



**Evaluation of the Decision  
Support Pilot – Final Report**  
Department of Social Services

June 2023

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# Glossary

<b>Acronym</b>	<b>Full name</b>
CALD	Culturally and Linguistically Diverse
DEX	Data Exchange
DSP	Decision Support Pilot
DSS	Department of Social Services
LAC	Local Area Coordinator
NDAP	National Disability Advocacy Program
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme

# Executive summary

## Background and Context

The Department of Social Services ('DSS') established the Decision Support Pilot ('the Pilot') in 2018 in response to a growing need to support current and future National Disability Insurance Scheme (NDIS) participants to engage in NDIS processes. The Pilot was established for people who:

- need to engage with the National Disability Insurance Agency (NDIA) about participation in the NDIS (as it relates to access, planning or implementation)
- are between the ages of 18 and 65
- have limited decision-making capacity, and
- have no other appropriate decision-making support such as a family member, carer or other significant person who is willing and able to support the person to make NDIS decisions.

The Pilot was delivered by eight National Disability Advocacy Program (NDAP) providers, one in each state and territory. Pilot providers used a set of operational guidelines to inform the implementation of their service, however there was a degree of variation in approaches, such as the types of service models implemented, the client cohorts targeted and triaging methods.

### **Differences between the Pilot and disability advocacy programs**

Pilot activities are delivered by advocates. However, it is noted that the types of decision support activities delivered by advocates as part of the Pilot are different to those delivered through advocacy programs.

The Pilot supports a cohort who have limited decision-making capacity and no other appropriate decision-making supports to make their own decision about NDIS processes. Through the Pilot, service providers support eligible clients with NDIS processes, such as: completing a NDIS Access Request; making decisions towards the development of their initial NDIS Plan (and subsequent plans if required), and; where necessary, supporting individuals to make decisions regarding plan implementation and system navigation.

In comparison, advocacy programs such as the NDAP provide a wider range of services to all people with disability, such as helping a person with disability to understand their rights and how to assert them; supporting a person with disability to access to a broad range of services and support; and acting on behalf of a person with disability to solve issues.

In July 2022, the Department engaged Deloitte to undertake an independent evaluation of the Decision Support Pilot over the period from July 2022 to June 2023. The purpose of the evaluation is to generate evidence on the implementation and outcomes of the Pilot. By understanding the Pilot's strengths and areas for improvement, the Department and other key stakeholders, such as the NDIA, can then make informed future policy decisions.

Since the Pilot's commencement in October 2018, the NDIA has rolled out the NDIS nation-wide and there has been a greater maturity in that time of the NDIA and its Partners in the Community to engage with and support people with complex vulnerabilities.

In May 2023, the NDIA released a co-designed Supported Decision Making Policy, working with people with disability. The NDIA partnered with Inclusion Australia, the national peak body that represents people with intellectual disability, to lead the co-design sessions with NDIS participants, families, carers and the disability sector. The purpose of this policy is to improve the way people with disability are supported to make decisions in the NDIS, such as applying their goals and how to use the supports in their plan.

The Pilot will conclude on 30 June 2023 in recognition that operational policies and processes to support people with disability to engage with the NDIS are now established in the NDIA, and the NDIA's Supported Decision Making Policy has been developed.

## Methodology

### Stage 1: Evaluation Planning

To commence the evaluation, Deloitte co-designed an Evaluation Plan with the Department. This Plan included a program logic, set out the key research questions to pursue as part of the evaluation, and identified the measurement indicators and data sources to inform each area of investigation. As part of the evaluation planning process, Human Research Ethics Committee (HREC) approval was obtained.

The evaluation questions canvassed three broad areas:

- **Appropriateness** of the Pilot, including the types of clients serviced and the extent to which the design and scope of the Pilot was appropriate in meeting client needs.
- **Effectiveness** of the Pilot in improving outcomes for clients and their NDIS experience.
- **Efficiency** of the Pilot, by assessing comparability to general advocacy services such as NDAP, the technical efficiency of providers, and the contribution of the Pilot to more timely NDIS processes.

### Stage 2: Data collection and reporting

Data collection occurred over the period September 2022 to April 2023 in alignment with the data sources and approach outlined in the Evaluation Plan. A mixed-methods approach was adopted, drawing on a range of primary and secondary data sources, including:

**Primary data collection and analysis.** Deloitte conducted over 40 consultations with different stakeholder groups, including the DSS Pilot Project Team, service providers, program partners (e.g., Support Coordinators, local community services, referrers etc.), and Pilot clients.

**Secondary data collection and analysis.** This included administrative data collected by each service provider, which contained information on client caseload, client interactions, and a client's final outcome prior to exiting the Pilot. This data was linked to the NDIS Access dataset via a unique statistical linkage variable, with the goal of assessing NDIS Access outcomes for both Pilot participants and a reference cohort.

### Stage 3: Triangulation and reporting

Insights were triangulated across all data sources, synthesised, and presented as part of this summative Report. The report also identifies several opportunities to guide the future implementation of comparable services. The evaluation findings were considered in the context of other relevant strategic policy, such as Australia's Disability Strategy 2021-2031, and the findings to date of the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (Disability Royal Commission).

## Key Findings

The key themes that emerged across the domains of appropriateness, effectiveness, and efficiency are presented below. Overall, the evidence from the evaluation demonstrated that the Pilot was effective in achieving its primary goal of supporting people with disability with limited decision-making capacity and no other appropriate decision-making support to access the NDIS and engage in NDIS processes.

## APPROPRIATENESS

### Client characteristics

As of 30 June 2022, the Pilot had serviced 1,209 client cases, of which, 77% were found to be eligible for the Pilot. Analysis of these cases showed:

- The majority of clients (66%) were non-existing NDIS participants seeking an NDIS Access Request. The remaining clients were existing NDIS participants seeking support with plan development, plan review, or plan implementation and system navigation.
- The New South Wales provider serviced a large share of clients (51%) relative to its budget allocation (25%). This may be because the provider in NSW had eight face-to-face outlets across the state, whereas most other providers had only one.
- At an aggregate level, representation of Pilot clients by disability type, age, Culturally and Linguistically Diverse (CALD) and Indigenous status broadly reflected the profile of the NDIS adult population by these characteristics, suggesting equity of access for different subpopulations.<sup>1</sup> However, analysis at the provider level showed more variation as some providers targeted specialised cohorts aligned with the target cohort/s of their broader organisation.
- There was diversity in client complexity, with approximately half of all cases triaged as 'moderate', one quarter as 'high', and the remaining quarter as 'low'.
- Relative to clients serviced by general advocacy programs such as NDAP, providers observed that Pilot clients were more complex, and typically presented with a range of social issues, such as a history of trauma and homelessness, which required more intense and longer-term support. Note that greater client complexity is a function of the Pilot's eligibility criteria.
- The two main referral sources to the Pilot were from disability service providers (21%) and self-referrals (21%).

### **Appropriateness of Pilot scope and design features**

Overall, stakeholders consulted broadly agreed that the Pilot's scope was appropriate in meeting the needs of the target cohort. Several success factors related to the Pilot's design features were highlighted:

- **The Pilot's flexibility in evolving its scope in response to client needs.** At the Pilot's outset, the program scope was primarily focused on supporting people with NDIS access and planning. Over time, a need emerged to also provide decision support to NDIS participants at the plan implementation stage, given growing challenges related to the NDIS participant experience (e.g., low plan utilisation rates, difficulty in navigating the system, provider conflict of interest issues etc.).
- **A service delivery model focused on addressing one specific disability-related issue (i.e., NDIS processes).** This provided service providers with the capacity to be proactive in encouraging help-seeking and preventing disengagement – a heightened risk in cases of psychosocial and intellectual disability. It also provided service providers with the time and resources to build rapport with the client and establish trusting relationships, which was critical for:
  - Supporting clients through NDIS access and planning processes, given previous adverse experiences and the time and emotional toll of gathering evidence.
  - Empowering clients and their capability to make their own decisions and self-advocate.
  - Supporting the emotional wellbeing of clients over the longer-term, by 'keeping the door open' to provide trusted advice, when needed. Many clients re-presented at the plan implementation stage for a different reason, citing their service provider as the only trusted advisor they felt they could contact.

This was cited in contrast to general advocacy programs such as NDAP, where there are cases that if a client does not respond to a phone call/email, the provider may not have the capacity to follow-up and encourage help-seeking. In general, NDAP provides short and medium-term

<sup>1</sup> Relative to the adult NDIS population. A core limitation is that it was not possible to compare the Pilot's equity of access relative to that of the underlying population of people eligible for the NDIS (i.e., current NDIS participants and people eligible for the NDIS who are not current NDIS participants). Relative to the current NDIS adult population, the eligible NDIS population is likely to include a higher percentage of people from disadvantaged cohorts who commonly face access barriers to programs and services.

issues-based advocacy support, in contrast to the Decision Support Pilot which utilises a longer-term, targeted case management approach.

- **Advocates' specialist skillset.** DSS stakeholders, provider program managers and Pilot clients highlighted advocates' subject matter expertise as a critical program enabler. This included a deep understanding of disability types; NDIS requirements for access, planning, and reviews; intersectional social issues (e.g., mental health, trauma and abuse, and homelessness); provision of person-centred and empathetic care; strategies for communicating with clients in an inclusive way (e.g., distilling the complex 'language' of the NDIS); and techniques for negotiating with government agencies.
- **Independence.** Provider organisations' independence was cited as another program enabler, given some clients could be distrusting of government agencies. There was a potential noted for a real or perceived conflict of interest between a decision supporter and a client's preferences.
- **Co-commissioning NDAP and the Pilot** through the same provider helped to achieve efficiencies in the recruitment and retention of advocates, high referral rates despite limited investment in program promotion, as well as an improved client experience for those receiving support from both services.
- **Patterns of demand.** The Pilot met an unmet need, as evidenced by high rates of demand and waitlists in each jurisdiction, despite limited investment in program promotion. Demand drivers related to both the volume of unique clients seeking support and the intensity of support required per case. The following factors contributed to the intensity of support required: the intersectional nature of client issues; the complexity of gathering evidence to inform an NDIS Access Request for those not known to health and community services; and the growing complexity of clients who have not engaged with the NDIS, despite potentially being eligible – some of those not yet on the NDIS may be more socially isolated and in need of decision support services.

Alongside these success factors, issues were raised related to the Pilot's reach across the target population:

- **Unknown unmet demand.** Providers did not publicly advertise the Pilot, instead relying on their existing networks for referrals. While this proved effective as a demand management strategy, some stakeholders expressed concern that there is likely to be a level of unknown unmet demand within the broader population, especially among those who are not known to existing health and community services.
- **Unmet demand at the plan implementation stage.** It was noted that most clients seeking support with NDIS system navigation and plan implementation were 'returning clients'. Few clients first engaged with the Pilot for system navigation and plan implementation reasons. Providers felt this did not reflect a lack of demand for decision support at this stage, but rather that the demand exists among people unaware of the Pilot and/or because LACs or Support Coordinators are not appropriately referring potential clients.

This finding is supported by the themes highlighted at the Disability Royal Commission,<sup>2</sup> which indicates there are NDIS participants who would benefit from decision support at the plan implementation stage, as they navigate issues such as finding suitable accommodation, changing providers, or exercising their rights and choice in cases of a provider conflict of interest.

## EFFECTIVENESS

Evidence from the evaluation shows the Pilot achieved outcomes across three broad areas:

<sup>2</sup> Department of Social Services, Australia's Disability Strategy 2021-2031 (2021). <<https://www.disabilitygateway.gov.au/ads/strategy>>

### **NDIS process outcomes**

Where the Pilot supported a client to submit an NDIS Access Request, a successful outcome was achieved in 70% of cases. This finding is significant as consultations indicated that in the absence of the Pilot, these clients would not have had the capability to complete the NDIS Access Request Form requirements on their own as they were too complex for this cohort of clients. For example, providers noted that some clients did not have a previous diagnosis of disability due to social isolation and challenges communicating their care needs. As one provider explained:

*You go to a number of boarding houses and many of them should be on the NDIS, but they don't even know it is an option for them or what it could do for them. And because of their impairment they don't have a GP or [are not] connected with the public hospital system. The burden of gathering evidence is significant and they couldn't do it without an advocate.*

Evidence from the evaluation also indicated that the Pilot contributed to timelier and streamlined access and planning processes. For example, at the plan review stage, Pilot clients experienced a mean wait time of 30 days to achieve a plan review outcome, relative to a mean of 39 days for the reference cohort.

Almost all clients consulted reported satisfaction with their experience of Pilot. Experiences with service providers were noted as positive and supportive. Clients highlighted achieving their intended outcomes, including a successful NDIS Access Request, finding an appropriate Support Coordinator, or more simply understanding NDIS rules and processes. Several clients expressed a desire to continue the relationship with their service provider, citing the rapport, trust and respect established over the course of their engagement with the Pilot.

### **Capability building outcomes**

Broader impacts of the Pilot included improved client personal empowerment and decision-making capability. For example, providers observed improved client confidence in decision-making capability and self-advocacy as part of plan implementation, citing clients taking proactive steps to change their accommodation provider or feeling empowered to say 'no' to a suggestion provided by a Support Coordinator, where they would have previously agreed.

### **System-level outcomes**

Other system-level outcomes were observed such as improved client wellbeing and improved connections to health and community services. Several providers noted a reduction in the frequency of distress and crisis in clients over the course of their support. In addition, some providers noted that at the point of entry to the Pilot, many clients had withdrawn from all types of social services. However, establishing a trusted relationship with the decision support provider, the client accepted advice and referrals to services such as primary care, mental health, housing support, and employment support, among others.

Despite these positive outcomes, 14% of clients withdrew from the Pilot. Reasons for withdrawal typically related to social isolation factors that led to clients ceasing communication or clients disengaging due to lengthy and 'exhausting' application processes.

Overall, the Pilot was effective in helping people requiring decision support to achieve their NDIS outcomes, as most individuals had their case closed because of an outcome being met ('Access', 'Plan' and Plan review' approved). Other broader impacts included improved client personal empowerment and decision-making capability, as well as increased help-seeking behaviour and willingness to accept referrals to other social services.

## **EFFICIENCY**

### **Differences to existing programs and services**

Stakeholders agreed the Pilot delivered value above what can be achieved through general advocacy programs by providing dedicated resources to address one specific decision support issue (i.e., NDIS processes). This provided service providers with the time and capacity to:

- Invest in building trusting relationships over an extended period.

- Proactively initiate contact to prevent disengagement, in cases where a client stopped communicating.
- Invest in liaison with clinicians and other community services providers. Providers frequently attended in-person meetings with GPs, housing providers, as well as NDIA planners and Support Coordinators. The time to attend these meetings helped to minimise knowledge loss between the client and the service provider and provided opportunities for the advocate to role model self-advocacy.

In addition, it was noted there is a clear distinction between the Pilot and Support Coordination, given that a service provider will typically refer the client to a Support Coordinator at the point of plan implementation. While some providers continue to offer support in cases where a Support Coordinator was engaged, the types of support differed. Examples of support provided at this stage included:

- Helping the client find a new Support Coordinator.
- Acting as a trusted advisor in cases where the client does not feel comfortable reaching out to their Support Coordinator, and there is a risk of withdrawal from NDIS services altogether.

### **Cost measures**

Providers reported an estimated cost per intervention for each case captured in quarterly spreadsheets. The national average cost per intervention was \$1,863. The Northern Territory provider had the lowest average estimated cost per intervention (\$861 per intervention), likely due to service coverage being limited to metropolitan areas. The NSW provider had the second-lowest average cost per intervention (\$996 per intervention), likely due to servicing a high volume of clients relative to budget allocation the lowest average hours of support per case (12 hours).

Whereas providers who had higher average hours of support per case generally had a higher average cost per intervention. This variation suggests there are opportunities for some providers to improve technical efficiency (i.e., cost per output) however, there is a need to consider both the differences in service models across jurisdictions and the cohorts that may require further intervention. An improvement in efficiency should not be pursued at the expense of meeting individualised client needs, as the person-centred approach and flexibility to invest time with clients is noted as one of the Pilot's critical success factors.

A limitation of this analysis is that providers differed in their approaches to delivering the Pilot, such as the types of service models implemented, the client cohorts targeted and triaging methods. To this end, any comparisons between providers on cost measures should be interpreted with caution.

### **Conclusion**

Overall, evidence from the evaluation shows that the Pilot was effective in achieving its primary goal of supporting people with disability with limited decision-making capacity and no other appropriate decision-making support to access the NDIS and engage in NDIS processes. Other broader impacts included improved client personal empowerment and decision-making capability, as well as increased help-seeking behaviour and willingness to accept referrals to other social services.

The outcomes from this evaluation are important to consider in the context of related themes presented at the Disability Royal Commission. Several submissions and transcripts highlight inequitable access to the NDIS for people with complex disabilities and/or without friends or family members who have experience in applications and advocacy to government agencies.<sup>6</sup> These themes coupled with the evidence from this evaluation suggests there is merit in implementing and scaling a comparable service in future.

## Considerations for Future Implementation of a Comparable Service

Several key learnings were identified that should be considered in any future implementation of a comparable service:

Learnings	Consideration
<b>Workforce</b>	
<p><b>Advocate skillsets</b></p> <ul style="list-style-type: none"> <li>• A number of advocates had deep subject matter expertise related to disability types, NDIS requirements, intersecting social issues, strategies for communicating with clients in an inclusive way, and techniques for negotiating with government agencies.</li> <li>• Advocate backgrounds included social work, disability employment services, hospital settings, and roles as LACs. A mix of interdisciplinary skillsets helped to facilitate peer learning and upskilling across advocate teams.</li> </ul>	<ul style="list-style-type: none"> <li>• Encourage providers to implement regular peer learning to facilitate interdisciplinary knowledge exchange and the sharing of specialist skills across service providers.</li> </ul>
<b>Program promotion and scope</b>	
<p><b>Referrals from LACs and Support Coordinators</b></p> <ul style="list-style-type: none"> <li>• Few clients first engaged with the Pilot for system navigation and plan implementation reasons. Providers felt this did not reflect the lack of demand for decision support among other NDIS participants, but rather that the demand exists among people unaware of the Pilot and/or because LACs or Support Coordinators are not appropriately referring potential clients. This was supported by analysis of referral sources, where relatively few referrals originated from LACs or Support Coordinators.</li> <li>• This finding was supported by themes highlighted at the Disability Royal Commission, which indicates that some NDIS participants would benefit from decision support at the plan implementation stage, as they navigate issues such as finding suitable accommodation, changing providers, or exercising their rights and choice in cases of a provider conflict of interest.</li> </ul>	<ul style="list-style-type: none"> <li>• Clients who require decision support at the plan implementation and system navigation stage would be well known to LACs and Support Coordinators. Any future implementation of a comparable service should thus consider how it can better engage and establish referral pathways with LACs and Support Coordinators. As part of this, advocates should communicate the delineation of roles between the Pilot and LACs / Support Coordinators, to avoid the perception of duplication, particularly for clients who have received NDIS access.</li> </ul>
<p><b>Eligibility criteria</b></p> <ul style="list-style-type: none"> <li>• Regarding the criterion for ‘no other appropriate decision-making support’, some service providers highlighted several cases where a client had informal supports, however the informal supporter was not appropriate to aid decision-making. This included informal supports who were perpetrators of abuse, recent migrants without knowledge of systems, or a parent or partner with cognitive impairment.</li> <li>• Regarding the age criterion of 18 to 65, providers felt it may be appropriate to adjust the upper end of the age bracket, given 6% of all NDIS participants are</li> </ul>	<ul style="list-style-type: none"> <li>• Consider the need to provide guidance to providers on what is considered an ‘appropriate’ decision-making support to ensure clients are not inappropriately deemed ineligible.</li> <li>• Consider adjusting the upper end of the age criterion to ensure equity of access for older NDIS participants.</li> <li>• The NDIS reached national implementation status three years ago, which means that most people transitioning from the old disability arrangements are now NDIS participants. As a result, a growing share of new NDIS entrants in each year are children, which warrants consideration of whether future</li> </ul>

Learnings	Consideration
<p>people over the age of 65. In addition, several providers felt that in some circumstances it was appropriate to accept a client below the age of 18.</p>	<p>implementation of a comparable service should also target select groups under the age of 18.</p>
<p><b>Equity of access</b></p> <ul style="list-style-type: none"> <li>At an aggregate level, the demographic profile of the Pilot indicated equity of access for different sub-populations relative to the adult NDIS population. However, analysis at the provider level showed more variation as some providers targeted specialised cohorts aligned with the target cohort/s of their broader organisation.</li> <li>By not advertising the Pilot, some stakeholders expressed concern that the people most in need of the Pilot (i.e., those who are not currently known to local social services) had no way of knowing about or accessing the service.</li> <li>Clients residing in remote areas had a notably lower cost per intervention and average hours of support relative to non-remote clients. Consultations with providers indicated this was because clients in metropolitan regions received more face-to-face modes of support.</li> </ul>	<ul style="list-style-type: none"> <li>If a program of this nature is scaled and capacity is expanded: <ul style="list-style-type: none"> <li>providers should be encouraged to attempt to reach a variety of client types to maximise equity of access in each jurisdiction</li> <li>proactively promote the program and conduct outreach (e.g., attending boarding houses, disability accommodation or prisons to encourage referrals) to better meet known and unknown demand for decision support with NDIS processes.</li> </ul> </li> <li>Consider ways to mitigate access barriers to equitable hours of support for people residing in remote areas. This may include more service provider-initiated check-ins via email or text message outside of routine meetings related to a NDIS process goal.</li> </ul>
<p><b>Disability Royal Commission as an input to program scope</b></p> <ul style="list-style-type: none"> <li>This report references several emerging themes presented at the Disability Royal Commission related to unmet needs for advocacy and decision support with NDIS processes. With the release of the Disability Royal Commission’s final report expected in September 2023, there is an opportunity to use the recommendations in conjunction with the findings from this evaluation to inform future program design and implementation.</li> </ul>	<ul style="list-style-type: none"> <li>Leverage the outcomes of the Disability Royal Commission in conjunction with the findings from this evaluation to inform program design and implementation.</li> </ul>
<p><b>Governance</b></p>	
<p><b>Selection of providers</b></p> <ul style="list-style-type: none"> <li>Selecting provider organisations based on high performance in NDAP proved to be an effective strategy, as local and sectorial networks were already established, and providers achieved high rates of demand with limited investment in program promotion.</li> <li>A perceived enabler of the Pilot, mentioned by both Pilot providers and clients, was its independence of the NDIA and disability service providers, given clients could be distrusting of government agencies and the potential for conflicts of interest.</li> </ul>	<ul style="list-style-type: none"> <li>Consider adopting a similar strategy of commissioning providers who have existing experience in disability advocacy, and nothing to gain – real or perceived – from NDIS access, plan budget development, or plan implementation outcomes.</li> </ul>
<p><b>Program administration</b> Providers highlighted opportunities to:</p>	<ul style="list-style-type: none"> <li>Consider funding arrangements and timing of operational announcements that provide predictability for providers.</li> </ul>

<b>Learnings</b>	<b>Consideration</b>
<ul style="list-style-type: none"><li>• Improve clarity and predictability related to funding arrangements and contract renewals, given the impacts on recruitment and retention, and in turn, the impact on continuity for clients.</li><li>• Improve mechanisms for collaboration, sharing of learnings and knowledge exchange across providers.</li><li>• Regarding the DEX transition, providers reported challenges in setting up and using the DEX system and queried the utility of certain fields captured.</li></ul>	<ul style="list-style-type: none"><li>• Consider forums such as a monthly community of practice focused on quality improvement (e.g., practical case studies, discussions that provide visibility of how other providers are delivering their service and resolving shared challenges) in addition to the provision of process and policy updates.</li><li>• Work closely with providers to design a data collection specification that maximises the utility of provider data collection for the purposes of assessing program processes and client outcomes.</li></ul>

# 1 Introduction

This section provides a background on the Decision Support Pilot and describes the overall purpose and objectives of the evaluation.

