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Key findings
People with a disability

- At June 2005, there were 204,300 people living in the NT.
- Twenty nine percent (approx 59,000) are Indigenous.
- There are approximately 39,500 people with a disability.
- About 40% (or 15,800) of these people are Indigenous.
- Approximately 11 – 12,000 people in the NT have a severe or profound disability.
- Of these, about 43% (or 5,000) people are Indigenous.
People with a disability

Estimated number of people with a disability by age group and Indigenous status in 2006:

| Age Group | All disability | | | | Severe/profound disability only | | | |
|-----------|----------------|----------------|----------------|--------|--------------------------------|--|--------|----------------|-----|--------|----------------------------------|--------|------|--------|-----|
|           | Indigenous     | Non-indigenous | Total          | Indigenous | Non-indigenous | Total | proportion |
| 0-14      | 4100           | 2400           | 6500           | 2100      | 1300           | 3400  | 40%       |
| 15-44     | 6500           | 8200           | 14700          | 1500      | 1900           | 3400  | 43%       |
| 45-64     | 3800           | 9300           | 13100          | 900       | 2100           | 3000  | 47%       |
| Total under 65 | 14400 | 19900 | 34300 | 4500 | 5300 | 9800 | 40% |
| 65+       | 1300           | 3800           | 5100           | 500       | 1400           | 1900  | 53%       |
| Total     | 15700          | 23700          | 39400          | 5000      | 6700           | 11700 | 43%       |

Source: KPMG estimates derived from ABS (2003): Survey of Disability, Ageing and Carers (SDAC); Burden of Disease data provided by the NT Department of Health and Community Services (DHCS) and 2006 estimated population, Charles Darwin University and NT government.
## People with a disability

By location:

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Darwin</th>
<th>Alice Springs</th>
<th>Katherine</th>
<th>Remote</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-14</td>
<td>2,400</td>
<td>700</td>
<td>300</td>
<td>3,100</td>
<td>6,500</td>
</tr>
<tr>
<td>15-44</td>
<td>6,500</td>
<td>1,700</td>
<td>600</td>
<td>5,800</td>
<td>14,600</td>
</tr>
<tr>
<td>45-64</td>
<td>6,500</td>
<td>1,700</td>
<td>600</td>
<td>4,300</td>
<td>13,100</td>
</tr>
<tr>
<td>65+</td>
<td>2,500</td>
<td>700</td>
<td>300</td>
<td>1,600</td>
<td>5,100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>17,900</td>
<td>4,800</td>
<td>1,800</td>
<td>14,900</td>
<td>39,300</td>
</tr>
<tr>
<td><strong>proportion</strong></td>
<td>45%</td>
<td>12%</td>
<td>5%</td>
<td>38%</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Indigenous**

<table>
<thead>
<tr>
<th></th>
<th>Darwin</th>
<th>Alice Springs</th>
<th>Katherine</th>
<th>Remote</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-14</td>
<td>2,900</td>
<td>1,400</td>
<td>600</td>
<td>10,900</td>
<td>15,800</td>
</tr>
</tbody>
</table>

Notes: Darwin is defined as the Darwin urban area and Palmerston; Alice Springs is the Alice Springs urban area (excluding town camps); Katherine is defined as the Katherine Local Government Area; Remote is defined as all areas outside of Darwin, Alice Springs and Katherine and includes all remote communities, small settlements, and the towns of Tennant Creek and Nhulunbuy.
People with a disability

People with a severe/profound disability by location:

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Darwin</th>
<th>Alice Springs</th>
<th>Katherine</th>
<th>Remote</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-14</td>
<td>1,300</td>
<td>400</td>
<td>&lt;200</td>
<td>1,600</td>
<td>3,500</td>
</tr>
<tr>
<td>15-44</td>
<td>1,500</td>
<td>400</td>
<td>&lt;150</td>
<td>1,300</td>
<td>3,300</td>
</tr>
<tr>
<td>45-64</td>
<td>1,500</td>
<td>400</td>
<td>&lt;150</td>
<td>1,000</td>
<td>3,000</td>
</tr>
<tr>
<td>65+</td>
<td>900</td>
<td>300</td>
<td>&lt;150</td>
<td>600</td>
<td>1,900</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>5,200</strong></td>
<td><strong>1,500</strong></td>
<td><strong>500</strong></td>
<td><strong>4,500</strong></td>
<td><strong>11,700</strong></td>
</tr>
</tbody>
</table>

**proportion**

- Indigenous: 900 (44%), 400 (12%), 200 (5%), 3,500 (39%), 5,000 (100%)

Source: KPMG estimates derived from ABS (2003) SDAC; Burden of Disease data provided by NT DHCS, 2006 estimated population (Charles Darwin University and NT Government), and ABS (2005): Regional Statistics NT.
People with a disability

Projections over the next 20 years:

**General population trends**

- Total population ↑ 33 percent (an average ↑ of 1.4 percent per annum)
- People aged 65 and over ↑ 130 percent (average of ↑ 4.2 percent per annum)
- The Indigenous population ↑ 1.5 percent per annum (slightly higher than the non-Indigenous population ↑ 1.4 percent per annum).
- Within the Indigenous population the largest growth will be in people aged over 65 (4.2 percent per annum) with significant growth for people aged 45-64 (3.3 percent per annum).

