Independent Advisory Council of the NDIS

Capacity building: Insights from NDIS data

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Introduction

The introduction of capacity building distinguishes the NDIS from state and territory disability service systems in a real and significant way. Described in the Price Guide as *support that enables a participant to build their independence and skills,* Capacity building is linked to goals, identified in the Price Guide and measured in the Outcomes Framework, signposts of the serious intent. With the pressures of phasing however, insufficient effort may have been directed at guiding all stakeholders in the opportunities and requirements of capacity building. This paper seeks to contribute to the understanding of ways in which the NDIA can achieve better outcomes from its investment in this area.

The IAC has had a long interest in capacity building. Its 2015 paper, *Capacity building for people with disability, their families and carers,* developed a framework for the assessment of capacity building, summarised the evidence in relation to approaches to be used in the ILC and in reasonable and necessary support and outlined the benefits and challenges related to the auspice of capacity building.

This current work responds to the disappointment experienced by the NDIA that capacity building as part of reasonable and necessary support has not achieved positive outcomes for participants nor reduced the need for core supports. This paper uses data on committed and provided supports in the year 2017-18[1] as at 30 September 2018 in relation to how capacity building resources are used by disability type, age, provider and capacity building domain.

Highlights

Underutilisation

Capacity building is not well understood or valued. There is significant underutilisation in the domains of relationships, daily living, home living, employment and Support Coordination (Table 6), that if used well, would significantly support participants to achieve the outcomes of independence, inclusion and self-management which are at the core of the NDIS. Better utilisation of these domains would also lead to reduction in the need for core supports arising from capacity building. Red flags include:

- 63% underutilisation of capacity building in the domain of Daily living for the cohort 19-24. This is cohort for which the NDIA should be able to expect maximum effort expended in enhancing skills for independence.
- 64% underutilisation in the domain of employment for the cohort 15-18 and 41% underutilisation for the cohort 19-24. In the general population these cohorts are focused on preparing for and establishing work roles. It is anticipated that the current NDIA focus on increasing employment participation will see an increase in utilisation of capacity building in the domain of employment.
- Across the lifespan, 69% underutilisation in the domain of relationships where assistance aims to reduce behaviours of concern that are significant drivers of an

[1] Excludes adjustment for the excess of in kind prices over NDIA benchmark prices, as well as in kind payments. These are not expected to be material for capacity building supports.

increase in the need for core support. Underutilisation in this domain may undermine work in all other areas.

- Across the lifespan, 47% underutilisation of Support Coordination, the NDIA lever to remediate crises, negotiate services and systems and open new opportunities. Support Coordination is expected to ensure all formal and informal supports are maximised to reduce the long term need for care and support.

Participant priorities for capacity building

Some types of capacity building are more understood and valued by participants than others.

- Significantly more capacity building resources are committed to the domain of daily living than any other domain (58% of total capacity building commitments).
- For the cohort 7-14, 42.1% of capacity building commitments are for support items classified as therapeutic supports.
- 16% of all capacity building funds are committed to Support Coordination with the proportion increasing over the lifespan from 1.6% of total capacity building for cohort 0-6 to 28.8% for cohort 65+.
- Very few resources are committed or utilised in the domains of health and wellbeing, home living and life-long learning.

Age

- Young children (birth to 6) use more of their capacity building supports than other cohorts. Utilisation is lowest for cohort 15-18 when the NDIS would hope to see increases in independence in preparation for adult life and work.
- Highest utilisation rate of capacity building support is for participants 0-6 (at 62%) declining to 54% for participants 7-14, reaching its lowest point for participants 15-18 (42%) and then remaining more or less steady over the adult life (between 45-47%).
- Participants 0-6 have the highest rate of self-management (25.0%).

Delivery

Therapists provide a significant minority of capacity building support, especially for children and young people. Taken together with the low utilisation by young people 15-18, there may be a role for alternate strategies to build capacity for this cohort.

- 28.9% of all capacity building supports are support items classified as therapeutic supports
- 56.5% are not therapeutic supports
- 14.6% are self-managed making it not possible to know provider
- Provision of therapeutic supports is highest for participants under 18 with 24.8% of services for 0-6 cohort classified as therapeutic supports, 42.1% of services for 7-14 cohort classified as therapeutic supports and 37.7% of services for the 15-18 cohort classified as therapeutic supports. Taken with the low utilisation of capacity building for participants 15-18, this may reflect a mismatch between opportunities offered and what participants want.

Price Catalogue

The Price Catalogue does not showcase more innovative capacity building approaches that build independence and inclusion, particularly for participants whose functional skills are unlikely to improve.

Options to assist participants to explore housing options alternate to group homes are not showcased.

Priority areas for action

The IAC recommends that the NDIA:

1. Explores qualitative data to deepen the understanding of the way in which capacity building is used.
2. Reviews the concept and practice of capacity building with specific reference to:
    a. the impact of limitations on flexibility
    b. factors related to the achievement of outcomes including the relationship between outcomes and provider type
    c. measures of success, including whether success is the ability to undertake the task independently or whether strategies that harness informal support to reduce the need for paid support represent success;
    d. factors that contribute to utilisation as perceived by participants, providers, LAC partners and NDIA staff. Priority attention should focus on:
        i. the domains of relationships, daily living, improved living arrangements and Support Coordination;
        ii. the cohorts of 7-14, 15-18 and 19-24
    e. whether the time frames for enhanced capacity are fit for purpose;
    f. what is required to sustain capacity building effort over time including whether there may be a need for ongoing skilled work at a low level.