## 1.1 Background on the Decision Support Pilot

The National Disability Insurance Scheme (NDIS), administered by the National Disability Insurance Agency (NDIA), provides Australians who have a permanent and significant disability with funding for supports to increase their independence and social and economic participation. The NDIS emerged from years of discussions about problems with the previous support for people with disability and the need for reform to enhance the quality and equity of disability services. The NDIS reached national implementation status in July 2020.

By introducing self-directed funding packages tailored to individualised needs and goals, the NDIS gives people with disability more choice and control over how, when and where their supports are provided.

Ensuring all participants have the right information, resources and support to help make decisions about the use of NDIS funds and how to navigate the NDIS ecosystem is thus critical to ensuring the NDIS operates effectively. While many participants have a family member, carer or other significant person supporting their decision-making, some participants do not have access to these informal supports. Even when participants do have these supports available, they may still face challenges making their own decisions, due to fragmentation across intersecting agencies and services, conflicting information, and/or provider conflicts of interest, among other issues. While there are several resources and NDIS intermediary roles available to address these issues, including Support Coordinators, Local Area Coordinators (LACs), and disability advocacy programs, they typically target certain issues or parts of the NDIS pathway. Some participants require more targeted and holistic end-to-end support, particularly those with no family member, carer or other significant person.

To address this need, the Department of Social Services (the Department) established the Decision Support Pilot ('the Pilot') in late 2018, over nine months. This funding was extended four times, for 12 months each time, until June 2023. The Pilot was an initiative that provides decision-making support for potential and current NDIS participants who require decision support. Specifically, the Pilot was established for people who:

- need to engage with the NDIA about participation in the NDIS (as it relates to access, planning or implementation)
- are between the ages of 18 and 65
- have limited decision-making capacity, and
- have no other appropriate decision-making support such as a family member, carer or other significant person who is willing and able to support the person to make NDIS decisions.

The Pilot aligned with the core principles of Australia's Disability Strategy 2021-2031 (2021)<sup>2</sup>, which aims to support people with a disability to their full potential as equal members of the community.

In 2018-19, the Department received funding to implement the Pilot over nine months. This funding was extended four times, for 12 months each time, until June 2023. Since the Pilot commenced in October 2018, the NDIS has rolled out nation-wide and there has been greater maturity of the NDIA and its Partners in the Community to engage with and support people with complex vulnerabilities. In early 2023, it was announced that the Pilot would not be extended further and would conclude on 30 June 2023. This is in recognition that operational policies and

processes to support people with disability to engage with the NDIS are now established in the NDIA, and the NDIA's Supported Decision Making Policy will begin to be implemented in 2023.

### 1.1.1 Pilot objectives and activities

The Pilot was delivered by eight National Disability Advocacy Program (NDAP) providers, one in each state and territory. The providers were selected based on high performance in the delivery of the NDAP, including meeting client targets and reporting milestones, engagement with the sector and experience supporting people with limited decision-making capacity. All providers commenced delivering the Pilot in October 2018, except for Darwin Community Legal Services (DCLS) which commenced in July 2019. Each provider and their geographic coverage is shown in Figure 1.1.

Figure 1.1: Decision Support providers in each state and territory



Source: Department of Social Services.

Pilot activities are delivered by service providers. However, it is noted that the types of decision support activities delivered by service providers as part of the Pilot are different to those delivered through advocacy programs (see box below). These service providers are required to:

- identify the target population within the coverage area(s)
- determine client eligibility based on the Pilot eligibility criteria
- support eligible clients with NDIS processes, such as:
  - completing a NDIS Access Request
  - making decisions towards the development of their initial NDIS Plan (and subsequent plans if required), and
  - where necessary, support the individual in the NDIS planning process.

### **Differences between the Pilot and disability advocacy programs**

Pilot activities are delivered by advocates. However, it is noted that the types of decision support activities delivered by advocates as part of the Pilot are different to those delivered through advocacy programs.

The Pilot supports a cohort who have limited decision-making capacity and no other appropriate decision-making supports to make their own decision about NDIS processes. Through the Pilot, service providers support eligible clients with NDIS processes, such as: completing a NDIS Access Request; making decisions towards the development of their initial NDIS Plan (and subsequent plans if required), and; where necessary, supporting individuals to make decisions regarding plan implementation and system navigation.

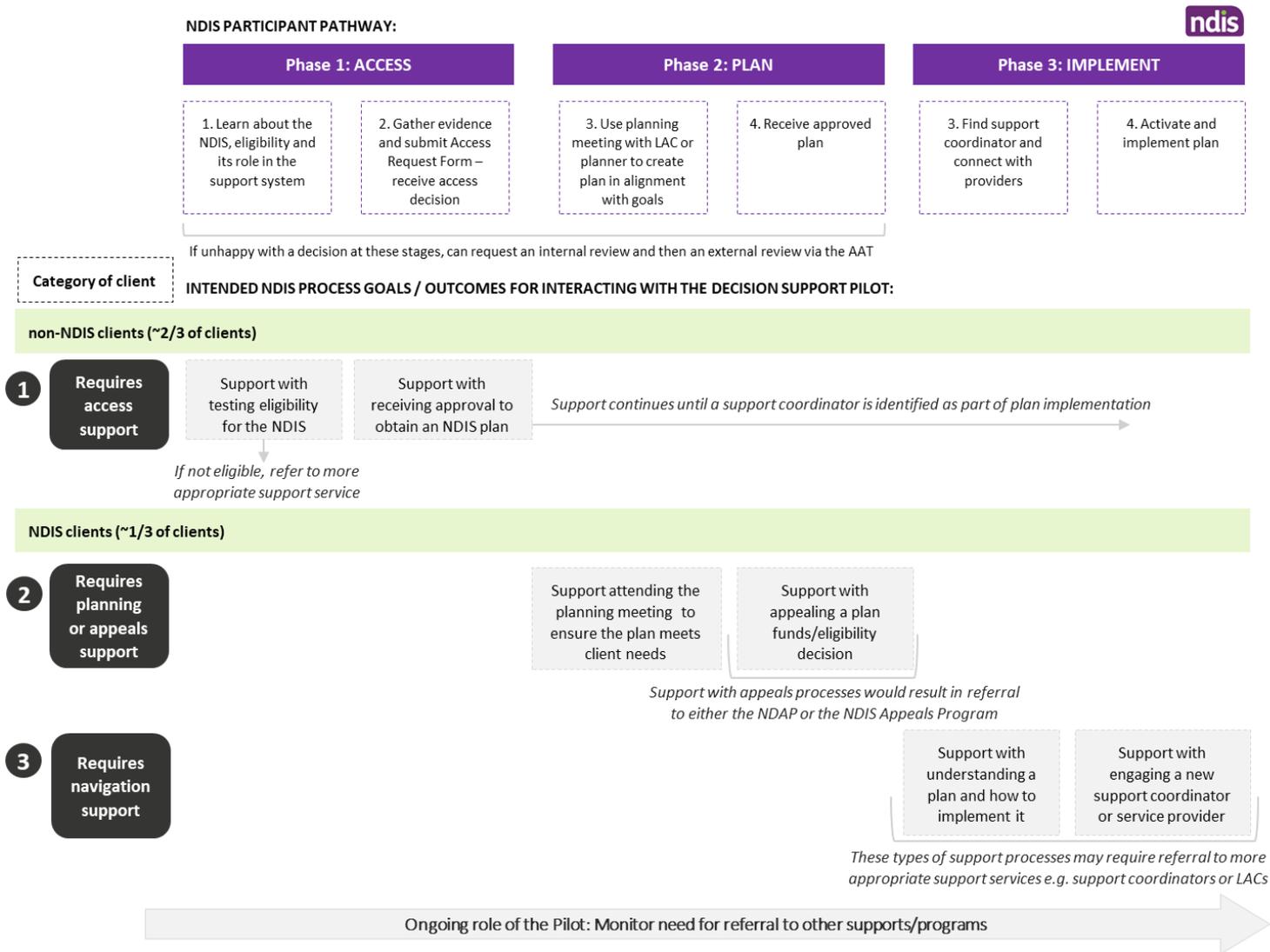
In comparison, advocacy programs such as the NDAP provide a wider range of services to all people with disability, such as helping a person with disability to understand their rights and how to assert them; supporting a person with disability to access to a broad range of services and support; and acting on behalf of a person with disability to solve issues.

The Pilot supports clients with different NDIS processes across the NDIS participant pathway (e.g., across access, planning and implementation). As such, there is no one standard pathway through the Pilot – it is dependent on whether the individual is:

- a non-NDIS participant seeking access to the NDIS, or
- an existing NDIS client seeking support with planning, appeals, plan implementation or system navigation.

Figure 1.1 provides a broad overview of the different categories of clients by their intended NDIS goals for interacting with the Pilot. Figure 1.1 also shows how the Pilot interacts with other services across the NDIS participant pathway, by showing where a service provider may refer a client to a more appropriate advocacy program (e.g., NDAP or the NDIS Appeals Program) or another type of support such as a Support Coordinator or LAC.

Figure 1.2: Overview of the role of the Pilot across the NDIS participant pathway



Source: Deloitte informed by Pilot documentation.

### 1.1.2 Recent quality improvement initiatives

The Department undertook an internal review<sup>3</sup> of the Pilot in 2021 (and finalised in April 2022) to better understand the type of clients supported by the Pilot, and their goals, outcomes and pathways associated with interacting with the Pilot. The review also sought to identify opportunities for quality improvement that could enhance service effectiveness and efficiency. The review recommended:

- the introduction of new Operational Guidelines for providers that more clearly define the scope of the program, with the goal of promoting best-practice and standardisation across providers, and
- improved data collection and reporting through the transition to the Data Exchange (DEX) platform and the introduction of new data fields.

Both initiatives were implemented in 2022.

## 1.2 Purpose and Scope of the Evaluation

In July 2022, the Department engaged Deloitte to undertake an independent evaluation of the Decision Support Pilot over the period from July 2022 to June 2023.

The purpose of the evaluation is to generate evidence on the implementation, outcomes and impact of the Pilot. By understanding the Pilot's strengths and areas for improvement, the Department and other key stakeholders, such as the NDIA, can then make informed future policy decisions.

The specific objectives of the evaluation included assessing the:

- **Appropriateness of the Pilot**, including the types of clients serviced, and the extent to which the design and scope of the Pilot was appropriate in meeting client needs.
- **Effectiveness of the Pilot** in improving outcomes for clients and their NDIS experience.
- **Efficiency of the Pilot** by assessing comparability to general advocacy services, the technical efficiency of providers, and the contribution of the Pilot to more timely NDIS processes.

The evaluation was delivered over the period from July 2022 to May 2023. The evaluation adopted a mixed-methods approach, which is detailed in Chapter 2. This summative Report presents a synthesis of the key insights generated over the course of the evaluation.

## 1.3 Structure of this Report

The remainder of this report is structured as follows:

**Chapter 2: Evaluation approach.** Provides an overview of the evaluation methodology, including the program logic, key evaluation questions and data sources.

**Chapter 3: Evaluation findings.** Presents the key themes that emerged through evaluation activities across the domains of appropriateness, effectiveness, and efficiency.

**Chapter 4: Concluding remarks and implications.** Summarises the key takeaways and presents a set of implications for future policy decision-making.

<sup>3</sup> Department of Social Services, Decision Support Pilot Internal Review (2022).

# 2 Evaluation Approach

This section provides an overview of the evaluation methodology, including the program logic, key evaluation questions and data sources.

Deloitte delivered the evaluation over three stages, as summarised in Figure 2.1. Further detail is provided in the sections below.

Figure 2.1: High-level overview of evaluation approach

Phase 1: Evaluation Planning	Phase 2: Data collection and reporting	Phase 3: Triangulation and Report
<ul style="list-style-type: none"> <li>Mobilise project</li> <li>Develop program logic</li> <li>Develop evaluation questions, measurement indicators, data sources and analytical approaches</li> <li>Develop stakeholder engagement plan</li> <li>Complete and submit ethics application</li> </ul>	<p><b>Preliminary analysis</b></p> <ul style="list-style-type: none"> <li>Analysis of provider program data</li> </ul> <p><b>Further analysis</b></p> <ul style="list-style-type: none"> <li>Execute stakeholder consultations (interviews &amp; focus groups)</li> <li>Undertake further linked analysis of provider program data and NDIA data</li> </ul>	<p><b>Preliminary analysis</b></p> <ul style="list-style-type: none"> <li>Present preliminary insights from program data in Interim Report</li> </ul> <p><b>Further analysis</b></p> <ul style="list-style-type: none"> <li>Underake thematic analysis of qualitative insights</li> <li>Undertake quantitative data analysis</li> <li>Triangulation themes and present insights through Final Report (this document)</li> </ul>

Source: Deloitte.

## 2.1 Evaluation Planning

To commence the evaluation, Deloitte co-designed an Evaluation Plan with the Department. This Plan included a program logic, set out the key research questions to pursue as part of the evaluation, and identified the measurement indicators and data sources to inform each area of investigation. As part of the evaluation planning process, Human Research Ethics Committee (HREC) approval was obtained.

### 2.1.1 Program logic

A program logic is a theory of intended cause and effect and consists of several 'if-then' statements. The program logic illustrates what a program will do and what the expected outcomes are. It is a tool used to link program inputs and outputs to the intended outcomes, through showing the intended causal links for the program. By clearly identifying the intended outcomes in a program logic, evaluators can then develop measurement indicators to assess the extent to which intended inputs, outputs and outcomes have been achieved.

A program logic for the Pilot was originally developed by the Department when the Pilot was established. This program logic was updated and revised as part of the evaluation (shown in Figure 2.2) to reflect recent changes to the Pilot and to incorporate client-level, service-level and system-level outcomes. As a caveat, and as noted in section 1.1.1, clients interact with the Pilot with different intended NDIS outcomes/goals, therefore not all client-level outcomes depicted in the program logic will be relevant to all clients.

Figure 2.2: Program logic of the Pilot



Source: Deloitte informed by Pilot documentation and consultation with the Department and the NDIA.

### 2.1.2 Evaluation questions

A set of evaluation questions were designed to guide the scope of research activities. The questions canvassed both implementation evaluation and outcome evaluation components, as outlined in Table 2.1.

Table 2.1: Evaluation questions

Evaluation Domain	Evaluation questions
<b>Appropriateness</b>	<ul style="list-style-type: none"> <li>• What are the characteristics of those accessing decision support services (e.g., demographics, circumstances, referral pathways)?</li> <li>• To what extent does the Pilot effectively engage the target population?</li> <li>• To what extent does the Pilot meet the needs of people with limited decision-making capacity and no other decision-making support?</li> </ul>
<b>Effectiveness</b>	<p data-bbox="435 705 879 734"><u>Efficacy of the Pilot on client outcomes</u></p> <ul style="list-style-type: none"> <li>• What are the client’s intended goals for the Pilot (both NDIS and non-NDIS) and how does this compare to their outcomes?</li> <li>• What are participant’s pathways through, and experience of, the Pilot?</li> <li>• What are the reasons for client disengagement or withdrawal for the Pilot?</li> </ul> <p data-bbox="435 882 831 911"><u>Efficacy of recent process changes</u></p> <ul style="list-style-type: none"> <li>• To what extent have the revised Operational Guidelines achieved the intended outcome of improving service delivery?</li> <li>• Has the introduction of DEX reporting improved data reporting and collection for the Pilot?</li> </ul>
<b>Efficiency</b>	<ul style="list-style-type: none"> <li>• How does the support offered under the Pilot differ from support offered under advocacy services and/or other relevant services/programs?</li> <li>• What do the cost measures suggest about efficiency?</li> <li>• What effect, if any, does the Pilot have on internal and external NDIS reviews?</li> </ul>

## 2.2 Data Collection and Gathering

Data collection occurred over the period September 2022 to April 2023 in alignment with the data sources and approach outlined in the Evaluation Plan. A mixed-methods approach was adopted, drawing on a range of primary and secondary data sources.

### 2.2.1 Primary data collection

A diverse group of stakeholders were consulted to solicit a broad range of views and perspectives, as outlined in Table 2.2.

Table 2.2: Details of stakeholder consultation

Stakeholder group	Detail
DSS Pilot Project Team	1 x virtual focus group with 5 project team members.
Pilot service providers	8 x virtual focus groups, one with each provider. Each focus group included the program managers and 3-4 advocates. Additional follow-up consultations were held, as needed.
Program partners (e.g., Support Coordinators, local community services, referrers etc.)	4 x virtual focus groups with 3-4 representatives per group. Focus groups included representation from the following regions: Victoria, Tasmania, Queensland and the Northern Territory.

Stakeholder group	Detail
Pilot clients	8 x virtual semi-structured interviews with representation across Victoria, New South Wales, Tasmania, Queensland, Northern Territory and Western Australia.