**Disability population trends**

- Total population with a disability ↑ 47 percent (more than 11,500 people), (av. ↑ 1.9 percent per year)
- People with a disability aged < 65 years ↑ 34 percent (an additional 3,000 people) (or 1.5 percent per annum)
- People with a severe or profound disability ↑ 48 percent (or more than 5,600 people) (or 2.0 percent per year)
- People with a severe or profound disability aged < 65 years ↑ 31 percent (an additional 3,000 people) (or 1.4 percent per annum.)
People with a disability - *implications*

- The high percentage of people with a disability living in remote communities presents significant challenges for the planning and distribution of services and resources. These include:
  - the ability to deliver services over a sustained period of time due to distance and remoteness;
  - appropriate infrastructure to support and deliver residential or centre based services such as respite and day programs;
  - the need to develop culturally appropriate services; and
  - the need for resource methodologies to consider the double disadvantage experienced by people with a disability living in remote communities.

- The community aged care system will move from being a small part of community service provision to a major service system given the ageing of the population.

- The high percentage of people with severe and profound disability living in remote communities means that a major area of service delivery is required in regions where the costs of provision are higher. This will need to factored into any investment planning.

- The NT is going to need to achieve real growth in the total level of service provided to meet increased demand. This will require efficiency gains or real growth above CPI.
Current funding levels – government and non-government services

- 59% of funding goes to NGOs.
- 32% is allocated to fund government services.
- 9% is allocated to services or service packages for individual clients – typically clients with high support needs or in need of crisis or time limited support.
- The majority of funded organisations are ‘block funded’, that is, they receive a grant for each service they deliver.
- Regional allocations are not population based nor weighted for remoteness or disadvantage factors.
## Current funding levels: government and non-government services

### 2004-05 funding by service and provider type

<table>
<thead>
<tr>
<th>Service Type</th>
<th>NGO Grants</th>
<th>Individual funding</th>
<th>Internal services</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>24-hour accommodation support</td>
<td>11.975</td>
<td>...</td>
<td>11.975</td>
<td></td>
</tr>
<tr>
<td>In-home support/personal care</td>
<td>0.749</td>
<td>1.797</td>
<td>...</td>
<td>2.546</td>
</tr>
<tr>
<td>Out-of-home care for children</td>
<td>0.979</td>
<td>...</td>
<td>...</td>
<td>0.979</td>
</tr>
<tr>
<td>Specialist children's services</td>
<td>0.550</td>
<td>0.043</td>
<td>3.179</td>
<td>3.772</td>
</tr>
<tr>
<td>Therapy and behaviour management¹</td>
<td>0.552</td>
<td>0.188</td>
<td>3.548</td>
<td>4.288</td>
</tr>
<tr>
<td>Day programs &amp; post school options</td>
<td>2.263</td>
<td>0.243</td>
<td>...</td>
<td>2.506</td>
</tr>
<tr>
<td>Respite</td>
<td>1.144</td>
<td>0.495</td>
<td>...</td>
<td>1.639</td>
</tr>
<tr>
<td>Coordination &amp; case management</td>
<td>...</td>
<td>...</td>
<td>0.663</td>
<td>0.663</td>
</tr>
<tr>
<td>Equipment (TIMES/SEAT)</td>
<td>...</td>
<td>...</td>
<td>2.156</td>
<td>2.156</td>
</tr>
<tr>
<td>Taxi Subsidy Scheme</td>
<td>...</td>
<td>...</td>
<td>0.466</td>
<td>0.466</td>
</tr>
<tr>
<td>Information and advocacy</td>
<td>0.167</td>
<td>...</td>
<td>...</td>
<td>0.167</td>
</tr>
<tr>
<td>Other services/unclassified</td>
<td>...</td>
<td>0.012</td>
<td>...</td>
<td>0.012</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>18.379</strong></td>
<td><strong>2.778</strong></td>
<td><strong>10.012</strong></td>
<td><strong>31.169</strong></td>
</tr>
</tbody>
</table>

**proportion**

<table>
<thead>
<tr>
<th>NGO Grants</th>
<th>Individual funding</th>
<th>Internal services</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>59%</td>
<td>9%</td>
<td>32%</td>
<td></td>
</tr>
</tbody>
</table>

¹ Includes community aged care and primary health care clients.

Excludes HACC services (other than community aged care services provided by internal service teams which are funded by HACC) and ACAT services, and administration.