3. Reviews the description of capacity building in the Price Catalogue including whether the descriptors:
    a. are meaningful to participants
    b. put the participant in the driver's seat
    c. highlight contemporary approaches known to build capacity.

4. Strengthens capacity building domains as indicated in Table1 with particular urgency in relation to changes that will facilitate moves from group homes to contemporary options of housing and support, Support Coordination, relationships and daily living.

5. Provides clear guidance to participants about:
    a. the purpose and anticipated outcomes from capacity building
    b. how to choose capacity building providers
    c. negotiating service agreements to reflect participant requirements and preferences
    d. monitoring for outcomes

e. negotiating for changed arrangements when participant is not progressing toward outcome
f. achieving value for money.

6. Enhances practice of capacity building providers by:
    a. establishing KPIs for capacity building
    b. ensuring communication between the participant's capacity building provider and his/her providers of core supports to promote maximum retention of capacity building in daily life
    c. where a participant has multiple capacity building providers, ensure Support Coordinators negotiate appropriate roles to maximise impact and avoid duplication.

7. Enhances NDIA processes by:
    a. ensuring planning processes guide participants in relation to expectations, evidence and ways to measure outcomes from capacity building.
    b. enhancing practice guidance to LACs and planners about capacity building in plans, communicating with participants and monitoring outcomes.
    c. reviewing expectations as to the level of assistance actually provided by LACs in selecting capacity building services, developing service agreements and monitoring outcomes.

8. Tracks qualitative and quantitative data longitudinally to understand outcomes and improve practice.

Table 1: Recommended adjustments to domains of capacity building

Domain	**Adjustments**
Improved life choice	Include support for life planning Include skill building to enable participants to manage staff and to utilise the full range of staffing models (including providers, employment platforms and direct employment).
Improved health and wellbeing	Develop practice guidance to clarify the role of this domain.
Improved daily living	Undertake more work with therapy providers to understand the NDIA expectations related to functional outcomes and enhancements to social and economic participation
Improved living arrangements	Reinstate the 'Exploring housing options package' (EHOP) Include assistance for participants in group homes to move into options that promote increased independence and reduce cost

Domain	Adjustments
	Include assistance to locate more suitable housing when challenges relate to the participant's disability support needs.
Improved learning	Include support for all new education transitions in the post school years. Include support for the establishment of an individual literacy or numeracy program that will be implemented by support workers.
Improved relationships	Identify support to implement as well as develop behaviour support plans. Include strategies that strengthen unpaid relationships around the participant.
Improved social and community participation	Develop resource materials to assist all stakeholders understand the opportunities from this domain Include ongoing assistance is available to support health of volunteer relationship including supporting and supervising the volunteer Authorise participants to substitute direct support (individual or in a group) for tuition fees if value for money.
Support Coordination	**Strengthen Support Coordination** by – articulating its capacity building elements and reflecting them in outcomes – differentiating Support Coordination by target group and life domain (e.g. housing, employment) – amending the registration requirements to ensure a people with a – broader range of qualifications, skills and experience can become registered providers. **Avoid conflict of interest** by**:** – requiring that the provider of Support Coordination is independent of the provider of SIL (or its affiliate) for participants in closed systems in of housing and support in metropolitan areas except where no other suitably qualified Support Coordination provider is available locally or the participant rejects the alternatives. – actively assisting participants to choose a suitably qualified provider of Support Coordination.

Domain	Adjustments
	Use the Market Enablement Framework to support **the emergence of a diverse market** of Support Coordinators including supports the development of a national network of independent support coordinators **Strengthen provider registration** by making representations to the Quality and Safeguards Commission to ensure provider registration requirements for support coordination reflect the knowledge, skills and experience required.

Analysis of capacity building data

The discussion below describes the very poor utilisation of capacity building supports. There is insufficient data however to explain the poor utilisation which may be related to factors linked to participants, factors linked to providers and/or factors linked to the failure of the National Disability Strategy to facilitate accessible and welcoming communities. Qualitative data derived from studies of participants over successive plans will assist the NDIA to understand the use of capacity building resources including those self-managed and will inform targeted approaches to improve practice.

Utilisation will be analysed by age, by provider type and by domain.

Utilisation by age

- Participants under 18 represent 47.9% of all participants.
- Most participant cohorts have an equitable share of committed capacity building supports with the 0-6 group a little under their equitable share (11.3% compared to equitable share of 13.4%) and the 19-24 cohort over their equitable share (12.9% compared to 9.5%).
- The dominance of therapeutic supports for the cohorts under 18 is documented above.