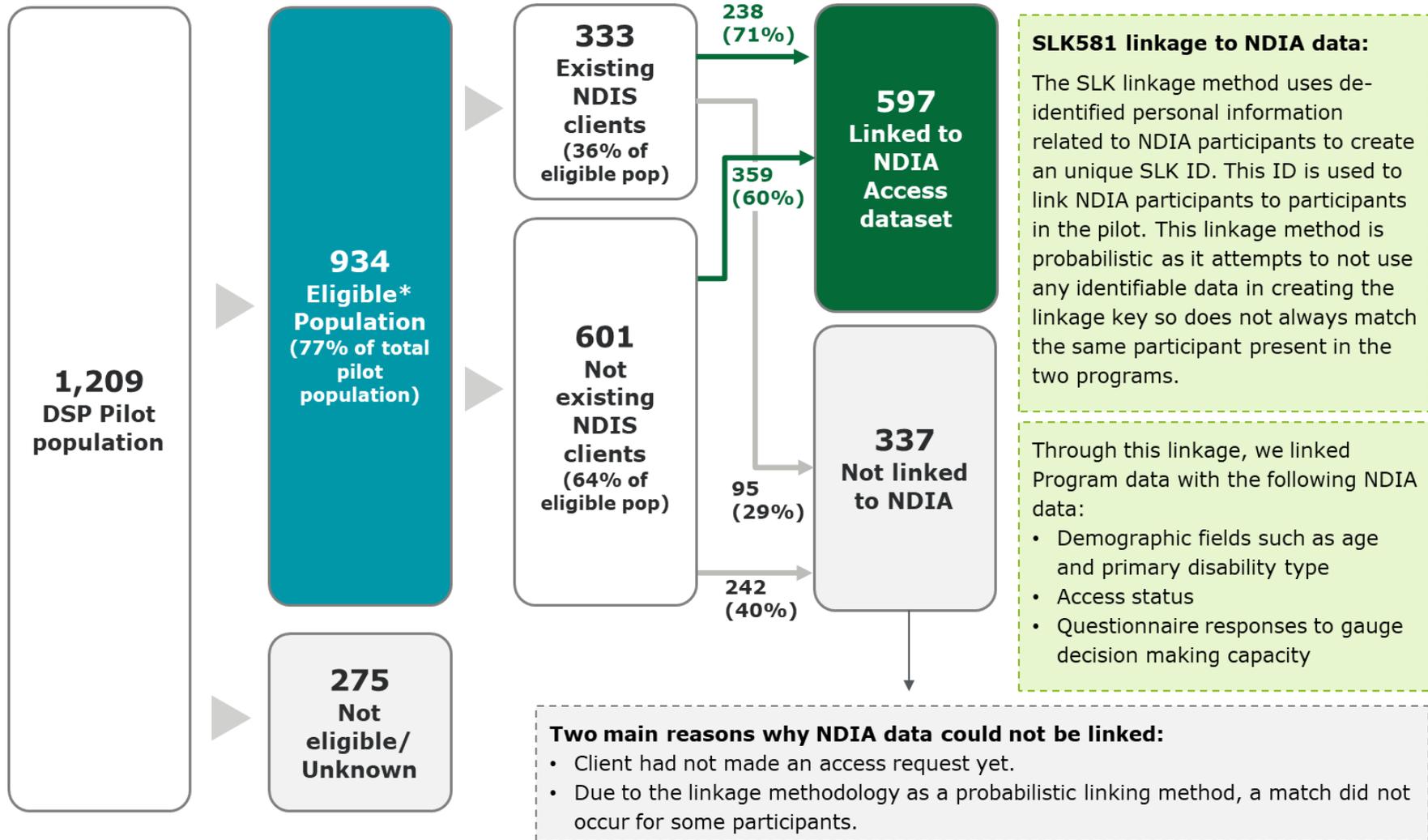
### 2.2.2 Secondary data collection

Primary data collection was supplemented with administrative Pilot program data and NDIA data, as outlined in Table 2.3.

Table 2.3: Secondary data sources

Data source	Description
Pilot program data	<p>This dataset refers to administrative data from the Decision Support Pilot collected by each service provider, via provider quarterly reporting spreadsheets or DEX. Data includes information about the provider as well as client-level information such as their:</p> <ul style="list-style-type: none"> <li>• demographic profile and personal circumstances</li> <li>• number and type of interactions with the Pilot</li> <li>• final outcome prior to existing the Pilot.</li> </ul> <p>Between October 2018 and June 2022 this data was captured by service providers in quarterly Excel spreadsheets. From July 2022, the equivalent data was captured and reported by service providers in a centralised DSS database, the DEX platform. Whilst program-related information for each client was captured as similarly as possible through DEX, it is important to consider that the fields did not map directly from the quarterly spreadsheets to DEX.</p>
NDIA access dataset	<p>This dataset refers to administrative data collected by the NDIA. This data was linked to Pilot program data via a unique statistical linkage variable to examine NDIS-related outcomes for both Pilot participants and a reference cohort (i.e., non-Pilot participants with comparable characteristics). This data included client-level information such as their:</p> <ul style="list-style-type: none"> <li>• demographic profile</li> <li>• NDIS Access Request outcome</li> <li>• requests to appeal decision.</li> </ul> <p>Figure 1.1 below details the process and outcome of the data matching process. In summary, 63% of the eligible client Pilot population (as of June 2022) could be matched to NDIA data. Further details on the construction of a reference cohort are provided in section 1.1.1.</p>

Figure 2.3: Process and outcomes of linking Pilot program data to NDIS administrative data



Source: Deloitte.

Note: \*Eligibility was determined and recorded by the service provider in quarterly spreadsheets when receiving the referral.

### 2.2.3 Reference cohort

A reference cohort was selected using a statistical technique known as propensity score matching, which seeks to estimate the effect of a treatment – in this case, the effect of the Pilot – by creating a sample group who did not receive the treatment (reference cohort) that is comparable on significant covariates to the group who did (Pilot cohort).

The propensity score matching technique aims to identify participants who are similar to the pilot participants, when considering the above-identified covariates, but are not in the pilot. The matching is to identify participants who are similar to those who were actually in the pilot and not necessarily representative of the target pilot participants.

Using propensity score matching, 597 individuals from the NDIS non-Pilot population were chosen for the reference cohort by matching to the 597 Pilot cohort individuals on the following covariates:

- age
- gender
- primary disability
- normalised severity score (banded)
- indigenous status
- cultural and linguistic diversity (CALD) status
- country of birth – Australia / not born in Australia
- primary language spoken at home – English / non-English
- Australian citizenship status
- remoteness description
- residential state
- whether the participant is currently active (i.e., access met and has not exited the NDIS)
- whether the participant was a trial participant (i.e., received a plan prior to 30 June 2016)
- what period the participant joined by based on access request data – December 2018, September 2019, June 2020, June 2021, June 2022, and
- decision-making capacity proxied by a response of 'My family, my friends, my service providers, Others' to the Short Form Outcomes Framework (SFOF) question Who makes the most decisions in your life?'

Further detail on the rationale for the choice of covariates is provided in the Appendix 5.2.

A limitation in the construction of the reference cohort was the lack of direct data on a participant's decision support requirement. We were able to match the response to a survey question 'Who makes the most decisions in your life?' as a proxy to this.

## 2.3 Triangulation and Reporting

Thematic analysis of qualitative data from stakeholder consultation was conducted using a structured process of review, reflection and refinement. Quantitative analysis was performed on the secondary data using descriptive statistics and cross-tabulations. The impact of the Pilot on improving NDIS outcomes was assessed by comparing NDIS-related outcomes for the Pilot cohort relative to the reference cohort, where possible.

Insights were triangulated across all data sources, synthesised and presented as part of this summative Report. This Report builds on interim findings presentations shared with the Department over the course of the evaluation. The report also identifies several opportunities to guide the future implementation of a comparable service.

The evaluation findings were considered in the context of other relevant strategic policy, such as Australia's Disability Strategy 2021-2031, the findings to date of the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (Disability Royal Commission) and the ongoing decision support work of the NDIA, including the NDIS Supported Decision Making Policy<sup>4</sup>.

<sup>4</sup> NDIS Supported Decision Policy (2023), <<https://www.ndis.gov.au/about-us/policies/supported-decision-making-policy>>.

## 2.4 Limitations

The evaluation was limited by the following factors, which should be noted when considering the findings presented in Chapter 3.

Table 2.4: Limitations of the evaluation

Limitation	Description
Quality and completeness of program data	The quality and completeness of Pilot program data collected through the quarterly spreadsheets varied across providers. In addition, there were indications that some providers had slightly different interpretations of certain variables and their categories, impacting robust comparability across providers (e.g., cost per case, rates of case closure).
Stakeholder engagement	There were noted difficulties in engagement with stakeholders, including service provider, support coordinator, LAC and program partner availability. Additionally, the Department notified stakeholders that were engaged in the consultation process, that the Decision Support Pilot was due to conclude at the end of the current term (June 30, 2023). Due to the nature of the announcement, some providers withdrew their nominations for Pilot clients to be interviewed.
Direct comparability with the reference cohort	As noted in section 1.1.1, there was no variable to identify a participant’s decision support requirement. As a proxy, and to the extent the data was available, the response to the survey question was used ‘Who makes the most decisions in your life’ as a proxy to decision support requirement.

# 3 Evaluation Findings

This section presents a synthesis of the key themes that emerged through evaluation activities across the domains of appropriateness, effectiveness, and efficiency.

## 3.1 Appropriateness

This section examines various questions related to the appropriateness of the Pilot, including:

- What are the characteristics of those accessing decision support services e.g., demographics, circumstances, referral pathways? (Section 3.1.1)
- To what extent does the Pilot meet the needs of people with limited decision-making capacity and no other decision-making support? To what extent does the Pilot effectively engage the target population? (Section 3.1.2)

As context to this section, it is important to note that Pilot providers used a set of operational guidelines to inform the implementation of their service, however there was a degree of variation in approaches, such as the types of service models implemented, the client cohorts targeted and triaging methods. These differences reflected providers tailoring the service to local needs, which was within scope of the Pilot's goals and guidelines.

### 3.1.1 What are the characteristics of those accessing decision support services?

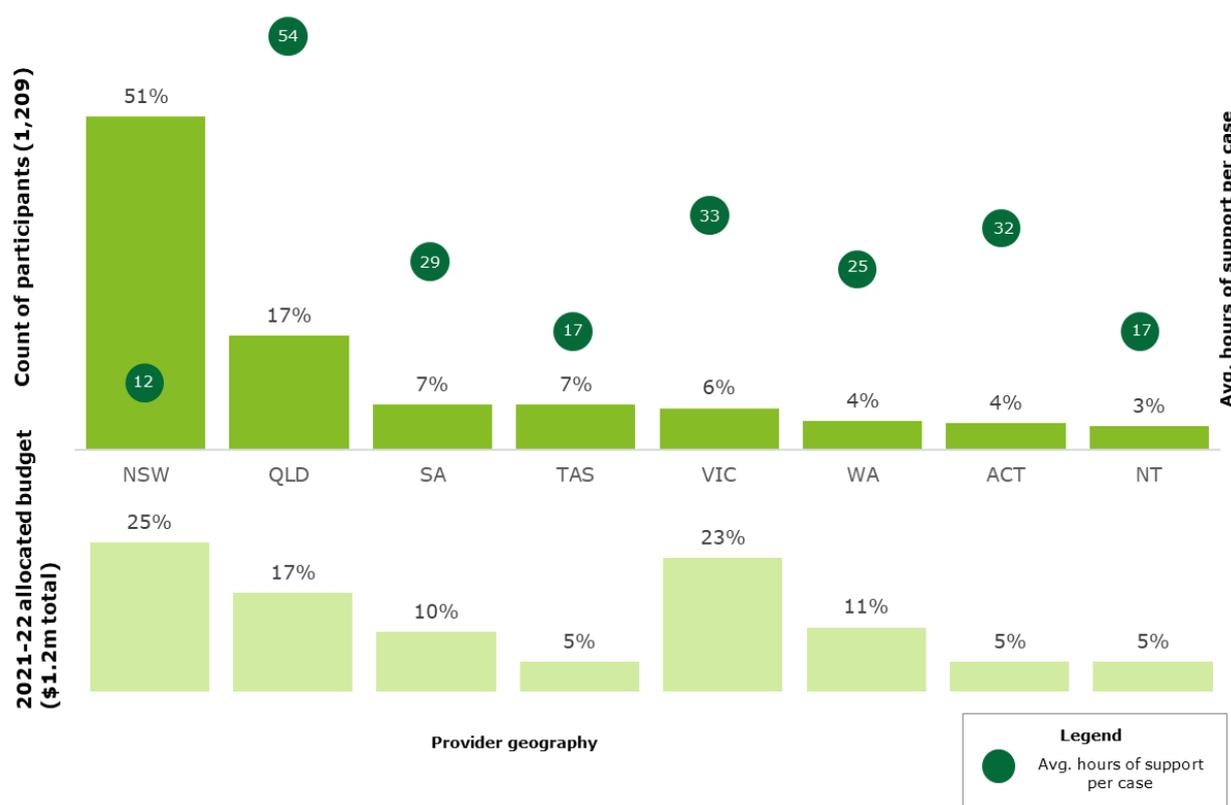
Based on provider quarterly spreadsheets, as of the end of June 2022, the Pilot had serviced 1,209 client cases (see Figure 3.1). This figure is likely to be slightly higher than the total number of unique clients serviced, as consultations indicated that some clients re-presented to the Pilot after their original case was closed. However, it was not possible to identify these cases within the data.

It is also important to consider that in cases where a client did re-present to the Pilot, consultations indicated this was not because their case was inappropriately ceased the first time, but rather because the client re-presented for a different reason. An example was where the original case sought NDIS Access, which was achieved with referral to a Support Coordinator for plan implementation. In some instances, the client would contact their service provider six to twelve months later due to issues with their Support Coordinator and/or one of their service providers.

As shown in Figure 3.1, most Pilot clients were residents of New South Wales, aligned with the Pilot's budget allocation, which broadly reflects the share of Pilot clients each jurisdiction was expected to service. The New South Wales provider serviced a large share of clients (51%) relative to its budget allocation (25%), which may be because of the service model offered, such as the greater number of service outlets with broad geographic coverage.

The share of clients serviced by the Victorian provider (6%) differed relative to its budget allocation (23%), while the other jurisdictions were broadly aligned. Consultations with the Victorian provider anecdotally highlighted the complex nature of their clients and the intensity of their service delivery model (e.g., frequency of contacts, home visits etc.) as a possible driver of variation. To validate this observation, analysis was performed on the average hours of support per case and cost per case measures recorded in provider quarterly spreadsheets, which provide a proxy for the intensity of support per case. The average hours of support per case and cost per case in New South Wales were the lowest of all jurisdictions, suggesting a higher volume of clients with less intensity. However, rates in Victoria were closer to average (cost per case is discussed further in section 3.3.2).

Figure 3.1: Share of Pilot clients by geography relative to geography budget allocation



Source: Pilot program data 2019 to June 2022.

As shown in Figure 3.2, the Pilot engaged individuals from a variety of different backgrounds, including:

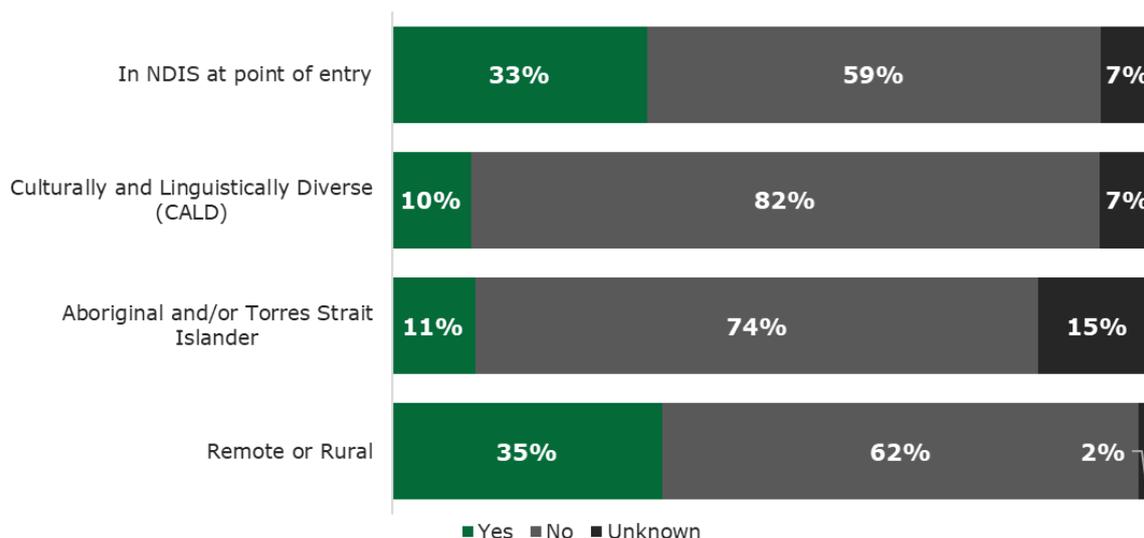
- people from Culturally and Linguistically Diverse (CALD) backgrounds (9%)
- Aboriginal and Torres Strait Islander people (11%)
- remote and regional areas (35%)

These statistics broadly align with the share of adult NDIS participants by these characteristics, as displayed in Figure 3.3.

The provider's quarterly spreadsheets did not capture the reasons/goals for interacting with the Pilot at the point of referral. However, reasons/goals can broadly be inferred from a client's NDIS status at the point of entry to the Pilot. Consultations with providers indicated that all Pilot clients who were not existing NDIS participants (66% of all Pilot clients) were seeking a NDIS Access Request. The remaining 33% of Pilot clients were existing NDIS participants (defined as a client who had already achieved a successful NDIS Access Request) who were seeking support with one or more of the following issues:

- assistance with preparing for a planning meeting to ensure they received an appropriate plan budget amount
- assistance with steps to appeal an NDIS decision (these clients would typically be referred to a more appropriate service such as NDIS Appeals)
- assistance with system navigation and plan implementation after receiving a plan
- unsatisfied with a Support Coordinator or a service provider and seeking assistance to find better-suited support – this tended to be in cases of re-presenting clients.

Figure 3.2: Proportion of Pilot clients by socio-demographic status



Source: Pilot program data 2019 to June 2022. Percentages may not total 100 due to rounding.

When receiving a referral, a provider assesses whether the individual meets the Pilot’s eligibility criteria. All providers, except for Queensland, experienced high eligibility rates, indicating the quality and appropriateness of referrals received by providers (see Figure 3.3).

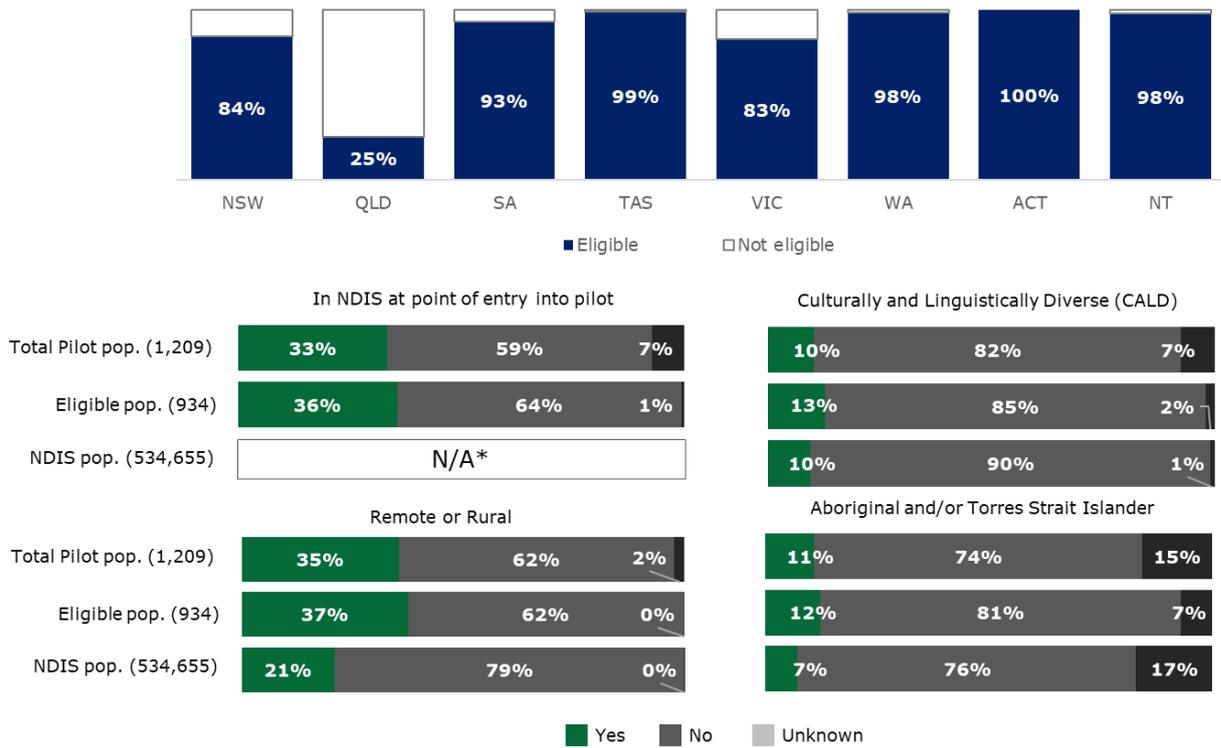
Consultations with the Queensland provider highlighted careful consideration of whether the client was more appropriate for their NDAP service and noted making several internal referrals to NDAP. In addition, the Internal Review (from 2022)<sup>3</sup> noted that the Queensland provider offered a fortnightly one-hour advice appointment for each advocate to enable them to provide limited advice, information, guidance, and referrals to people who were potentially eligible clients of the Pilot. This enabled their advocates to continue offering some support and referrals, even when at capacity. As these clients were not ongoing clients, either due to ineligibility or lack of capacity, they were classified as ineligible.

Consultations with providers also indicated varying interpretations of the eligibility criteria as another driver of variation. For example:

- Several providers felt that in some circumstances it was appropriate to accept a client below the age of 18.
- Most providers were stringent in their assessment of whether the individual had ‘no other appropriate decision-making support’ and often declined referrals because this criterion was not met. A few providers were less stringent – they felt that if the individual was seeking assistance from the Pilot, it was because they did not have access to informal supports, or if they did, those supports were not capable of providing decision support.