Source: DHCS
### Clients by service type – government and non-government services

#### 2004-05 clients by service and provider type

<table>
<thead>
<tr>
<th>Service Type</th>
<th>NGO Grants</th>
<th>Individual funding</th>
<th>Internal services</th>
</tr>
</thead>
<tbody>
<tr>
<td>24-hour accommodation support</td>
<td>145</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>In-home support/personal care</td>
<td>98</td>
<td>43</td>
<td>0</td>
</tr>
<tr>
<td>Out-of-home care for children</td>
<td>42</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Specialist children's services (^1)</td>
<td>71</td>
<td>4</td>
<td>2578</td>
</tr>
<tr>
<td>Therapy and behaviour management (^2)</td>
<td>251</td>
<td>21</td>
<td>2421</td>
</tr>
<tr>
<td>Day programs &amp; post school options (^3)</td>
<td>278</td>
<td>20</td>
<td>0</td>
</tr>
<tr>
<td>Respite</td>
<td>177</td>
<td>52</td>
<td>0</td>
</tr>
<tr>
<td>Local area coordination</td>
<td>0</td>
<td>0</td>
<td>376</td>
</tr>
<tr>
<td>TIMES/SEAT</td>
<td>0</td>
<td>0</td>
<td>1932</td>
</tr>
<tr>
<td>Taxi Subsidy Scheme</td>
<td>0</td>
<td>0</td>
<td>295</td>
</tr>
<tr>
<td>Other services/unclassified</td>
<td>0</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>

1Includes early childhood intervention and school therapy services
2Includes some community aged care and primary health services provided by urban and regional teams
3Includes recreation services

Excludes HACC services (other than community aged care services provided by internal service teams which are funded by HACC) and ACAT services, and administration.

Source: Various sources (CSTDA MDS, CCIS, HACC MDS, Individual funding database)
### Government provided disability services

#### Government service provision - clients and expenditure by location

<table>
<thead>
<tr>
<th>Service</th>
<th>Darwin</th>
<th>Alice Springs</th>
<th>Katherine</th>
<th>Remote</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early childhood intervention</td>
<td>685</td>
<td>276</td>
<td>88</td>
<td>334</td>
<td>1383</td>
</tr>
<tr>
<td>Adult therapy and coordination</td>
<td>1098</td>
<td>296</td>
<td>212</td>
<td>815</td>
<td>2421</td>
</tr>
<tr>
<td>Local area coordination</td>
<td>207</td>
<td>53</td>
<td>23</td>
<td>93</td>
<td>376</td>
</tr>
<tr>
<td>School therapy</td>
<td>731</td>
<td>171</td>
<td>58</td>
<td>235</td>
<td>1195</td>
</tr>
<tr>
<td>TIMES/SEAT</td>
<td>1160</td>
<td>240</td>
<td>79</td>
<td>453</td>
<td>1932</td>
</tr>
<tr>
<td>Taxi Subsidy Scheme</td>
<td>214</td>
<td>52</td>
<td>8</td>
<td>11</td>
<td>285</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>4095</td>
<td>1088</td>
<td>468</td>
<td>1941</td>
<td>7592</td>
</tr>
<tr>
<td><strong>proportion</strong></td>
<td>54%</td>
<td>14%</td>
<td>6%</td>
<td>26%</td>
<td></td>
</tr>
</tbody>
</table>

#### Expenditure ($m)

<table>
<thead>
<tr>
<th></th>
<th>Darwin</th>
<th>Alice Springs</th>
<th>Katherine</th>
<th>Remote</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Expenditure</strong></td>
<td>4.933</td>
<td>2.220</td>
<td>0.765</td>
<td>2.094</td>
<td>10.012</td>
</tr>
<tr>
<td><strong>proportion</strong></td>
<td>49%</td>
<td>22%</td>
<td>8%</td>
<td>21%</td>
<td></td>
</tr>
</tbody>
</table>

#### Comparison to population share

<table>
<thead>
<tr>
<th>Population Type</th>
<th>Darwin</th>
<th>Alice Springs</th>
<th>Katherine</th>
<th>Remote</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prop of general population</td>
<td>54%</td>
<td>13%</td>
<td>5%</td>
<td>29%</td>
<td></td>
</tr>
<tr>
<td>Prop of disability population</td>
<td>45%</td>
<td>12%</td>
<td>5%</td>
<td>38%</td>
<td></td>
</tr>
<tr>
<td>Prop of severe/profound disability population</td>
<td>44%</td>
<td>12%</td>
<td>5%</td>
<td>39%</td>
<td></td>
</tr>
</tbody>
</table>
Access to government services

- The majority of government provided services are adult therapy and coordination (allied health) (32%), followed by TIMES/SEAT (25 Percent).

- Fifty-four percent of government provided services are in Darwin urban.

- The majority of government services are provided to children aged 0 to 14 years (47 percent).