0-6

- Represents 13.4% of participants with 11.3% of total capacity building resources committed to this cohort with a 62% utilisation rate.
- 24.8% of capacity building is provided as therapeutic supports, 50.2% as non-therapeutic supports and 25.1% self-managed
- Most capacity building funds are spent in the domain of daily living at 97.4%.
- The underutilisation of capacity building in the domain of relationships (44%) is low leaving children struggling with behaviours that impede learning and inclusion.

7-14

- Represents 26.1% of participants with 24.5% of total capacity building resources committed to this cohort with a 54% utilisation rate.
- 42.1% of capacity building is provided as therapeutic supports, 33.6% as non-therapeutic supports and 24.2% self-managed
- Most capacity building funds are committed to the domains of daily living (81.2%) and Support Coordination (8.4%).
- The underutilisation of capacity building in the domains of daily living and relationships are of concern, missing opportunities to maximise independence, learning and inclusion.

15-18

- Represents 8.4% of participants with 8.4% of total capacity building resources committed to this cohort with a 42% utilisation rate.

- 37.7% of capacity building is provided as therapeutic supports, 44.6% as non-therapeutic supports and 17.7% self-managed
- Most capacity building funds are committed to daily living (58.1%), Support Coordination (15.6%), relationships (9.1%), social participation (8.4%) and employment (5.6%)
- The underutilisation of capacity building in the domain of relationships appears extremely troubling, apparently leaving participants with behaviours of concern that may contribute to the underutilisation in other capacity building domains. Further exploration is required to identify, for example, whether participants are receiving behaviour support through the education system.
- It is critical for the NDIA to understand the low utilisation in this cohort since on the cusp of adulthood, the NDIA would hope to see a focus on increasing independence. Qualitative data will assist the NDIA to shape effective approaches to capacity building based on an understanding of the role of participant factors such as a focus on the senior years of school, increased personal agency and exercising voice and choice or provider related factors such as the way in which capacity building is offered.

19-24

- Represents 9.5% of participants with 12.9% of total capacity building resources committed to this cohort with a 47% utilisation rate
- 17.9% provided by therapists, 73% by non-therapists and 9% self-managed
- Most capacity building funds are committed to the domain of, employment (31.4%) and Support Coordination (15.0%)
- As with the cohort 15-18, the underutilisation of capacity building in the domains of relationships is extremely troubling and may contribute to the underutilisation of other capacity building domains.

25-34

- Represents 9.5% of participants with 10.7% of total capacity building resources committed to this cohort with a 48% utilisation rate
- 19.8% of capacity building is provided as therapeutic supports, 72.5% as non-therapeutic supports and 7.7% self-managed
- Most capacity building funds are spent on daily living daily living (38.5%), employment (19.4%), Social Participation (9.5%) and Support Coordination (20.6%)
- The continued underutilisation in the domain of relationships may undermine all other areas.

35-44

- Represents 8.8% of participants with 9.4% of total capacity building resources committed to this cohort with a 48% utilisation rate.
- 21.1% of capacity building support is provided as therapeutic support, 73.6% as non-therapeutic support and 5.3% self-managed

- Most capacity building funds are committed to the domains are daily living (38.5%), employment (18.9%), social participation (7.8%), relationships (5.8) with 24.4% for Support Coordination.
- The continued underutilisation in the domain of relationships may undermine all other areas.

45-54

- Represents 10.9% of participants with 10.9% of total capacity building resources committed to this cohort with a 48% utilisation rate.
- 22.8% of capacity building is provided as therapeutic support, 72.2% as non-therapeutic support and 5% self-managed
- Most capacity building funds are committed to the domains of daily living (40.4%), employment (17.6%), social participation (6.4%), relationships (4.9%) and Support Coordination (26.2%)
- The continued underutilisation in the domain of relationships may undermine all other areas.

55-64

- Represents 11.5% of participants with 10.2% of total capacity building resources committed to this cohort with a 46% utilisation rate.
- 29.4% of capacity building support is provided as therapeutic support, 65.1% as non-therapeutic support and 5.5% self-managed.
- Most capacity building funds are committed to the domains of daily living (46.6%), employment (12.1%), social participation (5.1%) and Support Coordination (27.4%)
- The continued underutilisation in the domain of relationships may undermine all other areas.

65+

- Represents 1.7% of participants with 1.8% of total capacity building resources committed to this cohort with a 45% utilisation rate.
- 35.0% of capacity building support is provided as therapeutic support, 58.2% as non-therapeutic support and 6.8% self-managed.
- Most capacity building funds are committed to the domains of daily living (52.4%) and Support Coordination (28.8%).

Trends over the life span

- Allocated capacity building supports generally match % of participant population.
- Utilisation of capacity building funds
    - Only 50% of capacity building funds are utilised.
    - Greatest utilisation for participants 0-6 (62%), declining to 54% for participants 7-14, reaching its lowest point for participants 15-18 (42%) and then remaining more or less steady over the adult life (between 45-47%).
    - The very low utilisation of capacity building in the domains of relationships, daily living, employment and Support Coordination need urgent action to unlock possibilities to reduce the need for core support.
- Re provider

- In total 28.9% of capacity building services are therapeutic supports, 56.5% are non-therapeutic supports and 14.6% self-managed.
- Therapy providers provide 24.8% of capacity building supports for children 0-6
- The use of therapeutic supports dominates for participants of school age: 42.1% in the 7-14 cohort and 37.7% in the 15-18 cohort.
- The use of therapeutic supports increases for participants 55+ with 29.4% for participants 55-64 and 35% for participants 65+. This may reflect participants with acquired disabilities such as MS, stroke and 'other neurological' using therapeutic support to restore function or reduce deterioration.