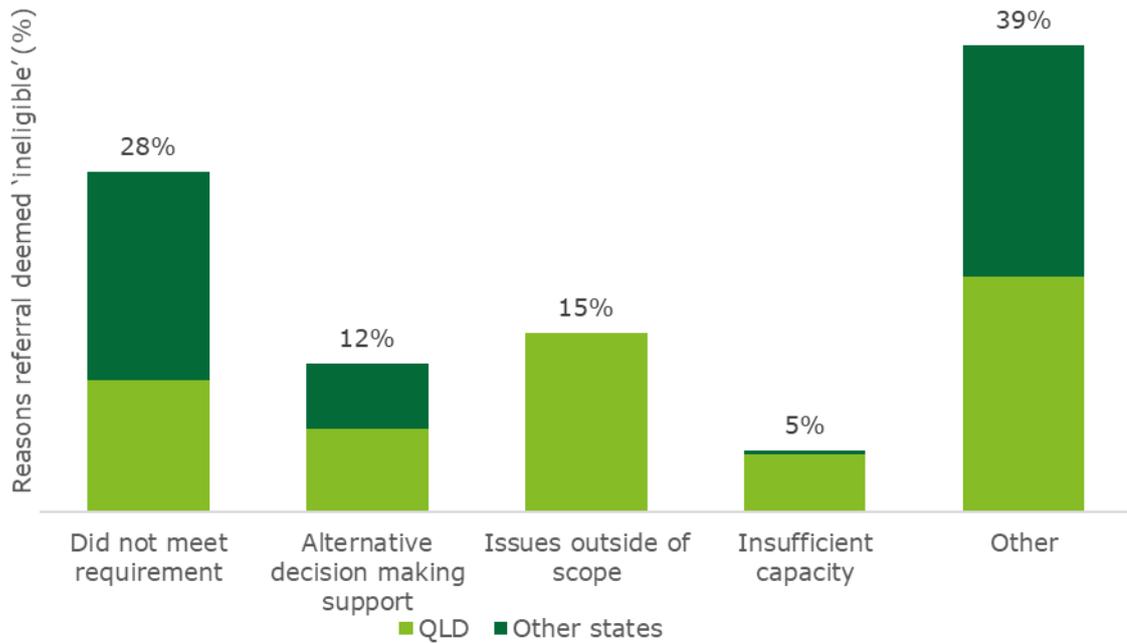
The most common reason clients were deemed ineligible was that the person had appropriate alternative decision-making support in place (see Figure 3.4 and Figure 3.3 where both ‘did not meet requirement’ and ‘alternative support’ reflect this reason), often a next of kin. All clients deemed ineligible because of an ‘issue outside of scope’ were referred elsewhere. Common referral points included community legal services, other general advocacy organisations, and community health services (including primary health clinicians).

Figure 3.3: Proportion of 'eligible' Pilot clients by geography and socio-demographic status



Source: Pilot program data 2019 to June 2022. The NDIS population dataset examined above pertains to the 534,655 participants who continue to be active in the NDIS as at 30 June 2022. Percentages may not total 100 due to rounding.

Figure 3.4: Reasons a referral was deemed 'ineligible'



Source: Pilot program data 2019 to June 2022.

After a client is deemed eligible, a provider triages their needs as 'high', 'moderate', or 'low priority'. This triaging process helps the provider to manage demand and waitlists by prioritising clients considered the highest need. As shown in Table 3.1, after removing the client cases where no priority level was recorded (and the anomaly of one provider, who recorded all cases by a singular priority), approximately half of all cases were triaged as 'moderate', one quarter as 'high', and the remaining quarter as 'low'. This bell-curve-like distribution suggests that the way providers triaged clients was effective in helping to manage demand. If almost all cases were classified as 'high', it would suggest providers should review their definitions for triaging to achieve a more appropriate level of prioritisation.

Table 3.1: Share of eligible clients by priority level

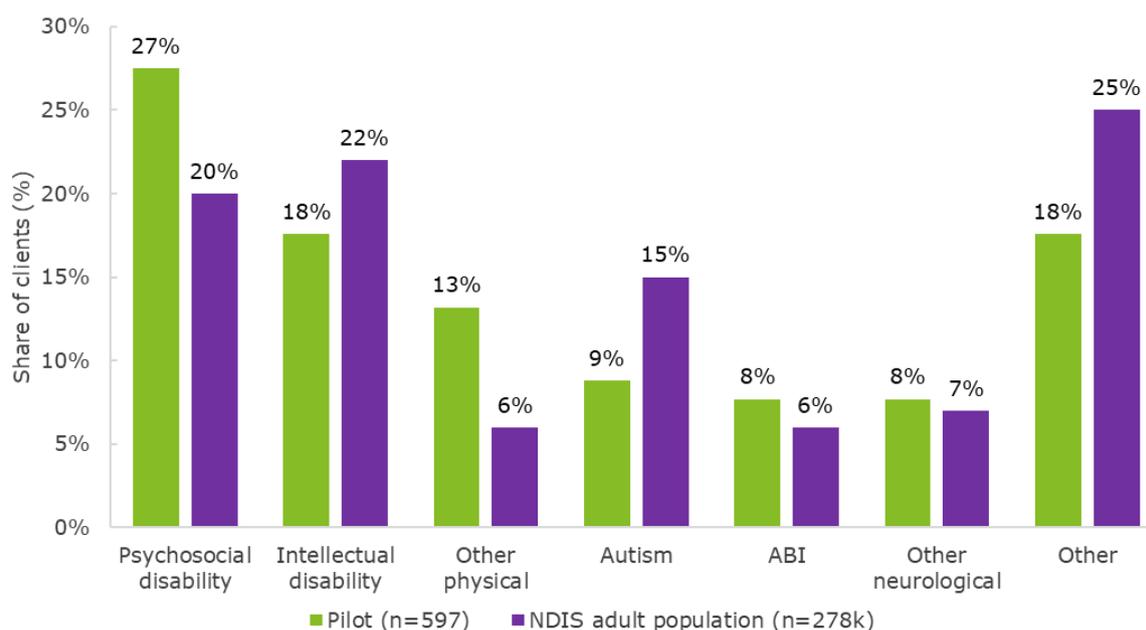
Priority level	(%)
High	26%
Moderate	38%
Low	23%
Reached ADACAS project priority*	5%
Unknown	8%

Source: Pilot program data 2019 to June 2022.

Note: Anomaly where one provider recorded all client cases by this category.

At an overall trend level, the distribution of clients by disability type broadly reflected the disability profile of the adult NDIS population (see Figure 3.5). The Pilot had a slightly higher share of clients with psychosocial disability and 'other physical' disability and a slightly lower share of clients with autism. In terms of total volume, psychosocial disability was the most prevalent primary disability type in the Pilot. This aligns with the higher prevalence of this disability type in the NDIS adult population, as well as the nature of the Pilot, where those requiring decision support are more likely to be individuals with a complex mental health condition.

Figure 3.5: Proportion of Pilot participants by disability type relative to adult NDIS population

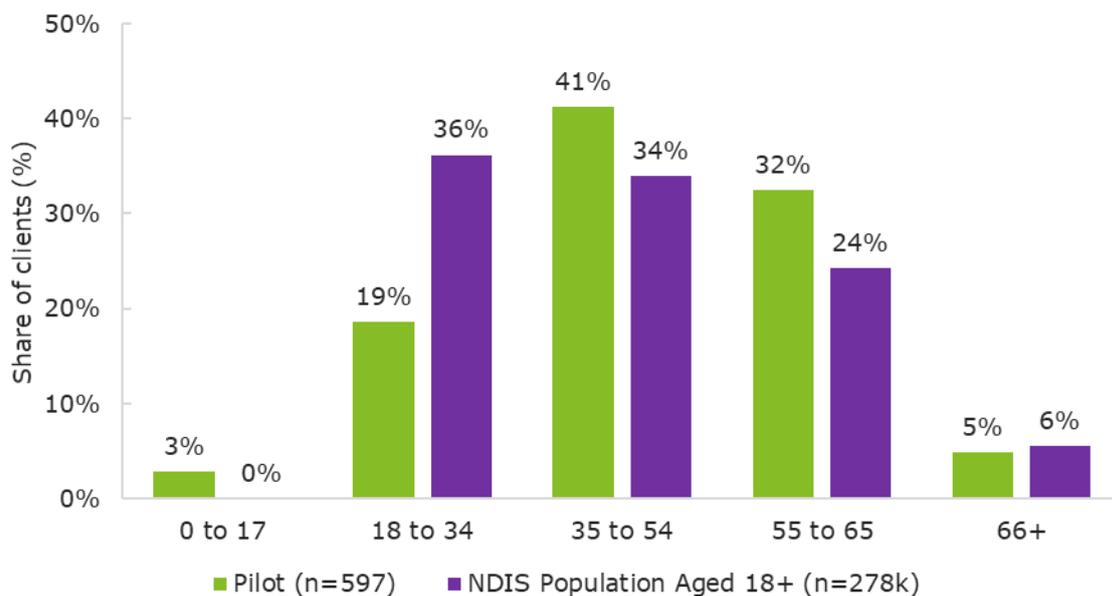


Source: Pilot program data 2019 to June 2022. NDIS Quarterly Report 2022.

Note: Primary disability types in 'Other' are: Stroke, Cerebral palsy, Visual Impairment, Multiple Sclerosis, Hearing Impairment, Spinal Chord Injury, Down Syndrome, Developmental Delay, Other Sensory/Speech, and Other (this refers to an NDIS disability type encompassing any disability not in the aforementioned categories).

At an overall trend level, the distribution of clients by age broadly reflected the age profile of the adult NDIS population (see Figure 3.5). The Pilot had a slightly higher share of clients aged 35 to 54 and a slightly lower share of clients aged 18 to 34. It is noted that 3% of all Pilot clients were below the age of 18 and 5% were above the age of 65, despite the age eligibility criterion for the Pilot being 18 to 65.

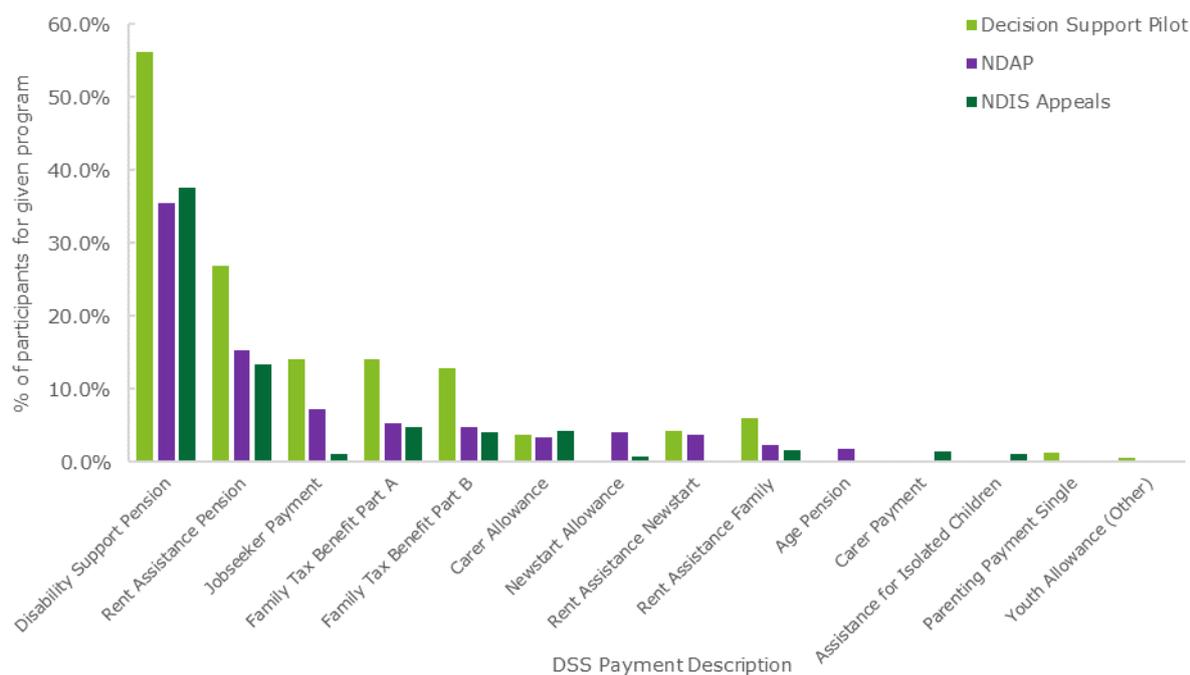
Figure 3.6: Proportion of Pilot participants by age relative to adult NDIS population



Source: Pilot program data 2019 to June 2022. NDIS Quarterly Report 2022.

At a broad level, individuals accessing the Pilot tended to have higher rates of accessing a range of other DSS payments, notably Disability Support Pension, Rent Assistance Pension, Jobseeker Payments and Family Tax Benefits Parts A & B. Whilst this represents a relatively small population of Pilot clients in DEX, this suggests that the Pilot was somewhat effective at reaching a more vulnerable cohort, relative to NDAP & NDIS Appeals.

Figure 3.7: Percentage of Pilot clients accessing other DSS Payments relative to other NDAP & NDIS Appeals.



Source: Pilot program data 2019 to June 2022. NDIS Quarterly Report.

The statistics presented in this section show that the demographic profile of Pilot clients at the aggregate program level broadly reflects the profile of the NDIS adult population, suggesting equity of access for different subpopulations. However, analysis at the provider level showed more variation as some providers targeted specialised cohorts aligned with the target cohort/s of their broader organisation. For example, the Western Australian provider targeted individuals from CALD backgrounds, while the South Australian provider targeted individuals with acquired brain injury. Other specialised cohorts included people in out-of-home care, people in prison, or those experiencing homelessness.

There were benefits to adopting a targeted client engagement approach, for example:

- providers who targeted specific cohorts tended to have a higher rate of eligible referrals
- providers were all capacity constrained (as evidenced by waitlists), and this approach appeared to help to manage demand.

However, if a comparable Pilot was scaled and capacity is expanded, providers should be encouraged to attempt to reach a variety of client types to maximise equity of access in each jurisdiction.

### 3.1.2 To what extent does the Pilot effectively engage the target population? To what extent does the Pilot meet the needs of people with limited decision-making capacity and no other decision-making support?

To assess the extent to which the Pilot appropriately engaged the target population and met their needs, various design features of the Pilot were examined including:

- program scope
- program promotion and referral
- capacity to deliver the program
- mode of engagement and operations
- program discharge
- overall program administration

This section is structured according to each of these design features.

### 3.1.2.1 Program scope

Stakeholders consulted broadly agreed the program scope was appropriate for meeting the needs of the target cohort. Key themes emerged related to reaching the target population, the eligibility criteria, and goals for interacting with the Pilot:

**Reaching the target population.** As noted above, at an aggregate level, the demographic profile indicated equity of access for different sub-populations relative to the adult NDIS population, however, some providers targeted specialised cohorts.<sup>5</sup> In addition, most providers did not publicly advertise their service and conducted limited outreach as they were capacity constrained. Many providers reported targeting clients who they were already aware of through their existing advocacy programs. While these methods helped to manage demand, there is likely to be a level of *unknown* unmet demand within the broader population. By not advertising the Pilot, some stakeholders expressed concern that the people most in need of the Pilot (i.e., the people most vulnerable who are not currently known to local social services) had no way of knowing about or accessing the service.

**Eligibility criteria.** Providers generally felt that the eligibility criteria reflected the cohort they had previously observed in NDAP as requiring more intensive support. Regarding the criterion for 'no other appropriate decision-making support', some service providers highlighted several cases where a client had informal support, however, the informal supporter was not appropriate to aid decision-making. This included informal supports who were perpetrators of abuse, recent migrants without knowledge of systems, or a parent or partner with cognitive impairment.

Regarding the age criterion of 18 to 65:

- **People over the age of 65.** Providers noted that while you cannot enrol in the NDIS over the age of 65, 6% of all NDIS participants are people over the age of 65. These people typically enrolled in the NDIS prior to their 65<sup>th</sup> birthday and have not yet exited into the aged care system. To this end, providers suggested adjusting the upper end of the age criterion.
- **People under the age of 18.** The NDIS reached national implementation status three years ago, which means that most people transitioning from the old disability arrangements are now NDIS participants. As a result, a growing share of new NDIS entrants in each year (i.e., people seeking NDIS Access Requests) are children or people with an acquired disability. The growing share of NDIS entrants who are children thus warrants consideration of whether future implementation of a comparable service should also target select groups under the age of 18.

**Goals for interacting with the Pilot.** As noted in Figure 3.2, 33% of Pilot clients were existing NDIS participants seeking support with either plan development/review or system navigation and plan implementation (i.e., clients in category two or three of the NDIS participant pathway shown in Figure 1.1). Providers and DSS stakeholders noted that at the project's outset, the scope of the Pilot was primarily focused on supporting people with NDIS access and planning. However, over time, a need emerged to also provide decision support to NDIS participants at the plan implementation stage, given growing challenges related to the NDIS participant experience (e.g., low plan utilisation rates, difficulty in navigating the system etc.) This flexibility in evolving program scope in response to client needs is an indicator of the appropriateness of the Pilot's scope.

However, it was noted that most clients seeking support with NDIS system navigation and plan implementation were 'returning clients' (e.g., their original case related to seeking a NDIS Access Request which was successfully achieved – they then re-presented at a later date because they were unsatisfied with their Support Coordinator). Few clients first engaged with the Pilot for

<sup>5</sup> A core limitation is that it was not possible to compare the Pilot's equity of access relative to the underlying population of people eligible for the NDIS (i.e., current NDIS participants and people eligible for the NDIS who are not current NDIS participants). Relative to the current NDIS adult population, the eligible NDIS population is likely to include a higher percentage of people from disadvantaged cohorts who commonly face access barriers to programs and services.

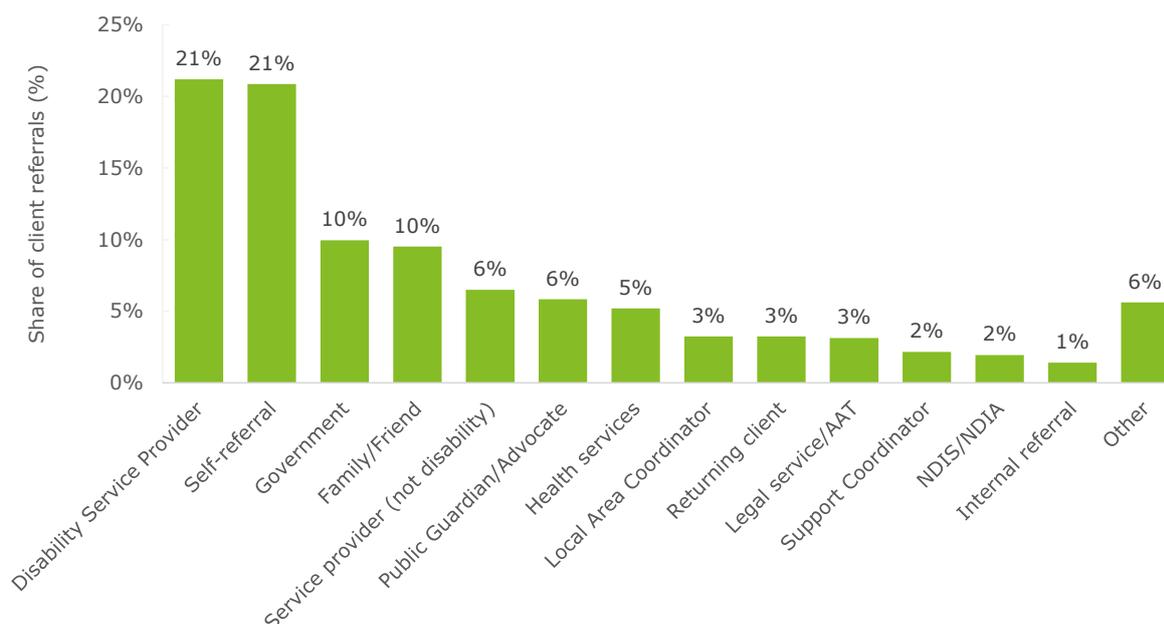
system navigation and plan implementation reasons. Providers felt this did not reflect a lack of demand for decision support among other NDIS participants, but rather that the demand exists among people unaware of the Pilot and/or because LACs or Support Coordinators are not appropriately referring potential clients. This finding is supported by themes highlighted at the Disability Royal Commission,<sup>6</sup> which indicates there are NDIS participants at the plan implementation stage who would benefit from decision support, as they navigate issues such as finding suitable accommodation, changing providers, or exercising their rights and choice in cases of a provider conflict of interest.

### 3.1.2.2 Program promotion and referral

Pilot providers were also NDAP providers and thus had existing networks within the disability sector and the local community. As a result, Pilot providers predominantly engaged their existing networks to raise awareness of the Pilot and encourage referrals. As noted, most providers did not actively promote the Pilot as they expected demand to exceed their capacity. Where providers did conduct outreach to encourage self-referrals, they typically attended boarding houses, disability accommodation or prisons. To encourage referrals from other services, some providers conducted education sessions with general practitioners, crisis support services, Support Coordinators, and general advocacy organisations. However, in general, it appeared that word-of-mouth was the main method of awareness raising.

Referrals for the Pilot came from a range of different sources, with referrals from disability service providers and self-referrals being the most prominent, as displayed in Figure 3.8.

Figure 3.8: Share of Pilot clients by referral sources



Source: Pilot program data 2019 to June 2022.

This analysis was validated by insights gleaned through consultations where providers indicated that most referrals originated from disability service providers or local community services, such as social workers or housing support organisations. Only 5% of referrals originated from LACs or Support Coordinators, despite a view from providers that LACs should be referring more often, particularly for people needing support with plan implementation and system navigation. Some providers reported that LACs were unwilling to engage with the Pilot as they were unclear on the role delineation between LACs and the Pilot.