- The majority of government services are provided to the non-Indigenous population (60 percent).

- Access to government provided services in remote areas is significantly less than service access in Darwin, Alice Springs and Katherine for all service types.

- Funding for government services is inequitably distributed comparative to population share and proportion of people with a disability.

- Funding for Alice Springs is substantially higher (22%) than population share (13%), and disability population (12% percent).

- Thirty eight percent of the population with a disability live in remote communities but only receive 21 percent of funding.
Access to government services - implications

- There are significant geographic and population group equity issues in relation to access to services and resources.

- The analysis does not suggest that Darwin is over serviced, rather that remote communities are substantially under serviced relative to population, funding share and prevalence of disability.

- The lack of services in remote communities by default forces people to relocate to urban centres to receive service, primarily Darwin. This places additional pressure on these service systems and is not always culturally appropriate.

- Future planning should consider a population based approach to drive equity based on population share followed by prevalence of disability.

- Service options should be place based where able, maximising access within local communities and enabling culturally appropriate responses.

- Any new resources should focus in part on addressing areas of inequity. An equalisation strategy would suggest that a proportion of new funds should go to remote communities. This may not necessarily equate to new services but more intensive services and supports.
Government provision of primary health services

- A significant proportion of services (up to 35 percent) provided by the regional ADP service teams are to people without a disability. This reflects their multiple roles in particular the primary health function that carried forward as part of the most recent program restructure.

- This has resulted in an increase in demand for limited resources including funding and staff, and confusion within the program as to who the target group is and subsequent priorities of access to service.

- In light of the unmet demand for specialist disability support the role of ADP service staff in the provision of services to people without disability (primary health) needs to be reconsidered.
# Access to non government services

## Non-government and individually-funded disability service provision - funding and clients by service type, 2004-05

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Funding $m</th>
<th>%</th>
<th>Clients No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>24-hour accommodation support</td>
<td>11.975</td>
<td>57%</td>
<td>145</td>
<td>12%</td>
</tr>
<tr>
<td>Out-of-home care for children</td>
<td>0.979</td>
<td>5%</td>
<td>42</td>
<td>4%</td>
</tr>
<tr>
<td>In-home support/personal care</td>
<td>2.546</td>
<td>12%</td>
<td>141</td>
<td>12%</td>
</tr>
<tr>
<td>Specialist children's services</td>
<td>0.593</td>
<td>3%</td>
<td>75</td>
<td>6%</td>
</tr>
<tr>
<td>Therapy and behaviour management(^1)</td>
<td>0.740</td>
<td>3%</td>
<td>272</td>
<td>23%</td>
</tr>
<tr>
<td>Day programs &amp; post school options(^2)</td>
<td>2.506</td>
<td>12%</td>
<td>303</td>
<td>26%</td>
</tr>
<tr>
<td>Respite</td>
<td>1.639</td>
<td>8%</td>
<td>229</td>
<td>19%</td>
</tr>
<tr>
<td>Information and advocacy</td>
<td>0.167</td>
<td>1%</td>
<td>na</td>
<td>na</td>
</tr>
<tr>
<td>Other services/unclassified</td>
<td>0.012</td>
<td>0%</td>
<td>2</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>21.157</strong></td>
<td></td>
<td><strong>1187</strong></td>
<td></td>
</tr>
</tbody>
</table>

Data includes individually-funded clients who receive services from NGOs or who purchase services from private providers. There may be some double-counting of individually-funded clients given some may be counted in both the CSTDA MDS and data sourced from DHCS’ individual funding database.

\(^1\)Includes counselling and case management.

\(^2\)Includes recreation programs.

\(^3\)Does not represent unique clients - some clients receive more than one service type, hence have been counted more than once.
Access to non government services

- The majority of clients are aged between 15 and 44 years (48 percent) and are non-Indigenous (58 percent).

- The majority of NGO funding is allocated to service providers in Darwin and Alice Springs and the majority of NGO clients live in these two urban centres.

- There are few NGOs in that provide services in remote areas, hence access to services relative to population is low in these areas.

- For some service types the access ratio for people with disability living in urban centres is 70 to 80 percent higher.

- The majority of services provided by NGOs are day programs and post school options (25 percent), therapy, counselling and case management (24 percent) and respite (17 percent).

- 24 hour accommodation support accounts for 57 percent of NGO funding but provides a service to only 12 percent of clients.

- The non government sector virtually has no presence in remote communities in relation to the delivery of specialist disability services.

- There is a need to increase the delivery of services within remote communities by the non government sector. This needs to include the types of services provided in urban centres and the introduction of new services.
Non government services – Accommodation Support

Funding for clients in accommodation support services is high in the NT relative to other jurisdictions as shown below.

**Funding per accommodation support client by jurisdiction 2004-05**

Non government services – Accommodation Support

- The NT has a high ratio of clients in accommodation support comparative to other jurisdictions (with the exception of New South Wales).

