 2020-2030*.

36. According to the Plan, in 2020 people with disability made up 39% of public and Aboriginal housing tenants (12,324), 37% of social housing registrations (6,390) and 25% of the private rental assistance program (13,933). Mental health, physical disabilities and intellectual disabilities were the primary disabilities.[11] Persons with disability residing in public and Aboriginal housing properties can request housing modifications if it does not meet their needs. Only SAHA offers disability housing modifications officially, and they must often be supported by comprehensive diagnostic and functional assessment reports that can be difficult or expensive to obtain.[12]

37. SAHA has also developed internal Sustainable Housing Principles which include detailed requirements about accessibility around and inside a house, as well as housing modifications.[13] However, SAHA has only committed to 'silver' access, which is the minimum requirement for accessibility as opposed to 'gold' or 'platinum' access.[14]

[11] SA Housing Authority, Disability Access and Inclusion Plan 2020-2024, 2020, Government of South Australia, p 5
[12] Housing modifications for people with a disability policy | SA Housing Authority
[13] Sustainable Housing Principles 2.3 SAHT Universal Housing Design Criteria
[14] SA Housing Authority, Disability Access and Inclusion Plan 2020-2024, 2020, Government of South Australia, p 21

38. Furthermore, the Standards only relate to new builds. Our clients have told us that older SAHA properties are inaccessible, particularly the high-density walk-up flat-style accommodation, or semi-detached accommodation. Reasons why our clients have noted that the properties are not accessible have been due to:

    a. Physical inaccessibility i.e. stairs, entry/exit steps, uneven ground, small doorways, narrow hallways;

    b. Individuals with sensory disabilities or impairments not being able to live in close proximity with neighbours. For example, due to noise from other apartment units that impact on their auditory-processing and cause distress, or due to sharing entrances/exits on an apartment level.

39. Moreover, the *DIA* only applies to government agencies and their partner organisations (for example, SAHA partnering with community housing providers). People with disability living in private rentals do not have the benefit of knowing that their landlord or real estate agent is accountable to a Disability Access and Inclusion Plan. This is despite many people with disability renting privately, particularly due to the reduction in numbers of public and community housing places available, and the lack of affordable houses available to purchase.

40. Persons with disability may also struggle to access housing that meets their needs in the private rental market. The *Residential Tenancies Act 1995* (SA) is the core legislation that governs private rental accommodation, including the rights of tenants and obligations of landlords or real estate agents. There are no obligations put on private landlords or real estate agents to allow for housing modifications, except that they cannot refuse installation of the internet or a digital television under s 70 of the Act and s 12 of the *Residential Tenancies Regulations 2010* (SA). This means there are no obligations on private agencies to allow for housing modifications. Many rental advertisements also state that they do not accept tenants with pets, which can be a significant barrier for persons with disabilities who rely on support companions.

41. The *Disability Discrimination Act 1992* (Cth) and the *Equal Opportunity Act 1984* (SA) may provide a legal avenue for persons with disability to make complaints about private landlords or real estate agents if they do not provide a housing modification when requested. However, the legal test for discrimination can be a high bar to meet, and it can be difficult to prove that someone is being discriminated against *because of* their disability.

42. Persons with disability have told us that the availability of accessible housing is of concern:

> *"I have been under pressure to be relocated by the agency that manages my property. The State Manager when told why I wanted particular colours for the painting of the interior of my house (to help positively affect my moods), instead of what I call Institutional Beige and 50 Shades of Depressing Grey, said a majority of their tenants had mental health issues and didn't ask for specific colours. Very dismissive of how people come to acquire mental health challenges and how individuals develop coping mechanisms"*

> *"I am frustrated by how little chance I have to change things in my rental, that I have inspections every 2.5 months requiring a high level of cleanliness and that repairs sometimes take a long time"*

> *"Special assistance disability housing service should be case-managed. Inclusive of physical, intellectual and mental health. More public housing and caps on private rental prices. Increased rent assistance for people with disability to access safe and appropriate private rental"*