<sup>6</sup> Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, Interim Report (2020) <<https://disability.royalcommission.gov.au/system/files/2020-10/Interim%20Report.pdf>>.

As noted in section 3.1.2.1, 33% of clients first engaged with the Pilot for system navigation and plan implementation reasons, despite a view among providers (and validated by themes emerging at the Disability Royal Commission)<sup>6</sup> that there is likely to be a degree of demand for decision support among socially isolated NDIS participants facing challenges implementing their plan. Given these types of clients would be well known to LACs and Support Coordinators, any future implementation of a comparable service should consider how it can better engage and establish referral pathways with them.

Regarding self-referrals (or referrals from family and friends) several Pilot clients noted that they 'Googled' advocacy services and support with NDIS access or planning, which led them to the Pilot provider who had the NDAP service publicly advertised. It was only after initial discussions with the provider that they became aware of, and assigned to, the Pilot.

Stratification of referral sources by provider showed variation that was reflective of targeted client engagement approaches. For example:

- The SA Provider, which targeted clients with brain injury, had a relatively high rate of referrals from a client's family or friends (who were themselves unable to provide decision support).
- The ACT Provider, which highlighted investing in awareness raising among GPs, had a relatively high rate of referrals from local health services.

### 3.1.2.3 Capacity of providers to deliver the program

All providers consulted commented on the high degree of demand for the Pilot. One provider noted they had expected to service 60 cases a year, and at the time of the interview (March 2023) had already supported 139 people. A service provider who adopted a targeted client engagement approach (i.e., worked with one or two specialised cohorts only) felt that if they encouraged referrals from other cohorts, they would have received up to three times as many referrals. As noted in section 3.1.2.1, providers were capacity constrained in their ability to meet existing levels of demand, and as such, invested minimal time and effort in raising awareness of the Pilot.

Demand drivers related to both the volume of unique clients seeking decision support and the complexity of cases/intensity of support required per case. The following themes related to demand were highlighted:

- **The intersectional nature of client issues.** As one provider explained: *None of the clients come to us with just one issue, [they] might have an NDIS issue, might have a housing issue, might have an issue with DV or exploitation, education issue, [or] Centrelink issue. Decision support clients are coming with around 4-5 issues each.*
- **The complexity of gathering evidence to inform a NDIS Access Request for those not known to health and community services.** As one provider explained: *You go to a number of boarding houses and a number of them should be on the NDIS. And because of their impairment, they don't have a GP or connected with the public hospital system. The burden of gathering evidence is significant and they couldn't do it without an advocate.*
- **The growing complexity of clients who have not engaged with the NDIS, despite potentially being eligible – some of those not yet on the NDIS may be more socially isolated and in need of decision support services.** To ensure these clients would not withdraw from the Pilot, service providers often had to proactively initiate contact, repeatedly follow up with clients, or travel to visit them face-to-face. As one provider explained: *Clients are becoming more complex and length of time to resolve matters has been on a steady trend since program commencement. People who have been disengaged from services, have ageing parents, community supports have fallen away. Cohorts without access are becoming more and more complex. There were transition programs but now it's you're eligible or you're not, and you have to support people because access to the NDIS is their last option. The isolation from supports means they have no existing evidence.*
- **Challenges with closing a case due to trusted advisor relationships.** Several providers noted that clients would often re-present with a different issue following case closure. Often,

their service provider was one of the few people with whom they had a trusted relationship, and it was thus difficult to 'close the door' on these clients.

- **Limited engagement in supported decision-making approaches and frameworks by disability services providers.** One provider felt that some of the cases referred to the Pilot could be avoided if disability services providers were more appropriately implementing supported decision-making frameworks (in line with the United Nations Convention of the Rights of Persons with Disabilities) in their everyday delivery practices. For example, giving the client choice, ensuring the information is provided in a way the client can understand, and ensuring the client understands their rights. It is acknowledged that this is a broader systemic issue that is a current focus of the Disability Royal Commission. It is also acknowledged that the recent release (May 2023) of the NDIA's Supported Decision Making Policy is a positive step toward better integrating decision support principles in the practices, processes and systems of NDIS staff and support providers.

Providers used varying strategies to help manage demand:

- **Waitlists.** Provider quarterly spreadsheets showed that all providers (except ACT) had a waitlist. In total, 14% of all eligible Pilot clients were placed on a waitlist before receiving support. This figure was highest in NSW, at 20% of all eligible Pilot clients.
- **Triaging.** All providers triaged clients based on their priority level (as discussed in section 3.1.1). Where appropriate, some low-priority clients were referred to general advocacy programs that could respond in a timelier manner. The provider in Queensland utilised a unique model to provide one-off low-touch support to those placed on a waitlist (as discussed in section 3.1.1). In addition, some providers supported clients to self-advocate as a first approach, where appropriate.

*"Demand is so high that people who have any capacity for self-advocating that is our first approach because the demand is so great. We triage as best we can and to be honest my advocates are amazing at how they can support multiple people at the same time."*

**– Service Provider**

#### 3.1.2.4 Mode of engagement and operations

When compared to general advocacy programs (e.g., NDAP), the Pilot was reported to be more time intensive as clients were more complex. In addition to the reasons outlined above, providers observed that clients tended to be people who needed more face-to-face support, more coordination support (scheduling and attendance at clinical appointments), and more provider-initiated contact to encourage help-seeking behaviour and prevent disengagement. As demonstrated by the quotes below, clients appreciated advocates' willingness to provide face-to-face support and attend meetings with health and community services.

*"I enjoyed the face-to-face meet ups, prefer to continue. Better understanding with face-to-face meeting, [they] understand me and my needs, it's convenient."*

**– Pilot Client**

*"Able to get access - [the advocate] could speak the same language, very professional. Put them [the Housing Officer] in their place at times, was able to push back."*

**– Pilot Client**

### Workforce considerations

Consultations indicated that advocates require a complex and sophisticated skillset to deliver the Pilot. This includes deep subject matter expertise related to:

- disability types
- NDIS requirements for access, planning, and reviews
- intersecting social issues (e.g., mental health, trauma and abuse, and homelessness)
- provision of person-centred and empathetic care; strategies for communicating with clients in an inclusive way (e.g., distilling the complex 'language' of the NDIS in a format that is easy to understand)
- techniques for negotiating with government agencies.

As an example, one client consulted noted that prior to receiving support from the Pilot they had submitted four unsuccessful NDIS Access Requests with support from health professionals. This individual then submitted a successful Access Request with the support of the Pilot, which was attributed to the advocate's nuanced understanding of NDIS access evidence requirements.

Providers consulted highlighted the diverse backgrounds of their advocates. Professional backgrounds included social work, disability employment services, hospital settings, and roles as LACs. In addition, many advocates had lived experience of disability (either themselves or in a carer capacity). Providers noted that this mix of interdisciplinary skills, coupled with the team's commitment to peer learning and knowledge exchange, enabled each advocate to provide the types of holistic and person-centred support necessary to perform their role.

*"Our advocacy officers come from a range of backgrounds, social work, employment, hospital, LACs. We have that broadness in experience. All our staff work in a culturally responsive way and individualised tailored ways... If an advocate doesn't have experience with [one area] there is someone they can go to. The peer learning and peer support is strong."*

**- Service Provider**

*"We have distinct individuals as advocates. Helps to make sure we are using the funds only for the program. My sole reason of being here is to help people get on the NDIS and a plan that will help them. Sole focus. In general advocacy have so many competing demands - e.g. eviction, court hearings etc. - whereas with DSP you can focus on supporting people less engaged and really devote to their needs."*

**- Service Provider**

*"Have complexity of SDP clients which burns out staff. With a mix of some other things, need to have the right scale so people can have leave, and government doesn't take into account that context, have to understand how advocacy works, having HR, having an EAP, having CRM. Need to stop looking at things just in isolation."*

**- Service Provider**

### The benefits of dedicated funding for an independent program

Regarding the service delivery model, providers reflected that a key enabler of the Pilot was the dedicated funding for a program to provide decision support to address one specific disability-related issue (i.e., NDIS processes). This allowed service providers to be patient with their clients, more proactive in encouraging help-seeking behaviour and preventing disengagement and afforded service providers enough time to build rapport with the client and establish trusting relationships. This was cited in contrast to general advocacy programs such as NDAP, where there are cases that if a client does not respond to a phone call/email, the provider may not have the capacity to follow-up and encourage help-seeking. In general, NDAP provides short and medium-

term issues-based advocacy support, in contrast to the Decision Support Pilot which utilises a longer-term, targeted case management approach.

Another perceived enabler of the Pilot was its independence (i.e., independent of the NDIA and service providers), noted by both Pilot providers and clients. This was cited as important because:

- **Some clients were distrusting of government.** Providers noted that some clients were reluctant to discuss the NDIS and accept support from the Pilot because of previous negative experiences with government agencies. To encourage help-seeking in these cases, service providers cited examples of investing over twelve months in building trusting relationships.
- **The issue of real or perceived conflicts of interest.** An issue raised in the NDIA's Consultation Paper (2021) on Support for Decision Making policy and discussed at the Disability Royal Commission is the potential for real or perceived conflict of interest. That is, the conflict of interest which can exist between a decision supporter's interests and a participant's preferences. The Pilot minimises this conflict by commissioning independent providers to deliver the Pilot who have nothing to gain – real or perceived – from access, plan budget development, or plan implementation outcomes.

*"Because this program is so focused on this one issue it gives us the space to hang in there for the long haul. It's much more based on them and their needs rather than us and our capacity, which is how it works in general advocacy."*

**– Service Provider**

*"We have no vested interested except for that of the person themselves."*

**– Service Provider**

*"Needs to be a disability advocate who is independent and has expertise in a number of areas, complex mental health, how pain interacts with disability, how Autism Spectrum Disorder interacts with people, how they receive information and how they process information, then need to be aware of their triggers. If they've experience horrific abuse, which is a standard thing, then the advocate needs to be completely aware of how to discuss things and when to bring them up. Make sure options are given but the person isn't overwhelmed. Many factors to the person getting onto the scheme and making sure they have good plan."*

**– Service Provider**

### **Delivery models**

As noted throughout this section, Pilot providers used a set of operational guidelines to inform the implementation of their service, however there was a degree of variation in approaches, such as the types of service models implemented, the client cohorts targeted, triaging methods and waitlists. These differences reflected providers tailoring the service to local needs, which was within scope of the Pilot's goals and guidelines.

Providers also differed in how they operationalised their advocates to deliver the model:

- A. Some providers recruited FTE advocates dedicated to the Pilot.
- B. Other providers recruited extra FTE for their organisation as a whole and tasked all advocates with delivering both NDAP and the Pilot.

Providers appreciated the flexibility to deliver staffing models in a way that best suited their organisation. However, it was anecdotally observed that providers who used approach (A) were better able to proactively follow up with Pilot clients and provide higher-touch support in rare cases where they had spare capacity. Any spare capacity among advocates under (B) would generally divert to NDAP given the high caseloads in general advocacy and the scope of requests which often require immediate assistance (e.g., attending court hearings etc.)

### Selection of provider organisations

Provider organisations were selected based on high performance in the delivery of the NDAP, including meeting client targets and reporting milestones, engagement with the sector and experience supporting people with limited decision-making capacity. This model of co-commissioning proved effective for several reasons:

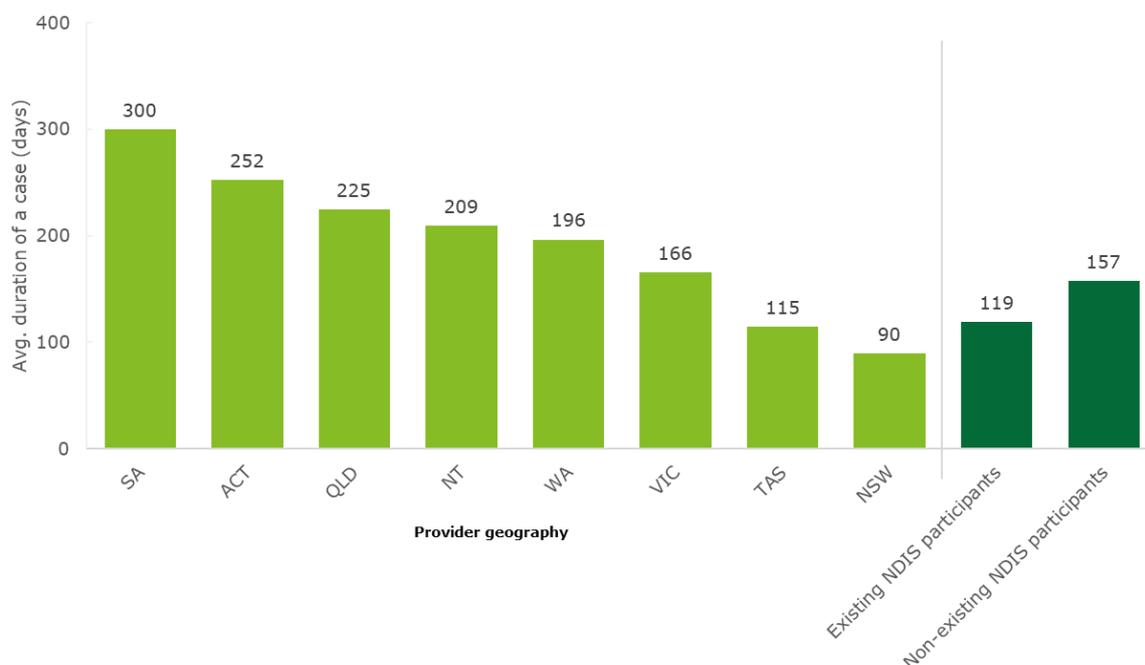
- Providers were able to triage and refer clients between programs in an efficient manner. This also prevented the need for clients to explain their stories multiple times, which can be taxing and distressing.
- Many clients satisfied with the Pilot, reported familiarity and satisfaction with the organisation themselves, and not solely the service provider. While most of the benefits discussed in this report relate to clients as the beneficiary, this finding suggests there were also benefits for the provider’s broader organisation.
- Based on existing networks, and the public-facing profile of the NDAP, providers achieved high rates of demand, and in some cases, large wait lists, with limited investment in program promotion.
- Drawing on experiences from the NDAP, providers were easily able to identify, recruit and train staff that met the unique skillset required to provide decision support services.

Any future implementation of a comparable service should consider adopting a similar approach.

#### 3.1.2.5 Duration of engagement and program discharge

As shown in Figure 3.9, the duration of support (i.e., the total number of days between accepting a client and closing the case) varied across providers. The South Australian provider had the highest duration, at 300 days, on average, while the NSW provider had the lowest, at 90 days. Clients who were previously NDIS participants and only seeking support with either the planning or plan implementation parts of the NDIS participant pathway, had a lower duration of support, at 119 days, on average, relative to non-existing NDIS participants, at 157 days. This trend reflects the time invested in supporting non-existing NDIS participants with the additional NDIS Access milestone, which consultations with providers indicated was the most time-intensive part of an advocate’s role.

Figure 3.9: Average duration of a case (days)



Source: Pilot program data 2019 to June 2022.

Variation by provider appeared to be driven by differences in conceptions of how to best meet the 'will, preference and support needs' of clients – the guidance in the operational guidelines for closing a case. For example, when the original goal of a client case was to obtain NDIS Access, once Access was achieved, some providers would cease the case and encourage self-advocacy for the planning and implementation phases. This was generally the providers with high demand-to-resourcing ratios, such as NSW.

Other providers were more flexible, choosing to keep the case open and volunteer support with system navigation and plan implementation, even in cases where a Support Coordinator was engaged. Providers in this group felt their flexible client-led approach was more appropriate, citing the growing number of clients who re-present and the emotional impact on clients from knowing they will continue to have someone 'on their side'. As one client explained: *My advocate said she would keep an eye on me, for the next 12 months. This made me happy, that they were still providing support.*

Some providers in this second group also highlighted concerns about the conflicts of interest that exist in the NDIS. A common example is where a Support Coordination provider also provides disability services; creating a risk that the Support Coordinator may influence decision-making in favour of their own service. Given these risks, some providers felt it was important the client knew they could continue to access independent decision support through the Pilot when needed.

*"When do you cease a case? Depends. Some go through multiple support coordinators (e.g. one person has gone through six). Some are confident to move forward and make decisions. Others have issues with challenges and tend to come back to the safe person, which is the Pilot, and we help redirect them to ask the right connections to find a new support coordinator. We are the 'trusted person' to get things back on track."*

**- Service Provider**

*Most of them once they are on the NDIS are okay. But some of them continue to have difficulties navigating the NDIS and where relationship with support coordinator isn't strong, we can support. If they have mood issues or paranoia that won't trust the system and Agency asks what's going on when not spending funds. We reconnect them because they 'trust' us. It's easy to give up on people who are difficult to engage - but they are the ones that need the most help."*

**- Service Provider**

In addition, consultations with providers indicated people with more complex disabilities required more intensive support. The South Australian provider serviced a relatively high share of clients with an acquired brain injury, who experience difficulties with short-term memory, and challenges in maintaining new relationships and routines. This may explain why the South Australian provider had the highest average duration of support.

As noted in section 3.1.2.3, providers reflected that the complexity of clients has increased over time, as the transition to the NDIS matures. That is, the NDIS has now been fully implemented for three years – those not yet on the NDIS are thus the most complex and socially isolated. Providers felt that growing client complexity has increased the intensity of support required per case as well as the duration of support per case.

*"The program needs to have the flexibility to pick them up again - not the hard and fast close case. Because this program is so focused on this issue it gives us the space to hang in there for the long haul. It's much more based on them and their needs rather than us and their capacity."*

**- Service Provider**

*"Clients are becoming more complex and length of time to resolve matters has been on a steady trend since program commencement. People who have been disengaged from services, have ageing parents, community supports have fallen away. Cohort without access are becoming more and more complex. There were transition programs but now its you're eligible or you're not, and you have to support people because access to the NDIS is their last option. The isolation from supports means they have no existing evidence."*

**- Service Provider**

*"One thing is that people are often isolated, they might be homeless or at risk of homelessness (which poses an issue with needing an address). A lot have ageing parents who've moved into aged care or are about to move into aged care. A few that have been in abusive situations, mental and physical abuse, neglect.. ..in those cases, abusers don't want anyone else involved"*

**- Service Provider**

*"You go to a number of boarding house and a number of them should be on the NDIS. And because of their impairment they don't have a GP or connected with the public hospital system. The burden of gathering evidence is significant and they couldn't do it without an advocate."*

**- Service Provider**

### **3.1.2.6 Program administration**

Providers were generally complimentary of the administrative role of DSS; however, several opportunities were identified to enhance future program administration:

- **Improved clarity and predictability related to funding arrangements and contract renewals**, which would support providers to recruit and retain talented staff, while also ensuring continuity of service provider relationships for clients.
- **Improved mechanisms for collaboration, sharing of learnings and knowledge exchange across providers**. For example, a monthly community of practice focused on quality improvement (e.g., practical case studies, discussions that provide visibility of how other providers are delivering their service and resolving shared challenges) in addition to the provision of process and policy updates.

## 3.2 Effectiveness

This section examines various questions related to the effectiveness of the Pilot, including:

- What are the client's intended goals for the Pilot and how does this compare to their outcomes? (Section 3.2.1)
- What are the reasons for client disengagement or withdrawal for the Pilot? (Section 3.2.2)
- What was the effectiveness of recent Program operational changes (e.g., DEX, the operational guidelines)? (Section 3.2.3)

### 3.2.1 What are the client's intended goals for the Pilot and how does this compare to their outcomes? What are participant's pathways through, and experience of, the Pilot?

As noted in section 3.1.1, clients' specific goals for interacting with the Pilot were not captured in provider quarterly spreadsheets, however, goals can broadly be inferred from a client's NDIS status at the point of entry to the Pilot:

- 66% of Pilot clients were not existing NDIS participants. Consultations indicated every client in this category was seeking a NDIS Access Request. This was supported by analysis of client interactions recorded in the DEX data for the six-month period to December 2022, which shows a similar proportion of sessions undertaken related to NDIS Access / Planning.
- The remaining 33% of Pilot clients were existing NDIS participants (defined as a client who had already obtained NDIS access). The DEX data supported a similar proportion of sessions were primarily used for implementing NDIS plans or accessing services. Consultations indicated these clients were seeking support with one or more of the following issues:
  - assistance with preparing for a planning meeting to ensure they received an appropriate plan
  - assistance with steps to appeal an NDIS decision (these clients would typically be referred to a more appropriate service such as NDIS Appeals)
  - assistance with system navigation and plan implementation after receiving a plan
  - unsatisfied with a Support Coordinator or a service provider and seeking assistance to find better-suited support – this tended to be in cases of re-presenting clients.

#### 3.2.1.1 Achievement of NDIS Outcomes

When examining the NDIS outcomes achieved for clients, two data sources provided an indication of the impact of the Pilot:

- The 'final outcome' variable in the provider's quarterly spreadsheets, which provides an indication of the final outcome that was achieved for the client, by the provider, before the case was closed.
- The NDIS access dataset (which was linked to provider quarterly spreadsheets) – this dataset provided an indication of each client's NDIS access status (i.e., whether they had a successful, unsuccessful or withdrawn NDIS Access Request, whether they had a plan approved, and whether they had initiated a request for a plan review). This dataset was most helpful for understanding the impact of the Pilot in facilitating successful NDIS Access Requests for clients who were not NDIS participants at the point of entry to the Pilot.