- The average cost per client for accommodation support in the NT is $76,000. This is higher than the Australian average.

- Excluding New South Wales, the NT has the lowest utilisation across Australia of in home support as a model.
Non government services – Accommodation Support - implications

• 24 hour accommodation support is an expensive model of support but is and will remain an appropriate form of support for a range for people with disability.

• Within the NT the 24 hour model is the primary form of supported accommodation.

• There is a need to explore different models of accommodation support to ensure:
  • the most suitable form of support for the person with a disability;
  • the most efficient use of resources; and
  • a form of support that maximises the persons levels of independence and community access.

• There are a range of accommodation support models utilised in other jurisdictions that involve different support arrangements and associated resource allocation methods to maximise flexibility, responsiveness and efficiency that the NT can look to and adapt for the NT environment. Some examples are provided on the following page.
Non government services – Accommodation Support - *implications*

- **Cluster housing** – two to three accommodation units on one block often with two persons in each unit. Provides smaller more individual type living arrangements for each person however staffing resources are shared which maximises efficient use of resources. This type of arrangement is often used for people with mild to moderate support needs.

- **Adjoining units** – two units that have separate entrances, kitchen, bedroom and bathroom facilities but shared common living areas. Staffing resources are shared across the two units. Often used for ageing clients who have high personal care needs but enjoy the company of others.

- **Accommodation units/houses within a one kilometre radius**. This model is often used for people with physical support needs who are moderately independent with mild or no intellectual disability. The units/houses are purpose built for people in wheelchairs. Technology is installed that enables buzzer systems between the houses and staff call arrangements. Staff arrangements are shared between the two houses with one house manager.

- **Two houses side by side**. This model is sometimes used for people with high and complex needs that may require nursing interventions. Whilst each house has separate rosters there is one house manager across the two houses and the nursing support is shared.
Key themes

The key themes that emerged from the data analysis, review of other services and consultations are:

- Theme 1: Characteristics of the NT
- Theme 2: Forward strategy and policy framework
- Theme 3: System navigation
- Theme 4: Target group and service access
- Theme 5: Program structure
- Theme 6: Service system
- Theme 7: Funding and financing
- Theme 8: Whole of government
- Theme 9: Quality management
- Theme 10: Workforce
Themes

Characteristics of the NT

- The NT’s small but geographically dispersed population, the large percentage of Indigenous people living in the remote communities, and the needs of culturally and linguistically diverse groups create many challenges for DHCS in delivering timely and efficient disability services.

- Any service structure must recognise and respond to the NT’s unique environment.

- Service structures must focus on managing the intersections between programs and establishing linkages through planning and resource allocation across programs to better respond to the needs of the population.

Forward strategy and policy framework

- A forward direction strategy that establishes the policy parameters and priorities for the disability sector is required. The strategy needs to link and align with key Australian Government and Territory policy frameworks and provide a framework for regional service delivery and the engagement of the non government sector.

- Operational policy to guide day-to-day practice and decision making needs to be developed.
Themes

System navigation

• There is a lack of information with regard to services and supports suggesting some confusion as to how to effectively navigate the service system.

• An information strategy to inform and assist the community to navigate the service system needs to be established.

Target group and service access

• The responsibilities of the ADP in relation to each target group they service must be clearly defined. In particular, the responsibilities of the ADP in relation to people with disabilities needs to be clearly defined for each sub target group.

• Policies and procedures to support decision making for eligibility and priority of access and resource allocation must be developed.

• A comprehensive assessment tool to support decision making for eligibility and priority of access and resource allocation is required.

• The role of the generic service system in response to people with disability needs to be defined. As part of this the relationship between the generic and specialist service systems need to be defined.
Themes

Program structure

- A joint planning model between primary and community health, aged and disability services, particularly in response to remote communities is required. The planning framework needs to build generic capacity and target specialisation where required.

- In light of the unmet demand for specialist disability support the role of ADP service staff in the provision of services to people without disability (primary health) needs to be reconsidered.

- There is a need to establish an increased focus on and capacity for facilitating and supporting community access and inclusion for people with disability and strengthening the capacity of the generic service system to respond to the needs of people with disability.

- The relationships between government and NGOs need to be strengthened to inform practice and service development. This needs to occur at both a client level through joint planning and at a service planning level.
Themes

Service system

- A framework for broadening the range of service options and capacity is required.

- Joint planning, assessment and integrated service provision is required across key DHCS programs.

- Investment to address current system deficits and increasing demand from the ageing of the population, both people with disability and carers is required.

- Investment must encourage new ways of thinking and structural reform to maximise service access.
Themes

Funding and financing

- Funding models need to be better targeted to service options to deliver accountability and flexibility.

- Improvements to data collection, analysis and reporting methods to enable effective trend analysis and review of performance must be undertaken.