- Re self-managed
  - 0-6 cohort have the highest % of capacity building resources self-managed (25.0%).
  - The rate of self-management decreases in every cohort except for participants 65+ where there is a slight rise in self-management.
- Support Coordination
  - Grows as a % of utilised capacity building funds over time from 1.6% of total capacity building for cohort 0-6 to 28.8% for cohort 65+.
  - The level of committed funds for Support Coordination is lowest for the early and school years ($1435 for 0-6, $2100 for 7-14 and $2796 for 15-18) and remaining relatively constant around $3,440 throughout the adult years.

Utilisation by provider

- 28.9% of all capacity building supports are therapeutic supports.
- 56.5% of capacity building supports are non-therapeutic supports.
- 14.6% are self-managed so source of provision unknown.
- Highest % of self-managed capacity building is in the domains of health and wellbeing and life-long learning, suggesting that the items in the Price Catalogue may not reflect what people are seeking.
- Highest level of self-managed capacity building is for participants with autism' (23%), spinal cord injury (22.9%) other (22.1%).
- Lowest level of self-managed capacity building is for participants with psychosocial disability (3.0%).
- Highest use of therapeutic supports is for participants with MS (45.5%), Stroke (47.3%), visual (39.9%) other neurological (39.7%) and other physical (39.1%) i.e. acquired disability where people looking to regain skills or slow degeneration.
- Lowest use of therapeutic supports is for participants with psychosocial disability (17.6%), intellectual disability (21.3%) and Down syndrome (22.5%).

Utilisation by domain

This section outlines the operation of capacity building in reasonable and necessary support, identifying

- challenges to its utilisation
- data on committed and utilised supports from 2017-18 and
- for each domain a description of current practice, its challenges and possibilities that will address NDIA issue of Scheme sustainability.

Challenges

Challenges in the use of capacity building resources arise from:

NIDA concept of capacity building

The Price Guide describes capacity building as *a support that enables a participant to build their independence and skills.* In practice, capacity building supports are time limited and outcomes focused. There is also a strong, if unwritten assumption, that the use of capacity building supports will reduce the quantum of core supports required.

Some participants, families and contemporary capacity building providers question the therapeutic approach to capacity building that focuses on eliminating functional impairment. Many participants cannot eliminate functional impairment. They can however build capacity and independence by a range of non-therapeutic approaches that lead to greater inclusion and independence in their daily lives including greater efforts to introduce unpaid people into their lives in ways that promote informal support, belonging and inclusion. This approach suggests that the outcomes and measures of success of capacity building should be expanded to include strategies that harness informal support to reduce the level of paid support.

Many also question three key NDIA expectations in relation to capacity building:

- expectations related to the time frames required to build capacity, especially for people with significant impairment
- expectations that increased capacity can be sustained without some level of skilled support.
- Expectations that building capacity will always result in a reduction of core support. Many argue that capacity building should be valued even where it does not reduce the need for paid support as it ultimately leads participants toward the intended outcomes of the scheme.

Complexity especially in applying the interface principles

There is a confusion between support for capacity building and treatment for an injury even where related to the disability. For example, a participant with MS might have poor gait and as a result, twists her ankle. Physiotherapy to treat her twisted ankle is the responsibility of the health system while the NDIS may provide physiotherapy to address her poor gait. This is

extremely complex and it is not surprising that it is beyond the understanding of participants especially in stressful times (such as with reduced mobility as a result of a twisted ankle) and providers.

Participants

Participants and their families and carers do not understand capacity building as this has not been a feature of previous systems and services. Too few organisations provide participants and families with the ongoing information and introduction to networks that could build their understanding of capacity building, in part as a result of a lack of strategic focus or funding to support the flourishing of this sector. Consequently, many participants and their families and carers do not see the need or the potential of such capacity building.

In addition, participants and their families have little or no assistance in differentiating between providers on the basis of their promotional material, negotiating service agreements that reflect their requirements and preferences, monitoring for outcomes and negotiating adjustments when support is not effective in progressing toward outcomes. In consequence, they often seek more core support or more short-term accommodation to respond to the stresses of life and behaviours of concern while not taking up the capacity building options.

The revised participant pathway sought to address concerns related to lack of focus on outcomes in planning and plan review. The effectiveness of the adjusted processes will be judged over time.

NDIA processes

There is a lack of resources to support good practice in capacity building.

There do not appear to be consistent processes to communicate with participants about expectations, evidence and ways to measure outcomes from capacity building.

There has been little guidance to LACs and planners about committing capacity building supports in plans, communicating with participants and monitoring outcomes. It is hoped that the revised Participant Pathway will have addressed these issues.

Many believe that the NDIA has unrealistic expectations as to the level of assistance actually provided by LACs.