Analysis of these two datasets is provided in Figure 1.1 and Figure 1.1, respectively, stratified by a client's NDIS status at the point of entry to the Pilot. As shown in Figure 1.1:

**For clients that were existing NDIS participants**, 53% had their case closed because of one of the following NDIS approvals 'Access approved / Plan approved / Plan review approved'. Given these clients already had access approved, it is likely that most cases are related to a planning approval outcome.

As noted earlier, not all existing NDIS participants were seeking decision support with planning, some were seeking assistance that required a referral elsewhere (13%). Examples of referrals elsewhere for this group included referrals to a support coordinator or general advocacy organisations. Other clients were seeking assistance with plan implementation and system navigation which was the main outcome covered under 'other outcomes' (28%).

**For clients that not were not existing NDIS participants**, 30% had their case closed because of one of the following NDIS approvals 'Access approved / Plan approved / Plan review approved'. Consultations with providers indicated that all clients in this category were seeking a NDIS Access Request, however, some also stayed on for support with the plan development process and/or plan implementation and system navigation. As such, while the final outcome recorded in quarterly spreadsheets for some clients may have related to a planning outcome or a plan implementation outcome (covered in 'other outcomes'), it is likely that the Pilot also facilitated access for these individuals. Some clients exited the Pilot because their NDIS Access Request was denied (9%), while others sought assistance requiring a referral elsewhere (9%). Referrals elsewhere for this group typically included advocacy organisations and community health services. A relatively large number of clients (33%) were categorised as 'other outcomes' which reflected a range of outcomes. Two examples are outlined in the case studies below.

### Case Study 1

An existing NDIS participant was referred to the Pilot by a Support Coordinator. This client required advice about the impact of requesting a change of circumstances review to seek access to Supported Independent Living (SIL), whilst an internal plan review was underway that was requesting additional plan funding. The advocate explained the impact of a change of circumstances review and advised that it would void the internal review. The Pilot provider advised the Support Coordinator and the client about the review process and the impacts of multiple reviews occurring at the same time.

**Outcome:** Following this, the client decided that the best option was to proceed with the internal review unless there was sufficient evidence to prove the change of circumstances and the need for SIL. The client was able to gain a greater understanding of the impact of review types and the broader process.

### Case Study 2

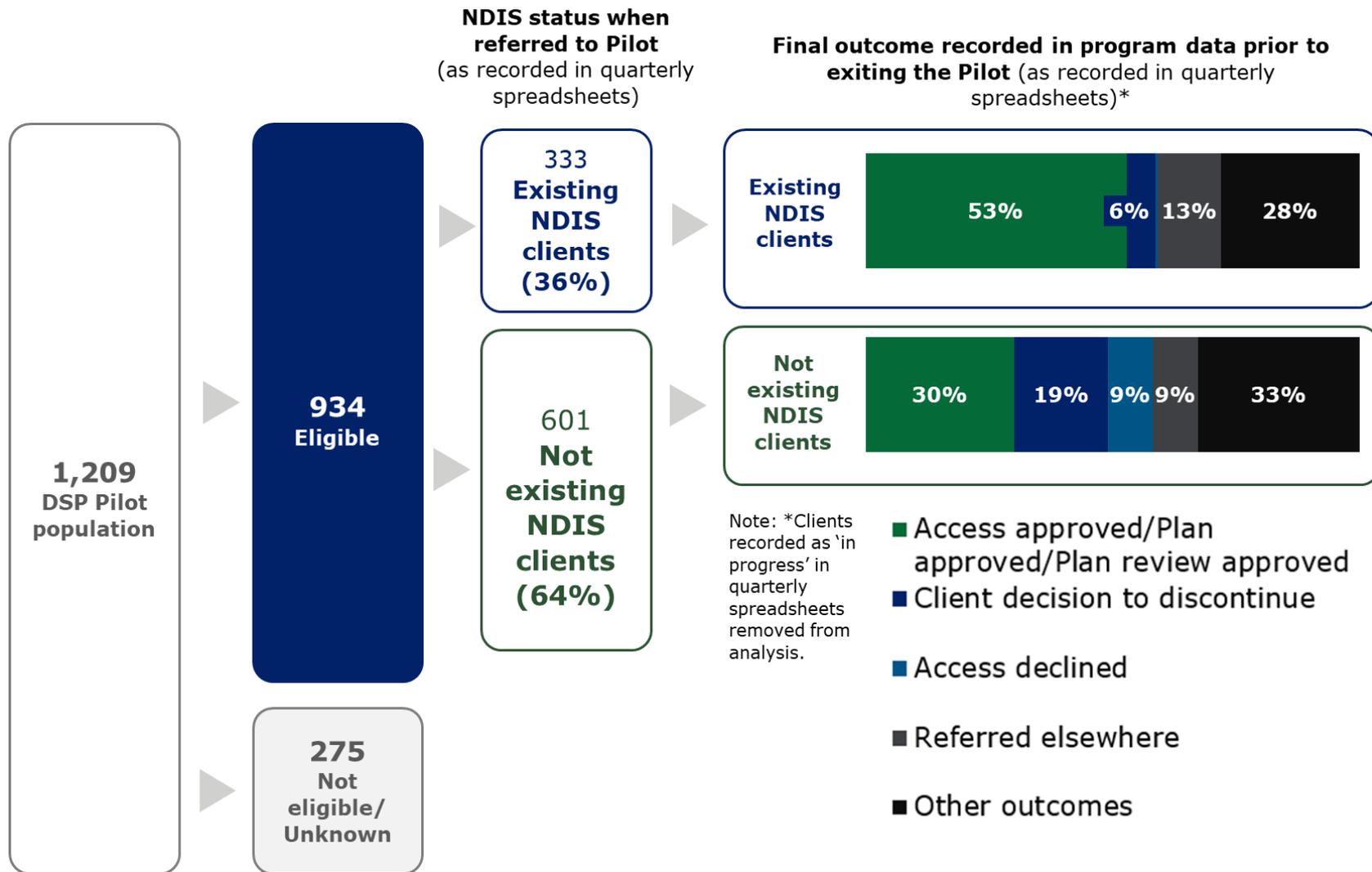
A client with an acquired brain injury required decision support for NDIS access and planning. Their initial application was made in 2018 (prior to the Pilot) yet was declined. Additionally, the client missed the review period because they did not understand their rights to appeal. The client's spouse was very confused about the complex application process and evidence requirements and was unable to provide decision support. Through the Pilot, assistance was then provided to gather evidence to support a new NDIS Access Request. An access request was submitted, and NDIA requested further evidence received, which the Pilot advocate supported with collation and resubmission, whilst supporting the informal carer (spouse) to understand the process.

**Outcome:** The informal carer (spouse) was deemed to have built their capacity to the extent that they would be able follow up with the NDIA, after being supported by the Pilot advocate. The advocate also offered the option for the client to return for support, if they needed assistance with their planning meeting.

The larger share of clients with their final outcome categorised as 'Access approved / Plan approved / Plan review approved' among existing NDIS participants relative to non-existing NDIS participants is unsurprising, given most clients in this group sought support with a planning outcome and everyone with NDIS access is guaranteed a plan. This differs from non-existing NDIS participants who were primarily seeking support with NDIS access. Access is not guaranteed and requires the individual to meet strict evidence requirements. In addition, the 'final outcome' field in the quarterly spreadsheets reflects the endpoint for the client, and as noted above, some clients who obtained a NDIS Access Request with the support of the Pilot stayed on for support with the plan implementation process after achieving access. As such, it is possible that the final outcome for these individuals was captured as 'referral elsewhere' or 'other outcome'.

Consultations with providers indicated that several clients seeking support with access chose to withdraw their application and engagement with the Pilot as they were so overwhelmed by the process of evidence gathering. This explains the higher rate of withdrawals among this group (19%) relative to existing NDIS participants (6%). Reasons for withdrawal are explored further in section 3.2.2.

Figure 3.10: Existing client NDIS status (at point of entry to the Pilot) by final outcome achieved prior to exiting the Pilot



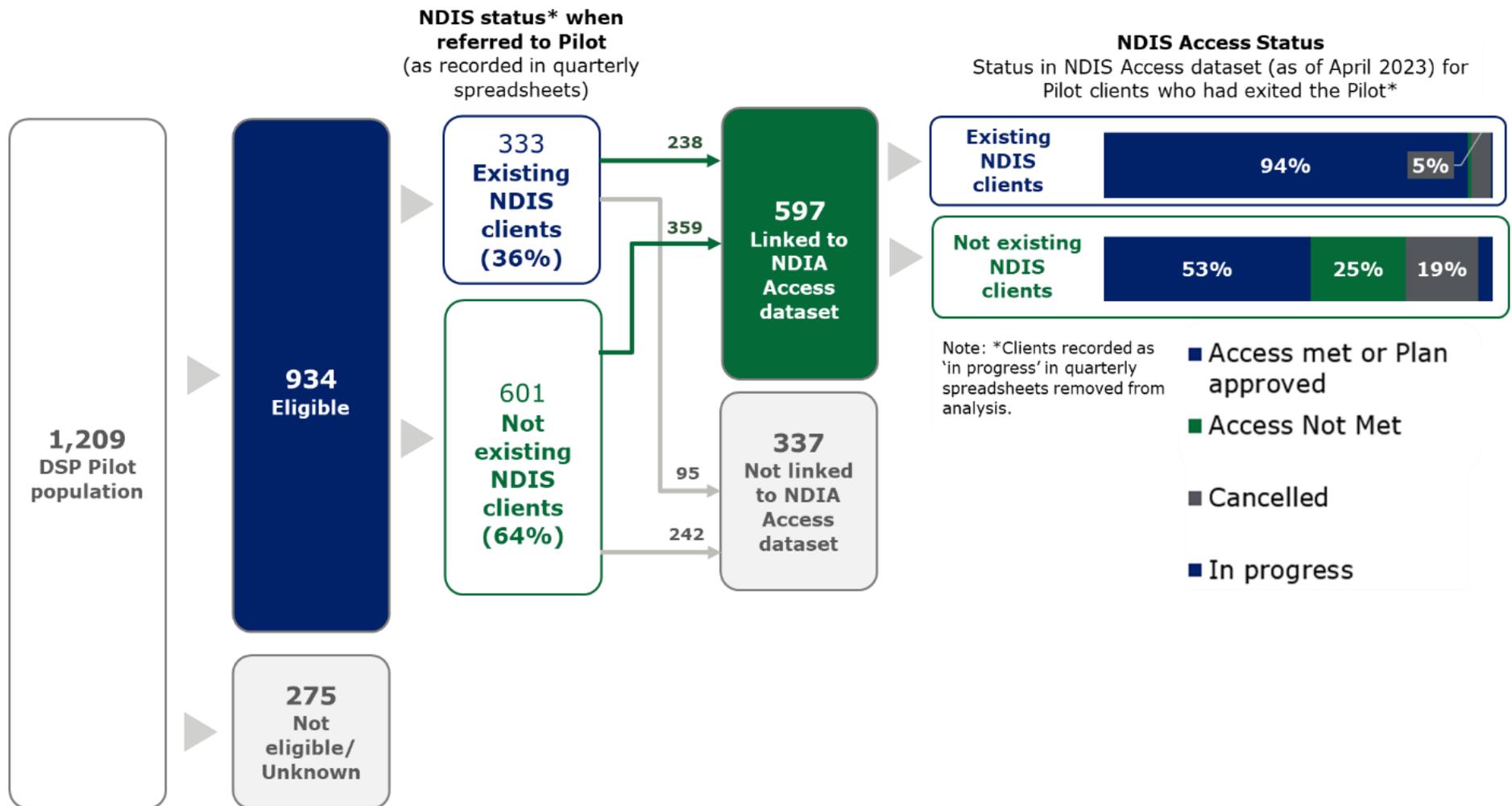
Source: Pilot program data (2019 to June 2022).

The NDIS access outcomes displayed in Figure 1.1 provides a better indication of the total rate of clients within the Pilot who had 'Access met or a plan approved'. As shown in Figure 1.1, almost all existing NDIS participants had 'Access met or a plan approved' (existing NDIS participants, as recorded in quarterly spreadsheets, were defined as people who had already obtained access) and suggests that this field was recorded accurately in quarterly spreadsheets.

For clients that were not existing NDIS participants, 53% had 'Access met or a plan approved', 25% had their status recorded as 'Access not met', 19% were recorded as 'cancelled' which typically reflected a withdrawn application, and 4% had an application 'in-progress'. This indicates that the Pilot was able to achieve an access rate of 53% for eligible clients that were likely seeking NDIS access as their reason for interacting with the Pilot. When excluding those with a 'cancelled' application or with an 'in-progress' application from the denominator, this figure rises to almost 70%. Explained another way, where the Pilot supported a client to submit a NDIS Access Request, a successful outcome was achieved in 70% of cases. This aligns with insights from consultations where providers indicated that most of their NDIS Access Requests were successful. It was typically only in cases of a technicality where an NDIS Access Request was denied (i.e., not meeting an evidence specification).

This finding is significant as consultations indicated that in the absence of the Pilot, these clients would not have had the capability or resources to complete the complex NDIS Access Request Form requirements on their own. For example, providers noted that many clients did not have a previous diagnosis of disability due to social isolation and challenges communicating their care needs. As one provider explained: *You go to a number of boarding houses and a number of them should be on the NDIS, but they don't even know it is an option for them or what it could do for them. And because of their impairment they don't have a GP or [are not] connected with the public hospital system. The burden of gathering evidence is significant and they couldn't do it without an advocate.*

Figure 3.11: Existing client NDIS status (at point of entry to the Pilot) by NDIS access status as of April 2023



Source: Pilot program data (2019 to June 2022) linked to NDIS Access dataset (2019 to April 2023).

Two final points are worth noting as a conclusion to this section:

- By contrast, the unique number of clients with ‘Access met or plan approved’ in the reference cohort was 65%. However, this should not be used as a baseline to estimate the incremental impact of the Pilot on access rates, as the reference cohort is made up of individuals who applied for access on their own terms, likely with the support of informal carers. Consultations indicated that the types of individuals who better reflect what would have happened to Pilot clients in the absence of the Pilot are people who have never applied for access, as noted above.
- It is at the discretion of the NDIA to determine if a client meets the requirements of NDIS access. The Pilot’s access success rate should thus not be considered a proxy for the Pilot’s level of success, as the objective of the Pilot was not to achieve an outcome such as access. Instead, the Pilot aims to support clients to make their own decisions when navigating the process so they provide the right information to receive a fair assessment.

### 3.2.1.2 Perceived impact of the Pilot on NDIS outcomes

Providers who participated in the consultations were asked to rate the extent to which they felt the Pilot was able to improve NDIS process outcomes for clients on a scale of one to ten. Most providers rated the success relative to the intended goals of the Pilot at an eight (3), nine (2) or a ten (2) out of ten. One provider rated a seven.

Providers generally felt that the Pilot was effective in achieving its intended outcomes (i.e., support with NDIS processes). Providers highlighted that in the absence of the Pilot, most clients who were not existing NDIS participants would likely never receive appropriate support. One provider shared the example of one client identified by an advocate through outreach at a boarding house who had no previous diagnosis of disability. This client received a \$200,000 package with the support of the Pilot.

This positive sentiment was balanced by the view that it was not always within the control of the Pilot to achieve a successful access or planning outcome due to external barriers or eligibility decisions at the discretion of the NDIA.

*"I would say it would be a stark difference. Someone might have been able to get access but might have burnt bridges with people or not included some things. One of the common factors with DSP clients is there are services in the [STATE / TERRITORY] they could use but they have exhausted their options through those services or have been banned. Helps a lot to have an advocate to facilitate the communications, made it easier for them to do it."*

**– Service Provider**

*"Award it a 10 on NDIS Process related outcomes. Lifechanging."*

**– Service Provider**

*All the people we've supported would not have got through to the NDIS without our support. E.g. someone has a 200k package now that previously didn't have a diagnosis and thus wasn't getting support."*

**– Service Provider**

Pilot clients provided an equally positive assessment of the Pilot’s impact on their NDIS process goals. Almost all clients consulted reported strong satisfaction with their experience of the Pilot. Experiences with advocates were noted as positive and supportive. Almost all clients consulted reported achieving their desired outcomes, including finding an appropriate Support Coordinator, achieving NDIS access, or more simply understanding an NDIS process. One client consulted reported dissatisfaction. Several clients expressed a desire to continue the relationship with their advocate, citing the rapport, trust and respect established over the course of their engagement with the Pilot.

### Case Study 3

One client entered the Pilot seeking support with NDIS access, following two unsuccessful attempts. These previous attempts had a profound impact on the wellbeing of the client, who felt overwhelmed, confused, and had given up hope. After working with their advocate to obtain the right evidence in the right format, an NDIS Access Request was submitted and granted.

**Outcome:** The client noted that they 'wouldn't be here' if it was not for the support of the advocate. The client felt relieved of the burden of the application process, noting the advocate took a 'heavy weight off me'. The client commented that they now have access to daily care and supports that has changed their life and they 'couldn't be happier'.

#### 3.2.1.3 External barriers to the achievement of NDIS outcomes

It is important to note that the Pilot's ability to support clients with their NDIS process goals was limited by the following external factors:

- **Client financial barriers to obtaining evidence to inform an NDIA Access Request.** Clinical evidence to inform a NDIS Access Request requires out-of-pocket payment to an occupational therapist to perform a functional assessment. Some clients also required reports from other medical specialists, such as psychiatrists and neurologists.
- **Timely access to clinicians to provide the necessary evidence and reports to inform a NDIS Access Request.** This was a particular barrier in remote areas. For some clients, waitlists for medical specialists were several months.
- **Access to Support Coordinators.** In cases where a client required assistance with plan implementation and system navigation, a service provider's first approach was typically to connect the client with a Support Coordinator or support the client in their conversations with a Support Coordinator. However, in rare cases, a client did not have funding for a Support Coordinator in their plan or their funding for a Support Coordinator was exhausted.

#### 3.2.1.4 Capacity building and personal empowerment outcomes

Both providers and clients agreed that the impact of the Pilot extended beyond NDIS process outcomes. Broader impacts included improved client personal empowerment and decision-making capability, which could be applied to future NDIS-related decisions and everyday life. For example, providers observed improved client confidence in decision making and self-advocacy as part of plan implementation, citing several cases of:

- Clients asking for choices when selecting a disability service provider.
- Clients taking proactive steps to change their accommodation provider.
- Feeling empowered to say 'no' to a suggestion provided by a Support Coordinator, where they would have previously agreed.

In one case study, a provider shared the example of a client who had NDIS access; however, they felt unheard by planning teams and community services and had stopped speaking to anyone entirely. After six months of support through the Pilot, this individual had the confidence to engage socially, make their own decisions, self-advocate and had secured relationships with several providers to implement their plan. Other case studies are provided below.

*"I used to be a YES man, she got me not to say YES anymore. Increased your confidence – to not only make the decisions, but come up with choices yourself. Able to make own decisions now."*

**- Client**

*"Never felt that we were made to beg, feeling worthless... [ADVOCATE NAME] always made the effort to contact me and keep me informed... Took that heavy weight off me. If I hadn't found them, I would have no idea what I would have done."*

**- Client**

*"Helped me gain my confidence again, that's one thing I've lost. Was getting angry and [ADVOCATE NAME] turned it around and got my confidence back to me. Without my team, including [ADVOCATE NAME], would not be able to function at all. Without [PROVIDER], I wouldn't be here today."*

**- Client**

*"We supported a person who was in hospital, they decided on their decision and then came back on another issue but then used the supported decision-making model to make that next decision on their own. Just needed that reassurance and capacity building."*

**- Service Provider**

*"Originally client had done access request and gained access and then came back into the system for help with a COS change and he needed a lot of support with decision making from advocate and relied on advocate opinions, then later decided he wanted to change COS and was much more prepared, knew what he wanted and what he wanted to say and had already called a COS and booked an appointment and already knew what he was going to do."*

**- Service Provider**

Another outcome highlighted was re-engagement with informal networks. When assessing eligibility for the client, an advocate assesses whether appropriate informal support is available to aid decision-making. As part of this process, providers shared examples of connecting clients with old foster carers or family members who had moved addresses or changed phone numbers.

### **3.2.1.5 Broader system-level outcomes**

Providers also highlighted the downstream impacts of the Pilot, such as reduced client use of health, justice, and community services. Several providers noted a reduction in the frequency of distress and crisis in clients over the course of their support. Providers also commented on the emotional toll of a denied NDIS Access Request and felt the Pilot was able to contribute to improved client wellbeing by enabling more favourable access and planning outcomes.

Another unexpected system-level outcome of the Pilot was improved connections to health and community services. Providers observed that at the point of entry to the Pilot, many clients had withdrawn from all types of social services. However, after establishing a trusted relationship with the decision support provider, they were willing to accept advice and referrals to services such as primary care, mental health, housing support, and employment support, among others.