- A clear policy basis/rationale to underpin funding decisions needs to be established.

- A system that links expenditure and service delivery effort to assess efficiency and performance is required.

- Population planning to support forward estimates of service delivery is required.
Themes

Whole of government

• There are few mechanisms in place to foster partnerships between the generic and specialist service systems, nor are there formal mechanisms in place to facilitate the development of cross government, multi agency responses to meeting the needs of people with a disability.

• There is no agreed understanding of the relationship between specialist and generic services and no agreed approach to responding to people with disability from a whole of government perspective. Therefore there is no agreed understanding as to the core business responsibilities for government agencies in responding to people with disabilities.

• The roles and responsibilities of government within the provision of services and supports for people with a disability and how government can work more effectively together in the development and delivery of those responses need to be clearly articulated.
Themes

Quality management

- The lack of effective monitoring and quality assurance frameworks is impacting upon the overall quality of services.

- NGOs needed to be held accountable for funding and performance. In particular, the lack of monitoring fails to deliver effective risk management in response to the vulnerabilities of people with a disability in receipt of services.

- There is a high degree of consensus between government and NGOs regarding the importance of establishing a quality framework. Service providers recognise that there are a number of challenges in establishing a quality management framework for the disability sector within the NT.

- A quality management framework for disability support provision within the NT needs to be established.

- As part of this, consideration should be given to identifying whether there is capacity to establish linkages to other existing systems.
Themes

Workforce

• Issues include attraction and retention of staff, remuneration, the structure of the workforce, competition from other sectors for the limited pool of potential staff, and Aboriginal participation in the workforce, among others.

• An industry workforce plan that addresses the requirements for the future workforce needs to be established. Consideration needs to be given to attraction and recruitment; learning and development and flexible employment models to support retention is required.
A new direction for disability support provision – an integrated approach to service delivery
Rationale for change

The provision of disability support within the NT has not been able to keep pace with changing policy frameworks and contemporary practice approaches.

The most significant shift in disability support, both internationally and within Australia, has been the heightened focus on people with disabilities being seen as partners, with a greater recognition of rights and responsibilities.

There has been an increased focus on inclusion. This has involved:

• a focus on integrated options from the beginning;

• an increased emphasis on community based support and tailoring service provision to the individual with a range of models focused on in home support and community based provision aimed at supporting the person with a disability to live in the community;

• recognition of the need for informal and formal support networks;

• an emphasis on individual planning and support and person centred approaches; and

• a focus on increasing the accessibility of mainstream human services.
Rationale for change

Experience in other jurisdictions has shown that the capacity of the sector and the community can grow through:

- flexibility (of models, service responses, funding methodologies);
- responsiveness (to the needs of the person and the local community); and
- taking a systemic perspective (whole of community and whole of government).

Finally, given the environment of increased competition for resources, there has been a need for improved cost effectiveness.

*The NT needs to take action to bring itself in line with contemporary support provision for people with disabilities within Australia.*

*The introduction of an integrated model of delivery not only ensures improved access and responsiveness for people with disabilities within the NT but an approach that can, through a contemporary model, deliver cutting edge practice.*
Vision, mission and objectives of the integrated service model

Vision
To provide responsive and integrated services to people with disability that promote equity, choice and increased access

Mission
Disability support provision is based on contemporary practice underpinned by partnerships and collaborative approaches

Objectives
• Greater equity in service access
• Increased access to a broader range of services within the community
• Policy driven system
• Transparency and objectivity in decision making
• Comprehensive and integrated approach to planning, assessment and resource allocation
• Quality and accountability
Vision, mission and objectives of the integrated service model

The proposed service model and associated investment plan form the forward direction for the provision of disability support services within the NT for the next five to 10 years.

The strategy aims to link and align with key Australian Government and Northern Territory policy frameworks and provide a framework for regional service delivery and the engagement of the non government sector.

The underpinning principles are based on principles evidenced in the Disability Services Act 1993 (NT) and the associated Disability Service Standards.

The core principles that underpin the service delivery model are that it is:

- future focused;
- equitable;
- sustainable;
- flexible and responsive;
- person centred;
- collaborative; and
- outcomes driven.
Characteristics of the integrated service model

• The proposed model has a number of components:

  • a program management structure;
  
  • an agreed policy, legislative and regulatory base;
  
  • a planning framework;
  
  • assessment and case management processes;
  
  • resource allocation methods;
  
  • an agreed service delivery platform; and
  
  • an approach to quality management.
Characteristics of the integrated service model

Program management structure

Establish an Office of Disability within DHCS responsible for:

- policy and planning;
- legislation and regulation;
- assessment and access to service;
- resource allocation;
- systems development;
- capacity building; and
- quality management.
Characteristics of the integrated service model

Policy and legislative framework

The context for the provision of disability services is provided by the relevant legislation and strategic policies:

- Australian Government level – the Commonwealth State and Territory Disability Agreement, the Home and Community Care program, and the community care reforms – The Way Forward;

- Territory level – the *Disability Services Act 1993* (NT) including the Disability Service Standards, *Building Healthy Communities, Aboriginal Health and Families: A five year framework for action implementation* and the *Carers Recognition Bill, 2006*; and

However, there is a need for the ADP to develop operational policy to guide disability practice and decision making.