Whilst the NDIA seeks to promote innovative supports, it simultaneously limits flexibility, a building block of innovation. The Price Catalogue promotes a shopping list of desires where what is required is an approach that directly responds to the participant question *what will help me to achieve the outcome in my plan?*

Even within a Price Catalogue approach, the line items often bear little resemblance to the domains. This is reflective of the NDIA desire to squeeze an existing price catalogue into the outcomes framework. Consequently, *Improved life choices* only refers to NDIA plan management options where participants would be forgiven for anticipating more than strategies to manage the funding in their NDIS plan and *Relationships* mainly refers to

behaviour management support rather than for example, strategies to support the participant meet more people.

Finally, there are no clear line items in the Price Catalogue for processes that are known to produce positive outcomes such as exploring and setting up a micro business, building informal relationships, starting a circle of support. Clarity as to how to secure reasonable and necessary support for these endeavours would promote their utilisation.

Providers

There are few KPIs for capacity building providers.

Capacity building providers do not always communicate with providers of core supports (e.g. providers of daily living or community participation support) or mainstream providers (e.g. schools) to ensure opportunities in day to day life to practice strategies and change behaviour in line with the capacity building plan.

Support Coordinators often do not ensure collaboration between capacity building providers and the participant to ensure duplication does not occur. For example, a participant may have speech therapy, occupational therapy and psychology all working, in their own way on assisting the participant to communicate and socialise.

Improved life choices

Data

- Represents 1.9% of all capacity building with a 77% utilisation rate.

Current practice

The NDIS Price Catalogue describes *Improved life choices* as plan and financial capacity building focused on *strengthening the participant's ability to undertake tasks associated with the management of their supports. This includes: building financial skills, organisational skills, enhancing the participant's ability to direct their supports and develop self-management capabilities.*

Plan and Financial Capacity Building providers are expected to assist the participant to develop their skills for self-management in future plans, where this is possible. As a part of this capacity building support, providers are to assist the participant with the overall management of the plan including assisting the participant to engage providers, develop service agreements, paying providers and claiming payment from the NDIA and assisting the participant to maintain records.

Challenges

There is a limited view of the options that may be involved in 'improving life choices' and even within the narrow NDIA scope of this domain, there are other ways to build a participant's skills in these areas.

Possibilities

Life planning:

Throughout life and especially leading to points of transition, participants would gain value from support to plan in a more detailed, nuanced and real-life way than their NDIS planning moment. Identified options for succession planning would increase confidence of participants and their families.

Staffing:

Many participants would gain value in building skills to:

- understand and utilise different models of staffing (e.g. employment platforms, direct employment of staff with an ABN, use of providers)
- manage staff including rostering, negotiating conflict and handling complaints as part of becoming effective self-managers.

This proposed use of *Improved life choices* would be cost effective for the NDIS because it would assist participants to gain value for money by assisting them to manage staff more effectively.

The IAC recommends that in the domain of *Improved life choices* includes:

- Options for life planning
- Skill building to enable participants to manage staff and to utilise the full range of staffing models (including providers, employment platforms and direct employment).

Improved daily living

Data

- 58% of capacity building funds are committed to the domain of daily living with a 48% utilisation rate. This represents the largest domain of capacity building.
- 51.4% is therapeutic support with 26% non-therapeutic support and 22% self-managed.
- Participants with global developmental delay (94.6%) and 'Other sensory/speech' (89.9%) have the highest % of their committed capacity building supports in the domain of daily living.
- Participants with psychosocial disability have least of their capacity building funds committed to the daily living domain at 33%.
- As would be expected, the domain of daily living is the most significant capacity building domain for cohorts 0-6 (97.4%), 7-14 (81.2%) and 15-18 (58.1%). The use of the capacity building in daily living plateaus from 19-45 (at approx. 36%) and then increases with each subsequent cohort rising to 52.4% for participants 65+.
- The underutilisation of capacity building in this domain, especially for participants under 24 deprives participants of skills for independence.

Current practice

The NDIS Price Catalogue describes *Improved daily* living as *the assessment, training, development and/or therapy to assist in the development or increase in skills for independence and community participation. Supports can be delivered in groups or individually.*

Therapy supports are provided for participants with an established disability to facilitate functional improvement where maximum medical improvement has been reached. The therapy is subject to a detailed support plan that is designed to deliver progress or change for the participant with therapy outcomes linked to the participant's goals, objectives and aspirations.

For early intervention participants, therapy as part of reasonable and necessary support *should be aimed at adjustment, adaptation and building capacity for community participation.*

The NDIS may fund reasonable and necessary training for non-skilled personnel to undertake this intervention as part of the usual daily personal care for participants whose medical condition, illness or disease requires a particular treatment to maintain the functioning of a body part, or slow/prevent the deterioration.

Challenges

Understanding outcomes

Participants and therapy providers are unfamiliar with communicating in terms of outcomes and hence may find it difficult to meet the reasonable and necessary criteria.

This proposed use of *Improved daily* would be cost effective for the NDIS because it would facilitate the use of appropriate price categories and ensure that therapy is included in reasonable and necessary support where appropriate.