### **3.2.2 What are the reasons for client disengagement or withdrawal for the Pilot?**

As shown in Figure 1.1, the rate of withdrawal from the Pilot was 9% for clients who were existing NDIS participants and 19% for clients who were not existing NDIS participants, for a rate of 14% overall. As noted in section 3.2.1.1, consultations with providers noted that several clients seeking support with Access chose to withdraw their application and engagement with the Pilot as they were so overwhelmed by the process of evidence gathering. This explains the higher rate of withdrawals among this group relative to existing NDIS participants. The other main reason for withdrawal related to social isolation and psychosocial barriers that led to some clients disengaging mid-way through a case.

Specific examples of withdrawal noted by Pilot providers and clients, included:

- withdrawal from the external review process as it was too strenuous for physical and mental health
- chose to concentrate on studies
- own belief would not be eligible for the NDIS
- mistrust of government systems
- a perception that the process for an Access Request 'went on for too long and they were over it'.

### **3.2.3 What was the effectiveness of recent Program operational changes (e.g., DEX reporting, the operational guidelines)?**

The Department undertook an internal review of the Pilot in 2021 and recommended:

- the introduction of new Operational Guidelines for providers that more clearly define the scope of the program, with the goal of promoting best-practice and standardisation across providers, and
- improved data collection and reporting through the transition to the DEX platform and the introduction of new data fields.

Both initiatives were implemented in 2022. Providers consulted were asked to share their experiences and views on the impact of these initiatives.

#### **3.2.3.1 Revised operational guidelines**

Overall, providers consulted welcomed a renewed approach to data collection and reporting, noting that the providers quarterly spreadsheets were limited in their ability to capture a client's journey and the different outcomes achieved. Many fields did not have pre-populated categories, instead relying on free text, limiting systematic comparisons across providers.

#### **3.2.3.2 DEX reporting**

Regarding the DEX transition, providers reported challenges in setting up and using the DEX system and queried the utility of certain fields captured. Challenges highlighted included:

- Inability to view total hours/duration of time spent with the client.
- No linkage or visibility to outcomes in the NDIS Access dataset, which would help providers to identify the outcomes of a client's access and planning request.
- The complexity of the system in general, which may compromise data integrity.
- A view that 'DEX-scoring' and the way that client outcomes are recorded is not client-centric. Some providers reflected that many of the questions did not fit the complex situations of Pilot clients. Specific examples included:
  - A client may have had progress on a housing issue and a provider may have helped them carry out a lot of activities related to the issue including building an understanding of public housing for the client. However, because a client may be unwilling to enter NDIS housing, the situation has not changed. This cannot be captured in DEX fields.
  - Providers noted that it would be ideal for the client to complete the satisfaction scoring, however when evaluating satisfaction outcomes clients, the client is typically unable to comprehend and answer the question.

Relative to the data collected in quarterly spreadsheets, DEX reporting captured some additional fields and removed others. Observations included:

- **Demographic fields:** In general, more fields were collected, providing a more holistic profile of participants compared to the quarterly reporting spreadsheets. For a more in-depth comparison, please see Appendix 5.3. An assessment of the DEX data over the period July to December 2022 showed that the demographic profile of the 165 Pilot participants were not materially different to the profile of the 597 client cohort captured over the period to June 2022.

- **Cost fields:** Key fields removed as part of the DEX transition included cost-related fields, such as the estimated cost of intervention and estimated intervention hours. This impedes direct analysis of the cost of Pilot clients' services, however, DEX captures session-level data which can be used as a proxy, by examining number of sessions per client per case. It is suggested that cost information be considered for inclusion in the DEX data to facilitate ongoing monitoring and evaluation.
- **Topics:** The session data captures the topic of the session. Key topics include:
  - NDIS - Access/Planning
  - NDIS - Supporting implementing plan/Accessing services
  - Access to non-NDIS services
  - Health/Mental Health
  - Government payments
  - Child Protection

For the Pilot population within the DEX data, a majority of activity related to NDIS - Access/Planning (67%) followed by NDIS - Supporting implementing plan/Accessing services (28%). The session topics provide a useful way to capture the purpose of sessions to gain an understanding of clients' needs.

- **Service Type:** The DEX data captures the Service Type for attendances, including:
  - Advocacy - External Review
  - Advocacy - Internal Review
  - Advocacy/Support
  - Information/Advice/Referral
  - Intake/Assessment
  - Outreach

The average number of Pilot sessions per client across all topics and service types is 29. The DEX data is linked to NDAP and NDIS Appeals, enabling assessment of Pilot clients who also participated in these programs. Analysis of this data showed that the half of Pilot clients received support through the Pilot only (50%), while 46% accessed both the Pilot and NDAP. For both programs, the majority of activity was categorised under the Advocacy/Support Service Type (~93%). Other Service Types accessed through both programs included Intake/Assessment and Information/Advice/Referral. Only NDAP had activity recorded under the Advocacy - Internal Review Service Type. A minority of Pilot clients also accessed NDIS Appeals (4%), of which the majority of activity was categorised under Advocacy - External Review.

- **Standard Client/Community Outcome Reporting (SCORE):** SCOREs are captured at the case level, and are reported using a five-point rating scale. This provides a consistent and comparable way to translate outcomes across programs using the Data Exchange. A SCORE is also recorded in two parts; using an initial SCORE towards the beginning of service and a subsequent SCORE either at the end of service delivery, or at regular intervals into the future to track a client's progress. SCOREs for the Pilot document outcomes for a total of 20 domains across 3 categories: Circumstances, Goals and Satisfaction. A full list of domains is included in Appendix 5.4.

It should be noted that these domains are common across programs which use DEX and hence are relatively general. There is usefulness in observing the SCOREs to understand clients' Circumstances, Goals and Satisfaction, however additional data collection can improve evaluation of future programs. We recommend considering the cost-benefit analysis of additional data capture on unique program domains within DEX or conducting regular participant surveys to capture additional data on outcomes. This will help facilitate ongoing program monitoring and evaluation to assess whether clients' needs are being met, by capturing the main goals and reasons for their engagement with the program.

Taking simple averages across the Circumstances and Goals domains showed an overall increase between Pre-SCORE and Post-SCORE outcomes with an average increase of 43%, which

encompasses a minimum 18% increase in the Circumstances domain 'Housing' to a maximum 82% increase in the Goals domain 'Changed skills'.

The Goals domains had the greatest increase between Pre-SCORE and Post-SCORE (48% increase from 2.22 to 3.29), closely followed by Circumstances domains (40% increase from 2.18 to 3.05). Noting that Satisfaction is only measured at the end of service delivery, it had an average Post-SCORE of 4.55.

### 3.3 Efficiency

This section examines various questions related to the efficiency of the Pilot, including:

- How does the support offered under the Pilot differ from support offered under advocacy services and/or other relevant services/programs? (Section 3.3.1)
- What do the cost measures suggest about efficiency? (Section 3.3.2)
- What effect, if any, does the Pilot have on internal and external NDIS appeals? (Section 3.3.2)

#### 3.3.1 How does the support offered under the Pilot differ from support offered under advocacy services and/or other relevant services?

There was consensus across providers and clients consulted that the Pilot does not duplicate existing advocacy or NDIS services and meets an important need for people with disability.

##### 3.3.1.1 Comparison to general advocacy

As noted in section 3.1.2.4, the Pilot delivers value above what can be achieved through general advocacy programs by providing dedicated resources to address one specific decision support issue (i.e., NDIS processes). This provides advocates with the time and capacity to:

- **Invest in building the types of trusting relationships** that are important for:
  - supporting clients through the NDIS access and planning processes, given previous adverse experiences and the time and emotional toll of gathering evidence, which creates potential for disengagement
  - empowering clients and their capability to make their own decisions and self-advocate
  - supporting the emotional wellbeing of clients over the longer-term, by 'keeping the door open' to provide trusted advice, when needed.
- **Proactively find people with unmet needs** (i.e., those who would not normally help-seek on their own). For example, one provider shared the example of engaging in outreach with boarding houses where they identified several people who would be eligible for the NDIS. These individuals were unaware they may be eligible, as they had no diagnosis of disability and no recent interactions with health or community services.
- **Proactively initiate contact to prevent disengagement**, in cases where a client has stopped communicating, which is common in cases of psychosocial and intellectual disability.
- **Invest in liaison with clinicians and other community services providers.** Providers frequently attended in-person meetings with GPs, housing providers, as well as NDIA planners and Support Coordinators. The time to attend these meetings helped to minimise knowledge loss between the client and the service provider. It also provided opportunities for the service provider to role model strategies for self-advocacy.

This was cited in contrast to general advocacy programs such as NDAP, where there are cases that if a client does not respond to a phone call/email, the provider may not have the capacity to follow-up and encourage help-seeking. In general, NDAP provides short and medium-term issues-based advocacy support, in contrast to the Decision Support Pilot which utilises a longer-term, targeted case management approach.

##### 3.3.1.2 Comparison with Support Coordination

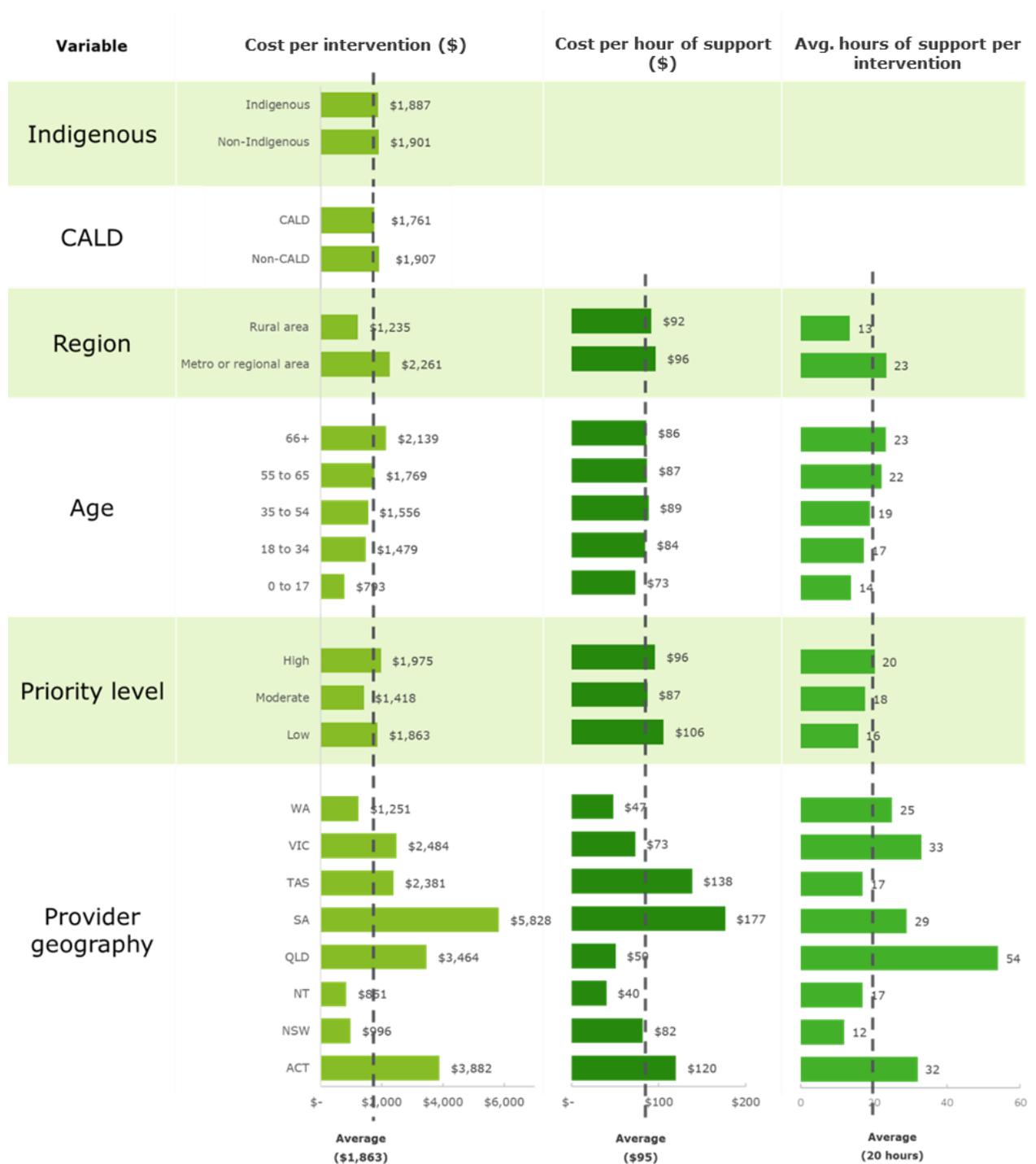
There is a clear distinction between the Pilot and Support Coordination, given that a service provider will typically refer the client to a Support Coordinator at the point of plan implementation. While some providers continue to offer support in cases where a Support Coordinator was engaged, the types of support differed. Examples of support provided at this stage included:

- Helping the client find a new Support Coordinator.
- Providing information to both the client and the Support Coordinator, where the Support Coordinator was unable to address a client's query to their satisfaction.
- Offering decision support where the client feels a conflict of interest may exist and the Support Coordinator is influencing decision-making in favour of their own service.
- Acting as a trusted advisor in cases where the client does not feel comfortable reaching out to their Support Coordinator, and there is a risk of withdrawal from NDIS services altogether.

### **3.3.2 What do the cost measures suggest about efficiency?**

Providers reported an estimated cost per intervention for each case captured in quarterly spreadsheets. There was a wide variation in the cost per intervention measured by the provider, as displayed in Figure 3.12.

Figure 3.12: Cost per case, cost per hour of support, average hours of support per case, by client and provider characteristics



Source: Pilot program data (2019 to June 2022).

### 3.3.2.2 Cost measures by provider

The national average cost per intervention was \$1,863. The Northern Territory provider had the lowest average estimated cost per intervention (\$861 per intervention). The NSW provider had the second-lowest average estimated cost per intervention (\$996 per intervention), likely due to servicing a high volume of clients relative to budget allocation (as discussed in section 3.1.1) and the lowest average hours of support per case (12 hours). Whereas providers who had higher average hours of support per case generally had a higher average cost per intervention.

A high cost per intervention relative to average suggests opportunities for some providers to improve technical efficiency (i.e., cost per output). There is also a need to consider both the differences in service models across jurisdictions and the cohorts that may require further intervention. However, this should not be pursued at the expense of meeting individualised client needs, as the person-centred approach and flexibility to invest time with clients is one of the Pilot's critical success factors.

As noted in section 3.1.1, the Victorian provider serviced a low volume of clients relative to budget allocation, suggesting possible higher rates of cost per intervention and hours of support per case, which may be due to the complex nature of their clients and the intensity of their service delivery model, noted by the Pilot provider. However, in both cases, Victoria was closer to the average cost of intervention, indicating there may be other factors influencing this unit cost (such as the utilisation of their budget allocation), that were not reflected in the data provided (as discussed in section 2.5).

### 3.3.2.3 Cost measures by other characteristics

Analysing the cost measures by other variables highlighted:

- A trend of increasing cost per intervention in line with **age**, reflecting the increase in complexity and comorbidities as people age.
- A trend of increasing average hours of support per case is in line with increasing **priority level**, however, there was no comparable trend observed for cost per intervention, suggesting complexity of the case influences the intensity of support, but there are other drivers of cost.
- Clients residing in **remote** areas had a notably lower cost per intervention and average hours of support relative to non-remote clients. Consultations with providers indicated this was because clients in metropolitan regions received more face-to-face modes of support. Any future implementation of a comparable service should thus consider ways to mitigate access barriers to equitable levels of support for people residing in remote areas. This may include more service provider-initiated check-ins via email or text message outside of routine meetings related to a NDIS process goal.
- Cost per intervention did not differ significantly by **CALD** or **Indigenous** status.

### 3.3.3 What effect, if any, does the Pilot have on timeliness of NDIS access, and internal and external NDIS reviews?

Among stakeholders consulted, there was a view that the Pilot facilitates more timely completion of NDIS processes. The sentiment was more mixed relating to the likely impact of the Pilot on reduced need for internal and external plan reviews.

#### 3.3.3.1 Timeliness of access and planning processes

To achieve a successful NDIS Access Request and an approved plan, applicants progress through a series of stages. At a high level, this includes the following steps:

##### NDIS Access Request

- In-progress
- Draft
- Participant to action - 1<sup>st</sup> wait for evidence
- Participant to action - 2<sup>nd</sup> wait for evidence
- Access met / not met

##### Plan development

- Submitted for plan approval
- Plan approved/rejected

Plan review

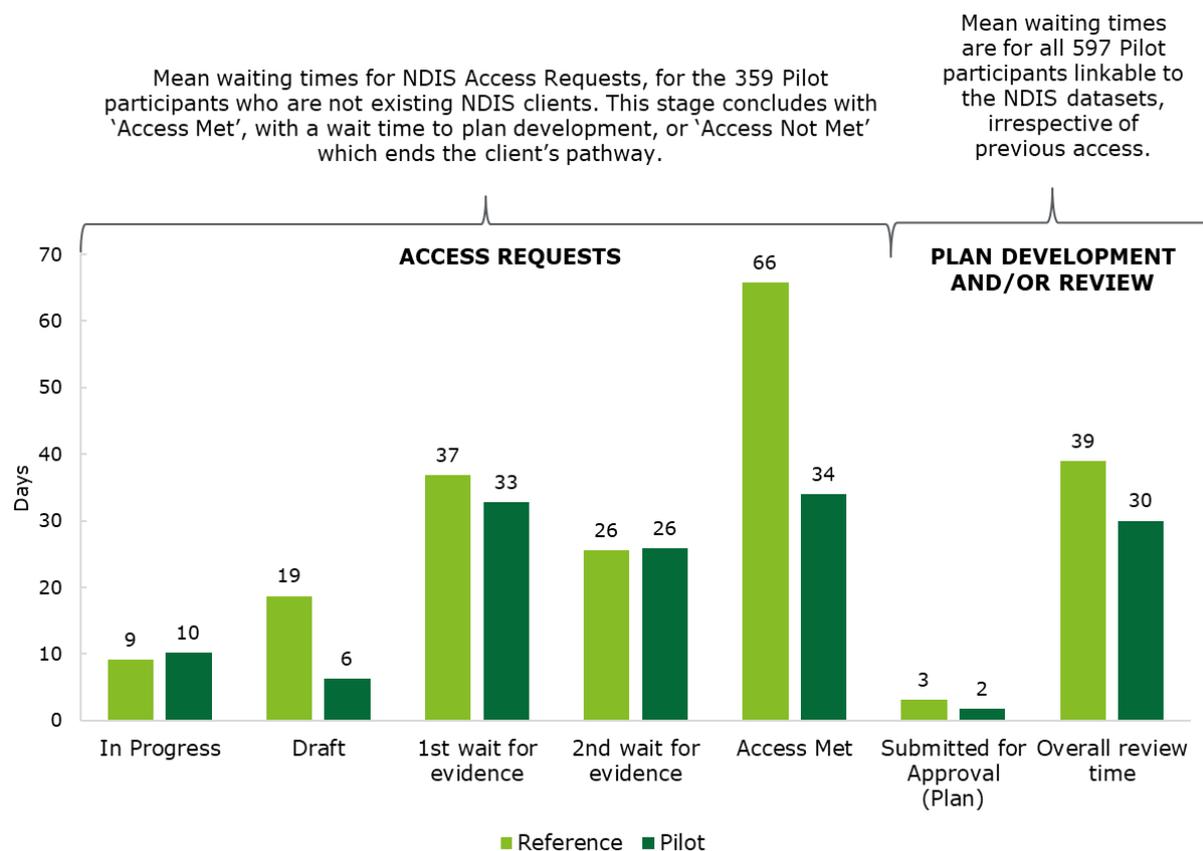
In addition, a participant may submit a request for a plan review.

Analysis of the NDIA Access dataset supported insights from consultations regarding the role of the Pilot in contributing to more timely and streamlined NDIS processes. As shown in Figure 3.12, at an overall level, Pilot clients had lower mean waiting times (in days) relative to the reference cohort, across all three stages. A notable difference was observed at the plan review stage, where Pilot clients experienced a mean wait time of 30 days to achieve a review outcome, relative to a mean of 39 days for the reference cohort.

As noted in section 2.4, a key limitation in the construction of the reference cohort was the use of a proxy to identify whether an individual ‘had no other appropriate decision-making support such as family member, carer or another significant person who is willing and able to support the person to make NDIS decisions’ – a key criterion for eligibility for the Pilot. If it was possible to more accurately isolate the reference cohort to these individuals, the difference in wait times is likely to be even greater.

The difference in wait times shows the value of a dedicated decision supporter in liaising with different stakeholders and ensuring NDIS access and planning documentation is appropriately structured and referenced.

Figure 3.13: Mean time wait times for Access Requests, plan development and plan review for Pilot and reference cohorts



Source: Pilot program data (2019 to June 2022) linked to NDIS Access dataset (2019 to April 2023).

Notes: The Pilot group for the Access stages includes only those clients who were not existing NDIS participants at the point of entry to the Pilot, as the Pilot did not contribute to the Access process for clients that were already NDIS participants. The Pilot group for the plan development and plan review

stages includes all Pilot clients (who progressed through these stages), as it was not possible to isolate the clients that the Pilot supported through plan development and/or plan review processes.