- Operational policy should include address:
  - service entry and eligibility requirements;
  - priority of access for services;
  - risk management requirements and obligations;
  - resource allocation processes and methods;
  - participation of families and carers in service planning;
  - duty of care and dignity of risk;
  - privacy and confidentiality; and
  - performance monitoring processes.
Characteristics of the integrated service model

Planning framework

• Joint DHCS program planning is required to maximise the effective use of resources.

• A population based model whereby resource allocation is linked to the number of people with disabilities in a region and the determination of an appropriate funding ratio per head of population.

• Planning in partnership between government, non government providers, community representatives and people with a disability would see a population based approach that gives consideration to the appropriate mix of resources for a region across the relevant DHSC programs (health, primary health, child and family, aged and disability).
Characteristics of the integrated service model

Assessment, eligibility, priority of access, referral and case management

• Assessment occurs at entry point (intake) into the service system and is the responsibility of government in their funding role.

• Assessment is multi-dimensional using a comprehensive assessment tool.

• Assessment determines eligibility and priority of access and appropriate referral pathway.

• Secondary assessment is undertaken by service providers.

• Eligible persons are those identified within the CSTDA and those targeted for service by the NT government.

• Local Area Coordination includes supporting individuals and families to access services as well as community capacity building to improve the capacity of the generic service system and the community in responding to people with a disability.

• Case management is a function of government service teams.

• Case management is available for people that require more complex facilitation of options and supports in responding to their needs.
Characteristics of the integrated service model

Resource allocation

• Funding is based on eligibility and relative need.

• There is a mixture of funding mechanisms that link to the model of support to maximise flexibility, efficiency and accountability.

• Resource allocation methodology supports the population based planning model and is based on prevalence of disability and weighted for remoteness and disadvantage.
Characteristics of the integrated service model

Service delivery platform

- Disability support provision should be integrated with mainstream programs.
- There is an opportunity for developing ‘bolt on’ service arrangements which sees disability expertise embedded in mainstream service provision.
Characteristics of the integrated service model

Quality management

- An integrated DHCS quality management framework is required.

- A quality management framework should have a focus on quality assurance, risk management, quality improvement and capacity building.

- Quality assurance strategies will underpin improvements to service provision.
A whole of government approach -

The primary objective of a whole of government approach in relation to people with disability in the NT is to improve the economic and social participation and contribution of people with disability within the Territory.

To achieve this it is necessary to:

- build on and strengthen partnerships between all stakeholders;
- promote acceptance that people with disabilities, and their families and carers, have the same fundamental rights as the rest of the community;
- identify and remove barriers in program development and delivery;
- eliminate discriminatory practices as employers and program administrators;
- promote the accessibility of buildings, transport and services; and
- develop plans, strategies and actions to ensure the needs of people with disabilities and their families and carers are taken into account in planning and service delivery.
A whole of government approach

There are two key elements of a framework for a whole of government approach to people with disability within the NT. The framework must:

- support and facilitate cross agency collaboration; and
- guide individual agencies in their roles in responding to people with disability.

Cross agency collaboration

The framework needs to:

- establish mechanisms to improve communication and information sharing to improve knowledge of current program operations and arrangements and support targeting of opportunities to work collaboratively;
- focus on strengthening key relationships and building on existing opportunities for improved collaboration and service coordination; and
- support the development of new opportunities to increase the social and economic participation and contribution of people with disability within the community.

Key relationships with other agencies: DEET and DPI in the NT, and FACSIA (AG)
A whole of government approach - role of other NT government agencies

A framework to guide individual agencies in their roles

Meeting the core business obligations of each agency’s roles in relation to people with disability across all services and programs requires;

- consultation processes to enable the inclusion of the views of people with disabilities to be considered;
- understanding the impact of policy on people with disabilities;
- compliance with the Disability Discrimination Act 1992 (Commonwealth);
- the provision of information in accessible formats;
- accessible and inclusive practices by agencies; and
- working across government to maximise responsiveness.
Implementing the integrated service model

To give effect to the new model of service delivery there is a need to ensure an integrated and coordinated approach to implementation.