Possibilities

The IAC recommends that the domain of *Improved daily living* includes:

- More work is undertaken with participants in relation to expectations of capacity building and negotiating service agreements with providers
- More work is undertaken with therapy providers to understand the NDIA expectations in relation to functional outcomes and enhancements to social and economic participation
- More work is undertaken to ensure services for children birth to 6 are family centred and utilise a team approach.

Finding and keeping a job

Data

- 11.6% of capacity building funds are committed to the domain of employment with a 69% utilisation rate.
- 97.6% is non-therapeutic support with 2% self-managed.
- Participants with intellectual disability (21.9%), Down Syndrome (21.3%) and psychosocial disability (12.1%) have the highest % of their committed capacity building supports in the domain of employment.
- Participants with MS, developmental delay and global developmental delay have least % of their committed capacity building supports in this domain.
- The significant underutilisation in the 15-18 (64%) and the 19-24 (41%) cohorts deprive participants of preparation and support for employment.

Current

Given the significant work currently being undertaken in this area by the NDIA, this paper will make no comment on this area of capacity building.

Improved health and wellbeing

Data

- 1.2% of capacity building funds are committed to the domain of improved health and wellbeing with a 38% utilisation rate.
- 11.2% is therapeutic support, 57.9% is non-therapeutic supports and 31% self-managed
- Participants with multiple sclerosis (6.9%) and spinal cord injury (5.8%) have the highest % of their committed capacity building supports in the domain of health and wellbeing.

Current practice

The NDIS Price Catalogue describes *Improved health and* wellbeing as *All activities to support, maintain or increase physical mobility or well-being such as personal training or exercise physiology. Physical well-being activities promote and encourage improved physical capacity and health.*

These supports can be funded by NDIS where the physical and wellbeing difficulties are directly attributable to their disability and can assist them to participate in the community.

The item also includes dietetics described as *Individual advice to a participant on managing diet for health and wellbeing due to the impact of their disability.*

Line items include dietician, exercise physiology and personal training and can be used to set up (but not implement) a program for the participant.

Challenges

This is an area of significant confusion and is seldom committed to participant plans. Some NDIA staff expressed the view that it is difficult to identify what might legitimately be included under this item because health and wellbeing is broader than the functional impacts of disability. Most therapies are included in Price Catalogue items in the area of *Improved daily living*.

Although the services of a dietician are itemised in the Price Catalogue, practice guidance allocates dietician support to Health. Changes in January 2019 implement an interim measure whereby the NDIS will fund the ongoing development, assessment and monitoring of meal plans for NDIS participants with dysphagia who aren't in a hospital or acute care setting.

Possibilities

The IAC recommends that practice guidance be developed to clarify the role of this domain in participant capacity building.

Improved living arrangements

Data

- Improved living arrangements is referred to as 'home' in the tables 2,3,6 and 7
- 0.1% of capacity building funds are committed to the domain of improved living arrangements with a 21% utilisation rate
- 95.1% is non-therapeutic support and 4.9% self-managed

Current

The NDIS Price Catalogue describes *Improved living arrangements* as *Support provided to guide, prompt, or undertake activities to ensure the participant obtains and/or retains appropriate accommodation. This may include assisting to apply for a rental tenancy or to undertake tenancy obligations in line with the participant's tenancy agreement.*

Agency staff describe '*Improved living arrangements'* as a time limited outcomes focused support to overcome challenges that put a tenancy at risk. It may include intensive housing management that assists a participant to understand their impact on others (such as neighbours) and engages with housing provider to secure the tenancy.

Challenges

Not well understood and may not assist participants to move to contemporary options of housing and support.

Possibilities

<u>Exploring housing options</u>

The previous 'Exploring Housing Options Package' (EHOP) provided a useful vehicle to assist participants to explore options other than group homes. Shared supported accommodation (the group home) is the default option for most people with disability moving out of the family home because:

- group homes are known by participants and families
- group homes are available, currently being developed by providers for participants they know will not be SDA eligible and
- most LACs and planners have insufficient knowledge, skills and experience to help a participant understand that there are options alternative to group homes that would enable a more inclusive life and would be more cost effective for the NDIS.

The EHOP package had been funded as Support Coordination but it appears more coherent to fund the support to explore alternatives under the outcome sought of improved living arrangements rather than input of Support Coordination.

This proposed use of *Improved living arrangements* would be cost effective for the NDIS because it would enable more participants to live in alternatives to group using informal support rather than being fully reliant on paid support.

Move to more suitable housing

Capacity building support in this domain could also be used to assist participants living in housing that is unsuitable for their disability support needs to locate more suitable housing.

This proposed use of *Improved living arrangements* would be cost effective for the NDIS because it would increase the likelihood that the participant will move to suitable housing in which he/she can be more independent and need less core support.

The IAC recommends that in the domain of *Improved living arrangements* includes:

- The reinstated 'Exploring housing options package' (EHOP)
- Assistance for participants in group homes to move into options that promote increased independence and reduce cost
- Assistance to locate more suitable housing when challenges relate to the participant's disability support.