### **3.3.3.2 Perceived impact of the Pilot on NDIS internal and external appeals**

Providers consulted varied in their views regarding the extent to which the Pilot had reduced the need for internal and external appeals of NDIS decisions. Some providers felt the time and resources invested in supporting the client at the access and planning stages ensured they received a fair access decision and/or plan budget amount, minimising the need to appeal a decision. Others commented on broader external barriers as the main driver of the need to appeal. Despite this, all providers agreed it was their goal to obtain the right evidence and documentation, which would continue to support the client in future (post-Pilot), including in cases of an appeal.

# 4 Concluding Remarks and Implications

This section provides concluding remarks as well as a summary of key lessons learned and considerations for future implementation of comparable services.

## 4.1 Concluding Remarks

Overall, evidence from the evaluation shows that the Pilot was effective in achieving its primary goal of supporting people with disability with limited decision-making capacity and no other appropriate decision-making support to access the NDIS and engage in NDIS processes. Other broader impacts included improved client personal empowerment and decision-making capability, as well as increased help-seeking behaviour and willingness to accept referrals to other social services.

The Pilot addressed a clear unmet need, as evidenced by the high rates of demand in each jurisdiction, despite limited investment in program promotion. Given providers rarely engaged in awareness raising, there is likely to be a level of unknown, unmet demand within the broader population, especially among those who are not known to existing health and community services.

Several design features of the Pilot were noted through consultations with both Pilot providers and clients, as important enablers to its success. These included:

- **The Pilot's flexibility in evolving its scope in response to client needs.** At the project's outset, the scope of the Pilot was primarily focused on supporting people with NDIS access and planning. Over time, a need emerged to also provide decision support to NDIS participants at the plan implementation stage, given growing challenges related to the NDIS participant experience (e.g., low plan utilisation rates, difficulty in navigating the system, provider conflict of interest issues, etc.) This flexibility in evolving program scope in response to client needs is an indicator of the appropriateness of the Pilot's scope.
- **Advocates' specialist skillset.** This included deep subject matter expertise related to disability types; NDIS requirements for access, planning, and reviews; intersecting issues (e.g., mental health, trauma and abuse, and homelessness); provision of person-centred and empathetic care; strategies for communicating with clients in an inclusive way (e.g., distilling the complex 'language' of the NDIS in a format that is easy to understand); and techniques for negotiating with government agencies.
- **Dedicated funding for a program to provide decision support to address one specific disability-related issue (i.e., NDIS processes).** This provided service providers with the capacity to be proactive in encouraging help-seeking and preventing disengagement – a heightened risk in cases of psychosocial and intellectual disability. It also provided advocates with the time and resources to build rapport with clients and establish trusting relationships. These trusted relationships were critical for:
  - Supporting clients through NDIS access and planning processes, given previous adverse experiences and the time and emotional toll of gathering evidence.
  - Empowering clients and supporting them to build their capability to make their own decisions and self-advocate.
  - Supporting the emotional wellbeing of clients over the longer-term, by 'keeping the door open' to provide trusted advice when needed. Many clients re-presented at the plan implementation stage for a different reason, citing their advocate as the only trusted advisor they felt they could contact.

This was cited in contrast to general advocacy programs such as NDAP, where there are cases that if a client does not respond to a phone call/email, the provider may not have the capacity to follow-up and encourage help-seeking. In general, NDAP provides short and medium-term issues-based advocacy support, in contrast to the Decision Support Pilot which utilises a longer-term, targeted case management approach.

- **Provider independence.** Provision of the Pilot by organisations independent of government was cited as important because clients could be distrusting of government agencies. In addition, there is a conflict of interest that can exist between a decision supporter's interests and a participant's preferences. The Pilot minimises this conflict by commissioning independent providers to deliver the Pilot who have nothing to gain – real or perceived – from access, plan budget development, or plan implementation outcomes.

The Pilot facilitated progress against several outcomes, including:

- **NDIS process outcomes.** Where the Pilot supported a client to submit a NDIS Access Request, a successful outcome was achieved in 70% of cases. This finding is significant as consultations indicated that in the absence of the Pilot these clients would not have had the capability to complete a NDIS Access Request Form on their own. For example, providers noted that some clients did not even have a previous diagnosis of disability due to social isolation and challenges communicating their care needs. Evidence from the evaluation also indicated that the Pilot contributed to more timely and streamlined access and planning processes.
- **Capability building outcomes.** Broader impacts of the Pilot included improved client personal empowerment and decision-making capabilities. For example, providers observed improved client confidence in decision-making capability and self-advocacy as part of plan implementation, citing clients proactively taking steps to change their accommodation provider or feeling empowered to say 'no' to a suggestion provided by a Support Coordinator, where they would have previously agreed.
- **System-level outcomes.** Other system-level outcomes were observed, such as improved client wellbeing and improved connections to health and community services. Several providers noted a reduction in the frequency of distress and clients in crisis over the course of their support. In addition, some providers noted that at the point of entry to the Pilot, many clients had withdrawn from all types of social services. However, after establishing a trusted relationship with the decision support provider, they were willing to accept advice and referrals to services such as primary care, mental health, housing support, and employment support, among others.

The outcomes from this evaluation are important to consider in the context of related themes presented at the **Disability Royal Commission**. Several submissions and transcripts highlight inequitable access to the NDIS for people with complex disabilities and/or without friends or family members who have experience in applications and advocacy to government agencies. Other submissions highlight the need for broader access to decision support roles at the plan implementation stage, as participants face challenges with system navigation and resolving issues such as provider conflicts of interest.<sup>6</sup> These themes, coupled with the evidence from this evaluation, suggests there is merit in providing decision support services.

## 4.2 Considerations for Future Implementation

Several key learnings were identified that should be considered in any future implementation of a comparable service:

Table 4.1: Learnings and considerations for future implementation of a comparable service

Learnings	Consideration
<b>Workforce</b>	
<p><b>Advocate skillsets</b></p> <ul style="list-style-type: none"> <li>A number of advocates had deep subject matter expertise related to disability types, NDIS requirements, intersecting social issues, strategies for communicating with clients in an inclusive way, and techniques for negotiating with government agencies.</li> <li>Advocate backgrounds included that of social work, disability employment services, hospital settings, and roles as LACs. A mix of interdisciplinary skillsets helped to facilitate peer learning and upskilling across advocate teams.</li> </ul>	<ul style="list-style-type: none"> <li>Encourage providers to implement regular peer learning to facilitate interdisciplinary knowledge exchange and the sharing of specialist skills across service providers.</li> </ul>
<b>Program promotion and scope</b>	
<p><b>Referrals from LACs and Support Coordinators</b></p> <ul style="list-style-type: none"> <li>Most clients seeking support with NDIS system navigation and plan implementation were 'returning' clients. Few clients first engaged with the Pilot for system navigation and plan implementation reasons. Providers felt this did not reflect the lack of demand for decision support among other NDIS participants, but rather that the demand exists amongst people that are unaware of the Pilot and/or because LACs or Support Coordinators are not appropriately referring potential clients. This was supported by the analysis of referral sources, where relatively few referrals originated from LACs or Support Coordinators.</li> <li>This finding was supported by themes highlighted at the Disability Royal Commission, which indicates there are NDIS participants at the plan implementation stage who would benefit from decision support, as they navigate issues such as finding suitable accommodation, changing providers, or exercising their rights and choice in cases of a provider conflict of interest.</li> </ul>	<ul style="list-style-type: none"> <li>Clients who require decision support at the plan implementation and system navigation stage would be well known to LACs and Support Coordinators. Any future implementation of a comparable service should thus consider how it can better engage and establish referral pathways with LACs and Support Coordinators. As part of this, advocates should communicate the delineation of roles between the Pilot and LACs/Support Coordinators, to avoid the perception of duplication, particularly for clients who have received NDIS access.</li> </ul>
<p><b>Eligibility criteria</b></p> <ul style="list-style-type: none"> <li>Regarding the criterion for 'no other appropriate decision-making support', some service providers highlighted several cases where a client had informal supports, however the informal supporter was not appropriate to aid decision-making. This included informal supports who were perpetrators of abuse, recent migrants without knowledge of systems, or a parent or partner with cognitive impairment.</li> </ul>	<ul style="list-style-type: none"> <li>Consider the need to provide guidance to providers on what is considered an 'appropriate' decision-making support to ensure clients are not inappropriately deemed ineligible.</li> <li>Consider adjusting the upper end of the age criterion to ensure equity of access for older NDIS participants.</li> </ul>

Learnings	Consideration
<ul style="list-style-type: none"> <li>Regarding the age criterion of 18 to 65 years, some providers felt it was appropriate to adjust the upper end of the age bracket, given 6% of all NDIS participants are people over the age of 65. In addition, several providers felt that in some circumstances it was appropriate to accept a client below the age of 18.</li> </ul>	<ul style="list-style-type: none"> <li>The NDIS reached national implementation status three years ago, which means that most people transitioning from the old disability arrangements are now NDIS participants. As a result, a growing share of new NDIS entrants in each year are children, which warrants consideration of whether future implementation of a comparable service should also target select groups under the age of 18.</li> </ul>
<p><b>Equity of access</b></p> <ul style="list-style-type: none"> <li>At an aggregate level, the demographic profile of the Pilot indicated equity of access for different sub-populations relative to the adult NDIS population. However, analysis at the provider level showed more variation as some providers targeted specialised cohorts aligned with the target cohort/s of their broader organisation.</li> <li>By not advertising the Pilot, some stakeholders expressed concern that the people most in need of the Pilot (i.e., those most vulnerable who are not currently known to local social services) would have had no way of knowing about or accessing the service.</li> <li>Clients residing in remote areas had a notably lower cost per intervention and average hours of support, relative to non-remote clients. Consultations with providers indicated this was because clients in metropolitan regions received more face-to-face modes of support.</li> </ul>	<ul style="list-style-type: none"> <li>If a program of this nature is scaled and capacity is expanded: <ul style="list-style-type: none"> <li>providers should be encouraged to attempt to reach a variety of client types to maximise equity of access in each jurisdiction</li> <li>proactively promote the program and conduct outreach (e.g., attending boarding houses, disability accommodation or prisons to encourage referrals) to better meet known and unknown demand for decision support with NDIS processes.</li> </ul> </li> <li>Consider ways to mitigate access barriers to equitable hours of support for people residing in remote areas. This may include more service provider-initiated check-ins via email or text message outside of routine meetings related to a NDIS process goal.</li> </ul>
<p><b>Disability Royal Commission as an input to program scope</b></p> <ul style="list-style-type: none"> <li>This report references several emerging themes presented at the Disability Royal Commission related to unmet needs for advocacy and decision support with NDIS processes. With the release of the Disability Royal Commission’s final report expected in September 2023, there is an opportunity to use the recommendations in conjunction with the findings from this evaluation to inform future program design and implementation.</li> </ul>	<ul style="list-style-type: none"> <li>Leverage the outcomes of the Disability Royal Commission in conjunction with the findings from this evaluation to inform program design and implementation.</li> </ul>
<p><b>Governance</b></p>	
<p><b>Selection of providers</b></p> <ul style="list-style-type: none"> <li>Selecting provider organisations based on high performance in NDAP proved to be an effective strategy, as local and sectorial networks were already established, and providers achieved high rates of demand with limited investment in program promotion.</li> </ul>	<ul style="list-style-type: none"> <li>Consider adopting a similar strategy of commissioning providers who have existing experience in disability advocacy, and nothing to gain – real or perceived – from NDIS access, plan budget development, or plan implementation outcomes.</li> </ul>

Learnings	Consideration
<ul style="list-style-type: none"> <li>A perceived enabler of the Pilot, mentioned by both Pilot providers and clients, was its independence of the NDIA and disability service providers, given clients could be distrusting of government agencies and the potential for conflicts of interest.</li> </ul>	
<p><b>Program administration</b>            Providers highlighted opportunities to:</p> <ul style="list-style-type: none"> <li>Improve clarity and predictability related to funding arrangements and contract renewals, given the impacts on recruitment and retention, and in turn, the impact on continuity for clients.</li> <li>Improve mechanisms for collaboration, sharing of learnings and knowledge exchange across providers.</li> <li>Regarding the DEX transition, providers reported challenges in setting up and using the DEX system and queried the utility of certain fields captured.</li> </ul>	<ul style="list-style-type: none"> <li>Consider funding arrangements and timing of operational announcements that provide predictability for providers.</li> <li>Consider forums such as a monthly community of practice focused on quality improvement (e.g., practical case studies, discussions that provide visibility of how other providers are delivering their service and resolving shared challenges) in addition to the provision of process and policy updates.</li> <li>Work closely with providers to design a data specification that maximises the utility of provider data collection for the purposes of assessing program processes and outcomes.</li> </ul>

# 5 Appendix

## 5.1 List of received datasets

The following table outlines a list of all datasets provided to inform the analysis.

Dataset	Source	Description
Decision Support Pilot R&A Dataset Historical Mar 2022	Decision Support Pilot	Quarterly decision support data as at March 2022
Decision Support Pilot R&A Dataset Historical Jun 2022	Decision Support Pilot	Quarterly decision support data as at June 2022
dss_pilot_match_access_req	NDIS	NDIS decision outcome status for pilot matched participants
dss_pilot_match_demog	NDIS	Demographic (disability, severity, age etc.) information for pilot matched participants
dss_pilot_match_ids	NDIS	Participant ID links between authorised and pilot match datasets
dss_pilot_match_internal_reviews	NDIS	Internal review statuses and outcomes for pilot matched participants
dss_pilot_match_outcomes	NDIS	Outcomes Survey responses for pilot matched participants
dss_pilot_match_outcomes_q	NDIS	Outcomes Survey question and possible responses list
dss_pilot_match_plan_supports	NDIS	Support Category and Type for each plan for pilot matched participants
dss_pilot_match_planning	NDIS	Plan budget information for pilot matched participants
dss_pilot_match_survey	NDIS	Participant pathway satisfaction survey results for pilot matched participants
dss_pilot_unmatched	NDIS	List of 192 participant IDs
dss_accessrequests	NDIS	Access request outcomes information for all participants who have ever been in the NDIS
dss_f_outcomes_0to14	NDIS	Family outcomes survey for NDIS participants aged 0 to 14
dss_f_outcomes_15to24	NDIS	Family outcomes survey for NDIS participants aged 15 to 24
dss_f_outcomes_25plus	NDIS	Family outcomes survey for NDIS participants aged 25 plus
dss_p_outcomes_p0toss	NDIS	Participant outcomes survey for NDIS participants aged 0 to 14
dss_p_outcomes_p15to24	NDIS	Participant outcomes survey for NDIS participants aged 15 to 24
dss_p_outcomes_p25plus	NDIS	Participant outcomes survey for NDIS participants aged 25 plus

<b>Dataset</b>	<b>Source</b>	<b>Description</b>
dss_p_outcomes_psto14	NDIS	Participant outcomes survey for NDIS participants preschool aged to 14
dss_participant_demographics	NDIS	Demographics for all participants who have ever been in the NDIS
dss_payments	NDIS	Payment information (record-level) for all participants who have ever been in the NDIS
dss_plansupport	NDIS	Plan budget information for all participants who have ever been in the NDIS
ndis_access_requests_dec_2018	NDIS	Access request outcomes information for all participants who have ever been in the NDIS - 2018
dss_participantdemographics_2019Sep	NDIS	Access request outcomes information for all participants who have ever been in the NDIS - 2019
dss_participantdemographics_2020June	NDIS	Access request outcomes information for all participants who have ever been in the NDIS - 2020
dss_participantdemographics_2021June	NDIS	Access request outcomes information for all participants who have ever been in the NDIS - 2021
dss_participantdemographics_2022June	NDIS	Access request outcomes information for all participants who have ever been in the NDIS - 2022
dss_pilot_match_access_req_long	NDIS	Access request outcomes information - longitudinal for pilot
dss_pilot_match_plan_ids	NDIS	Participant ID links between authorised and pilot match datasets
dss_pilot_match_plan_payments	NDIS	Total payments per person per plan for pilot
dss_ref_match_access_req_long	NDIS	Access request outcomes information - longitudinal for reference
dss_ref_match_ids	NDIS	Participant ID links between authorised and reference match datasets
dss_ref_match_plan_ids	NDIS	Participant ID links between authorised and ref match datasets
dss_ref_match_plan_payments	NDIS	Total payments per person per plan for reference cohort
dex_activity	NDIS-DEX	Reference table for activity IDs and names
dex_attendance	NDIS-DEX	NDIS-DEX linked dataset for Pilot participant attendances, including referral information
dex_client	NDIS-DEX	NDIS-DEX linked dataset for demographic data of Pilot participants
dex_client_assessment	NDIS-DEX	NDIS-DEX linked dataset for SCORE assessments of Pilot participants
dex_outlet	NDIS-DEX	Reference table for synthetic provider outlet IDs and names
dex_service_type	NDIS-DEX	Reference table for service type IDs and names
dex_session	NDIS-DEX	NDIS-DEX linked dataset for session information, including topic codes
ndis_ccdn	NDIS-DEX	Reference table for synthetic client IDs and NDIS PRSNWITHDSBLTYIDS

## 5.2 Reference cohort methodology

A reference cohort was selected using a statistical technique known as propensity score matching. This seeks to estimate the effect of a treatment – in this case, the effect of the Pilot – by creating a sample group who did not receive the treatment (reference cohort) that is comparable on significant covariates to those who did (Pilot cohort).

Using logistic regression, covariates such as demographic characteristics are used to estimate a propensity score, where 0 indicates a non-Pilot participant and 1 indicates a Pilot participant.

A non-Pilot participant is chosen to match each individual Pilot participant, using nearest neighbour matching of propensity scores. While this does not guarantee a perfect match of all covariates for all individuals, variations in a few covariates are likely to lead to a similar propensity score regardless, which allows for a similar non-exact match. The distributions of each covariate can be compared to ensure the reasonableness of the matched reference cohort selected.

The matching algorithm relies on complete data for all covariates, hence only the 597 eligible Pilot population linked to the NDIS could be matched, as the Quarterly spreadsheet data lacked sufficient detail to perform matching to a level of robustness sufficient for evaluation.

Ultimately, 597 individuals from the NDIS non-Pilot population were chosen for the reference cohort by matching to the 597 Pilot cohort individuals on the following covariates:

- age
- gender
- primary disability
- normalised severity score (banded)
- indigenous status
- cultural and linguistic diversity (CALD) status
- country of birth – Australia / not born in Australia
- primary language spoken at home – English / non-English
- Australian citizenship status
- remoteness description
- residential state
- whether the participant is currently active (i.e., access met and has not exited the NDIS)
- whether the participant was a trial participant (i.e., received a plan prior to 30 June 2016)
- what period the participant joined by based on access request data – December 2018, September 2019, June 2020, June 2021, June 2022, and
- decision-making capacity proxied by a response of 'My family, my friends, my service providers, Others' to the Short Form Outcomes Framework (SFOF) question 'Who makes the most decisions in your life?'

All complete demographic covariates were selected except the indicators for whether the participant has ever been a Young Person in Residential Aged Care (YPIRAC) and whether the participant has ever been eligible for the NDIS. The latter also exhibited collinearity with a selected covariate, the indicator for whether the participant is currently active in the NDIS.

The final three covariates are additional indicators to approximate the timeframe of the participant's engagement with the NDIS and their decision-making capacity, to enhance the quality of the match between Pilot and non-Pilot participants.

## 5.3 Comparison of demographic fields in Quarterly Spreadsheets and DEX data

New fields in the DEX data compared to the Quarterly Spreadsheets included:

- Date of birth, from which age can be calculated,
- Gender,
- Household composition,
- Highest level of education / qualification,
- Employment status, and

- Income source and frequency.

Some existing fields were also expanded or had been replaced:

- The Indigenous status indicator was expanded to distinguish clients who are Aboriginal, Torres Strait Islander or both,
- The cultural and linguistic diversity (CALD) status indicator was modified to instead be inferred from country of birth, main language spoken at home, and ancestry,
- The remoteness indicator was replaced with a specific client postcode, and
- The current NDIS participant indicator was replaced with NDIS eligibility – eligible, ineligible or access request in progress.

Less prevalent demographic fields were omitted, including details if the client is a Younger Person in Residential Aged Care or if there is host family involvement.

Other fields no longer reported in DEX include the priority level at assessment (a provider-reported field evaluating need for decision support), accessibility requirements and if clients were on a waitlist prior to service. Fields relating to eligibility for the client are also dropped, as expected ineligible clients will not be reported in DEX.

#### **5.4 Full list of Standard Client/Community Outcome Reporting (SCORE) Domains**

The full list of Standard Client/Community Outcome Reporting (SCORE) domains are listed below:

- Circumstances
  - Age-appropriate development
  - Community participation and networks
  - Education and skills training
  - Employment
  - Family functioning
  - Financial resilience
  - Housing
  - Material wellbeing and basic necessities
  - Mental health, wellbeing and self-care
  - Personal and family safety
  - Physical health
  - Household composition,
- Goals
  - Changed behaviours
  - Changed impact of immediate crisis
  - Changed knowledge and access to information
  - Changed skills
  - Empowerment, choice and control to make own decisions
  - Engagement with relevant support services
- Satisfaction
  - I am better able to deal with issues that I sought help with
  - I am satisfied with the services I have received
  - The service listened to me and understood my issues

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