Key to implementing the new model of delivery will be:

- taking a staged approach to implementation to ensure appropriate planning can occur;
- the development of an Industry Plan to support the long term development of the sector;
- the development of a Workforce Plan to attract, recruit and retain a skilled and competent workforce;
- developing a communication strategy to inform key stakeholders of the proposed directions and how implementation will occur; and
- engaging the sector in key development activities to ensure the best use of knowledge and resources from within the sector and to drive ownership of the proposed directions.
Recommendations
Recommendations

Recommendation 1:
That DHCS endorse the proposed service delivery model and implement the model fully within the next five years. This includes endorsing the vision, mission and underpinning principles supporting the model and the core components of the operating model which are the:

- program management structure;
- policy and legislative framework;
- planning framework;
- assessment, eligibility and case management procedures;
- resource allocation processes and methodologies;
- service delivery platform; and
- quality management requirements.

Recommendation 2:
That DHCS endorse the proposed investment strategy to underpin the implementation of the integrated model for service delivery. This investment strategy has two focuses:

- investment to drive practice change creating new models of support and structural efficiencies; and
- investment to support the implementation of the integrated service model which includes establishing the structure, systems and supports to ensure the sector is able to move forward with the proposed directions.
Recommendations

Recommendation 3:
That DHCS develop a detailed plan to support the implementation of the new model of delivery over the next five years. The implementation plan should identify key areas of action, the timing of those actions, responsibility for implementation and how implementation activity will be measured.

Recommendation 4:
That DHCS establish a governance structure to oversee the implementation of the new service arrangements. The governance structure should involve:
- people with disabilities, their families and carers;
- service providers (both disability and mainstream);
- ADP representatives; and
- DHCS representatives.

Recommendation 5:
That DHCS, in partnership with the sector, develop and implement a communication strategy to inform all stakeholders about the integrated service delivery model. Communication about the integrated service model needs to include:
- the nature, shape and purpose of the service delivery model;
- how it will work;
- how it will be implemented;
- how stakeholders can contribute to the implementation process;
- the benefits to be derived for people with disabilities, their families and carers and service providers from the integrated service model; and
- the ongoing provision of information throughout the implementation phase.
Recommendations

Recommendation 6:
That DHCS establish the Office of Disability within the Department to lead the implementation of the integrated service delivery model. As part of this the roles, functions and responsibilities of the Office of Disability need to be articulated and endorsed.

Recommendation 7:
That DHCS develop a quality management framework to underpin the integrated service delivery model. That in the interim the ADP introduce short term measures to address quality assurance requirements for service provision. These strategies include:

- operational policies and procedures to guide practice;
- risk and incident management;
- improved data collection;
- complaints mechanism;
- organisational quality plans; and
- improved service level agreement monitoring.
Recommendation 8:
That DHCS develop and implement an Industry Plan to support the growth and development of the sector to give effect to the five year plan. The Industry Plan should focus on specific strategies that facilitate and support:

- partnerships and collaborative approaches;
- building the skills and capacity of the sector;
- changes to traditional service models to establish new and flexible ways of delivery;
- strengthening the management capacity and leadership of the sector;
- knowledge and information sharing;
- greater involvement of people with disabilities in service planning and support; and
- transitioning resources from traditional service arrangements to establish support and choice options for individuals currently in receipt of:
  - accommodation support services;
  - centre based day programs; and
  - respite services.
Recommendations

Recommendation 9:
That DHCS develop and implement a workforce strategy to support the attraction, recruitment and retention of a qualified and skilled workforce to deliver on the objectives of the five year plan. As part of this consideration will need to be given to:

- agreement with regard to the size, nature and shape of the workforce required to give effect to the forward direction for disability services;
- a minimum entry qualification framework for workers with competencies and skills consistent with those require to provide support in a manner consistent with that envisaged within the integrated model of delivery;
- consideration of the establishment of a broader workforce category and associated career structure to provide opportunities for expanding the potential pool of resources available;
- a view about how to support the non government sector to undertake workforce planning and agreement about the necessary data required to be collected to support effective workforce planning;
- innovative and targeted attraction and recruitment strategies that provide realistic job previews, understand the target market and are prepared to explore and penetrate new markets;
- a learning and development strategy that is linked to the requirements of the program both now and into the future and considers the needs of the non government sector;
- an emphasis on innovative employment models with the primary aim of retaining quality staff; and
- development of partnerships with other health and human service providers with regard to attraction, recruitment, training and development.
Recommendations

Recommendation 10:
That DHCS work with the other NT government agencies to agree and implement the whole of government approach to people with disability within the NT. There are two key elements to establishing a whole of government approach to people with disability in the NT. These are a framework that:

- supports and facilitates cross agency collaboration; and
- guides individual agencies in their core business roles in responding to people with disability.
The information contained herein is of a general nature and is not intended to address the circumstances of any particular individual or entity. Although we endeavour to provide accurate and timely information, there can be no guarantee that such information is accurate as of the date it is received or that it will continue to be accurate in the future. No one should act on such information without appropriate professional advice after a thorough examination of the particular situation.

Liz Forsyth
Partner,
National Health and
Human Services Practice
0418 659 857
lforsyth@kpmg.com.au