Improved learning

Data

- 0.04% of capacity building funds are committed to the domain of improved learning with a 23% utilisation rate
- This is the domain with lowest % of committed supports
- 68.2% is non-therapeutic supports and 31.8% self-managed

Current

The NDIS Price Catalogue describes *Improved learning* as the *provision of skills training, advice, assistance with arrangements and orientation to assist a participant moving from school to further education.*

Challenges

Transitions in education are more frequent than from school to further education. Many Australians including NDIS participants will have a number of transitions in post school education over their lifetime and could benefit from capacity building support for each of those transitions.

Possibilities

Improved literacy

Many participants want to continue to focus on improving their literacy, especially in the immediate post school years, and would value the opportunity to set up a literacy and numeracy program implemented together with a support worker.

This proposed use of *Improved learning* would be cost effective for the NDIS because it would overcome a barrier to increased acquisition of skills, including for work.

The IAC recommends that in the domain of *Improved learning* includes:

- Support for all new education transitions in the post school years
- Support for the establishment of an individual literacy or numeracy program that will be implemented by support workers.

Improved relationships

Data

- 5.4% of capacity building funds are committed to the domain of improved relationships with a 31% utilisation rate
- 85% is provided as support items not classified as therapeutic supports and 14.8% self-managed.
- Participants with autism (7.5%), intellectual disability (7.5%), ABI (5.2%) and psychosocial disability (5.1%) have the highest % of their committed capacity building supports in the domain of relationships.
- The very significant underutilisation at all ages (average 69% of committed supports not utilised) limits the key to reducing behaviours of concern that increase the need for core support.

Current

The NDIS Price Catalogue describes *Improved relationships* as *the provision of specialised assessment where the participant may have complex or unclear needs, requiring long term and/or intensive supports to address behaviours of concern.*

The item includes the development of a behaviour support plan, specialist behavioural intervention support for a participant to address significantly harmful or persistent behaviours of concern and skill development for family and support persons with the intended outcome of eliminating or reducing behaviours of concern.

The item also includes *Individual social skills development.*

Challenges

There has been a reluctance of families to engage with behaviour support practitioners. There are very few quality practitioners with widespread use of use of restrictive practices and approaches that are not evidence based and put unreasonable demands on the family.

It is anticipated that this will change with the Quality of Safeguards Commission because services that engage with participants with behaviours of concern will be required to meet specialist behaviour support requirements for registration, leading to greater implementation of behaviour support plans and in principle, the reduction in behaviours of concern and use of restrictive practices.

Many families of participants and Support Coordinators indicate that the NDIA budget allocation for *Improved relationships* is often only sufficient to develop and not implement the behaviour support plan and hence suggest two Price Catalogue items – one for plan development and the second for implementation.

The market of skilled practitioners registered and capable of delivering high quality behaviour support work is a challenge in some areas with reports that Support Coordinators and families find difficulty in locating clinicians who can support the participant, set up the environment and train staff, families and carers in a timely manner.

The options available in this capacity building domain are unnecessarily limited.

Possibilities

<u>Developing and strengthening informal support</u>

Many participants and people concerned to maximise contemporary options see opportunities under this item to source capacity building assistance to cultivate relationships with unpaid people who may become friends and informal supporters. The use of *improved relationships* to develop and facilitate circles of support, networks of unpaid people who plan and assist an individual to have a full life.

The catalogue item *Individual social skills development* may provide practical support to go out to meet new people but is not priced to reflect the skill required to plan and support others who will help a participant to build relationships.

The Participant Pathway allocates responsibility for strengthening informal support to LACs and Support Coordinators. Experience demonstrates that the development and strengthening of informal relationships takes time and intentional strategies and is beyond any realistic expectation of the role of a LAC or Support Coordinator. [2] NDIA staff expressed the view that for child participants, it is the role of state departments of child and family services to support informal relationships. Whilst child and family services may have a role with some very vulnerable families, they do not provide a generic auspice to assist families to take intentional steps required to build relationships that have the potential to provide informal support.

This proposed use of *Improved relationships* would be cost effective for the NDIS because it would bring unpaid people into the lives of people with disability increasing safeguards, reducing vulnerability and reducing need long term need for paid support.

The IAC recommends that in the domain of *Improved relationships* includes:

- Support to implement as well as develop behaviour support plans
- Strategies that strengthen unpaid relationships around the person with disability.

Increased social and community participation

Data

- 5.5% of capacity building funds are committed to the domain of increased social and community participation with a 32% utilisation rate
- 81.7% is non- therapeutic support and 18.3% is self-managed.
- Participants with psychosocial disability (13.9%), visual impairment (5.5%) intellectual disability (6.8%), Down Syndrome (6.8%) and ABI (5.8%) have the highest % of their committed capacity building supports in the domain of social participation.

Current

The NDIS Price Catalogue describes *Increased social and community* participation as *supports for skills-based learning to develop independence in accessing the community* as well as 'innovative community participation' described as *support designed to allow providers to offer new and innovative services to NDIS participants.* Focus on enabling providers rather than participants appears inconsistent with the NDIS focus of putting participants in the driving seat.