> *"Huge increase to access, commit to accessibility standards. Make affordable housing"*

> *"I would like to see rental inspections reduced from as often as a month to twice a year at most. I would like more insulation for rental properties, the ability to have pets, more affordable housing, less discrimination against families and people with children, more ability to make changes to a rental property"*

> *"I wish there was more affordable housing for lower income, and that we were not discriminated against if we have pets, most of us have animals, as they are for support"*

> *"Bring back more affordable homes through HAS, bring back community buses in back streets, don't put people with disabilities in hilly areas, far from shops and transport. Don't mix us with home-owners that treat us poorly, stigmatising and discriminating us causing more stress and anxiety to the point of being too scared to even go outside. More community support from experienced people… NDIS is useless"*

> *"[We need] more availability of purpose-built accommodation suitable for disabled people"*

> *"Houses should be designed not to be as narrow and sardine-can-like as possible. Most public houses should be accessible for everyone. And public transport in metropolitan areas should have to be much closer to these houses"*

Training and staff capability

43. Training for staff in the housing industry should be reviewed and updated to ensure that organisations are accessible for persons with disabilities.

44. SAHA has disability awareness training which could be updated to include mental health first aid training and autism-awareness training.

45. It is unclear whether community housing providers deliver disability awareness or mental health first aid training across the board.

46. Private real estate agents or property managers are not required to have disability awareness or mental health first aid training. In South Australia they are required to follow a professional code of conduct. However, professional development such as ethics or disability awareness is not mandated as part of maintaining their practice licence.

47. Due to COVID-19 there is also currently a shortage of builders and construction workers that is impacting the capability of South Australia's workforce. Some workers have also moved interstate to take up the opportunities in Victoria and Western Australia who are making big investments into social housing.

DRAS Case Studies[15]

Case Study #1:

The client is an NDIS participant. They are not eligible for SDA/SIL. They had to leave a SAHA property due to domestic violence and stayed temporarily with family, however, this was not a long-term option. They found a private rental through a roommate app and are on a sub-lease, which was the only affordable place they could find while on JobSeeker. They attempted to apply for the Disability Support Pension but were rejected. The property they are now living in is old and the landlord is refusing to do any renovations. There is mould in the property, part of the ceiling has collapsed, the drain piping has shattered, the toilet is not flushing, and there is raw sewage going into the backyard. DRAS attended a meeting with the client and SAHA who advised that the property may be sub-standard. The client is concerned about asking for a property assessment with the landlord as they may deem that the home is unliveable and then the client will face homelessness. They have been deemed to only be Category 2 for public and community housing because they are technically housed and not physically homeless right now. However, this raises a broader issue about people with disabilities living in inappropriate accommodation because they have no other option.

Case Study #2:

The client is living in their car with their dog. They have been in Category 1 with SAHA for a few months now. They have been told that they will need to wait for up to 5 years for a house. They describe their body as broken physically – with a smashed leg and a broken hand that has not mended. They forced themselves to work through the pain and it got worse. The client has a degenerative spine disease that was gained as child due to a hit-and-run. They have chronic depression and anxiety. They said that they cannot get the DSP because they cannot afford a spinal surgeon or a psychiatrist.

[15] More case studies can be made available on request if needed.

Case Study #3:

A client who lives in a SAHA property requested advocacy support regarding maintenance. They had an assessment by a roofing plumber who told them that there was black mould in the ceiling insulation and one of the beams was rotten, because of a leak due to structural issues with the silicone in the roof. The roofing plumber raised that this issue had been present for several years. The leak also caused flooding in the kitchen. The leak was fixed, however, the issue with the black mould was not resolved. The ceiling paint in the kitchen is peeling, and the client had raised a maintenance request three years ago, which was never actioned. The kitchen tiles fell off. Currently there is a water-damaged backdoor. The client sought assistance from DRAS and we have raised these concerns with SAHA. There has been some movement with maintenance visiting the property, and the kitchen tiles have been fixed. However, the water-damaged backdoor has not been fixed, and neither has the black mould in the ceiling insulation. The client is impacted by the black mould which affects their asthma and causes headaches, itchy eyes and sinus problems. The client notices a change in their health when they are not staying in the house, such as when they are visiting family. The client had previously had an assessment by an Occupational Therapist who recommended that the kitchen be renovated to make it more accessible, however, this has not been actioned after several years. The client has also made a complaint to the State Ombudsman. The client is on the Disability Support Pension and is getting help from DRAS to appeal the decision to reject their NDIS Access claim.

ADELAIDE OFFICE

411 Henley Beach Rd Brooklyn Park SA 5032
PO Box 411 Brooklyn Park SA 5032
Phone: 08 8351 9500
Email: administration@dras.com.au

RIVERLAND

2a Ahern Street Berri SA 5343
PO Box 868 Berri SA 5343
Phone: 08 8351 9500
Email: administration@dras.com.au

SOUTH EAST

PO Box 1210 Mount Gambier SA 5290
Phone: 08 8351 9500
Email: administration@dras.com.au

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Recommendations

1. Increase public and community housing stock to a level that meets community demand. For example, investing in an additional 20,000 social housing places.
2. Increase renter's rights and amend the *RTA* to include the following:
    a. A right of housing modifications for persons with disabilities;
    b. A right to bring pets into residential properties;
    c. A ban on no-cause evictions;
    d. Limiting periodic tenancies.
3. SAHA, community housing providers and private rental investors make a commitment to 100% 'platinum' access for all new housing builds as per *Livable Housing Australia* guidelines.[16]
4. The *DIA* State Disability Inclusion Plan to include an action point as to how State Government will work with private housing organisations and associations to make housing more affordable, available and accessible for persons with disability.
5. More collaboration between SAHA, community housing providers, the NDIA and homelessness support services when persons with disability are facing eviction, non-renewal of lease or homelessness and attempting to obtain secure housing.
6. Ensuring that persons on the Disability Support Pension can be placed on at least Category 2 for SAHA in both the registration *and* transfer process.
7. Review the accessibility and safety of crisis accommodation, short-stay accommodation and boarding/rooming houses.
8. Extend funding to homelessness support organisations so individuals can get assistance to avoid homelessness. Shift the focus to preventing homelessness rather than waiting until people are sleeping rough or couch-surfing.
9. The State Government should work with the Federal Government to review the level of accessibility and affordability for Specialist Disability Accommodation (SDA) and Supported Independent Living (SIL).

[16] LHA Platinum (livablehousingaustralia.org.au)

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10. The State Government should collect data on the number of young people with disability in Aged Care facilities in South Australia and monitor their experiences. More secure and stable housing options should be created so young people with disability can have sustainable social networks with peers.

11. The State Government should advocate to the Federal Government for amendments to the *Disability Discrimination Act 1992* (Cth) to make it clearer that refusing a housing modification is discrimination against persons with disability. The State Government should amend the *Equal Opportunity Act 1984* (SA) to the same effect.

12. DRAS welcomes the Federal Government's recent increase to Commonwealth Rent Assistance and Income Support Payments for those relying on Centrelink. However, we share the same concerns from the Australian Council of Social Services (ACOSS) that it is only a modest increase that will not lift people out of poverty.

13. Review government Home-Buyer schemes to investigate the impact on inflation and house prices, with a view to ensuring they do not inadvertently cause house prices to rise.

14. Mandate training for SAHA and community housing frontline staff for disability awareness, mental health first aid training, cultural awareness and trauma-informed practice. This should also include training for responding to disclosures of domestic or sexual violence.

15. Update the requirements that real estate agents and property managers need to maintain their practice licence, by mandating disability awareness, mental health first aid training, cultural awareness and trauma-informed practice.

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