The Price catalogue outlines eligible community participation activities including *tuition fees, art classes, sports coaching and similar activities that build skills and independence. Camps, classes and vacation activities that have capacity building components. These may include*

[2] Further information about circles of support: Accessed at https://www.ric.org.au/learn-about/building-support-networks/circles-of-support/ 26 January 2019
Stancliffe, R., (2013) *Support to retirement,* Accessed at https://sydney.edu.au/health-sciences/cdrp/pdfs/policy-bulletin-2-retirement-2013.pdf 26 January 2019

assistance to establish volunteer arrangements in the community, mentoring, peer support or individual skill development.

The Price Catalogue clarifies that the inclusion of any of the above activities needs to be determined as reasonable and necessary given the participant's plan goals and could include, but are not limited to:

- *Universal recreational activities: A limited number of lessons could be funded to enable a participant to try out an activity and test their capability and interest in pursuing this activity further – such as horse riding, art, dance or singing classes*
- *Funding to attend a "camp" or groups that build a person's relationship skills and offer a range of activities and opportunities to explore wider interests.*

Other items or adjustments such as customised tools required because of the person's disability, could also be funded.

Challenges

Confusion

There is considerable confusion as to how reasonable and necessary criteria are applied to enable tuition fees and activities to be included in plans. In addition, many participants reliant on the DSP find difficulty in meeting the ongoing costs of social and community participation and would prefer to substitute tuition fees for direct support (either individual or in a group).

Volunteer relationships

Whilst *Improved community participation* can be used to establish volunteer relationships, evidence indicates that participants (mentees) in volunteer relationships are more likely to achieve a positive outcome their mentor is supported and supervised, and when the health of the volunteer relationship is monitored.[3] The inability to use a small amount of this capacity building over an extended period of time to support informal arrangements is a limitation of this capacity building item.

The Price Catalogue item, *Life Transition Planning Including Mentoring, Peer-Support and Individual Skill Development* (Ref No. 09_006_106_6_3) enables the payment of a peer. In addition, the Price Catalogue has 2 similar items at different prices for this type of capacity building:

- Under *Improved social and community participation,* the item, *Individual skill development and training* (ref no. 09_009_0117_6_3 is priced at $57.22/hour, covers *Individual life skills development and training including public transport training and support, developing skills for community, social and recreational participation*
- Under *Improved daily living,* the item, *Individual skill development and training including public transport training,* (ref no. 15_037_0117_1_3) is priced at $44.54/hour and covers *individual training provided in the home for general life skills to increase independence.*

[3]IAC (2015) *Capacity building for people with disability, their families and carers*

- It is reported that participants seldom have individual skill development in social and community participation in their plans with planners preferring to source the support at the lower rate in *Improved daily living* ($44.54). In addition, the oblique description of *developing skills for community, social and recreational participation* may need some additional guidance material.

Possibilities

Payment of participation fees

Many participants prefer to attend mainstream and community activities and classes to meet new people and further their inclusion into their community but are hindered by their ability to pay for the activity or class. Many participants would like the opportunity to trade paid support for participation costs if it represents value for money for the NDIS.

For young children, the ability to pay participation fees would promote the likelihood that therapy or other support would follow the child into the natural environment and support inclusion in these activities. With the additional planning and support, there would be a higher level of success along with building capacity of child, family and community over time.

This proposed use of *Improved social and community participation* would be cost effective for the NDIS because it would improve the effectiveness of support.

The IAC recommends that in the domain of *Improved social and community participation* includes:

- Support to implement therapy and other capacity building programs paid at the same rate as direct support
- Resource materials to assist all stakeholders understand the opportunities from this domain
- Ongoing assistance to support health of volunteer relationship including supporting and supervising the volunteer
- The ability for participants to substitute direct support (individual or in a group) for tuition fees if value for money.

Support Coordination

Data

- Support Coordination is the second highest domain of committed capacity building resources at 16.1% with a utilisation rate of 53%.
- 98.4% of Support Coordination is provided as support items not classified as therapeutic supports with 1.6% self-managed
- Participants with psychosocial disability (31.9%) ABI (27.4%), stroke (24.8%) spinal cord injury (20.9%), multiple sclerosis (20.4), other neurological (22.2%), intellectual

disability (19.2%) and other (19%) have the highest % of their committed capacity building supports for Support Coordination.

- On average, participants with ABI have the highest quantum of committed Support Coordination (at $3,886), with participants with cerebral palsy, Down Syndrome, intellectual disability, other neurological, psychosocial and spinal cord injury having more than $3,000 in committed supports. Participants with global developmental delay have the lowest average committed for Support Coordination at $1,224
- The level of Support Coordination is lowest for the early and school years ($1,435 for 0-6, $2,100 for 7-14 and $2,796 for 15-18) and remains relatively constant around $3,440 throughout the adult years.
- The very significant underutilisation at all ages (average 47% of committed supports not utilised) is of enormous concern. Support Coordination is the key to unlocking the barriers and enabling the opportunities of the NDIS for vulnerable participants.

Current practice

The NDIS Price Catalogue describes Support Coordination as *a fixed amount for strengthening participant's abilities to coordinate and implement supports in their plans and to participate more fully in the community*. Its purpose is to assist strengthening a participant's ability to design and then build their supports with an emphasis on linking the broader systems of support across a complex service delivery environment. The Price Catalogue specifically identifies tasks of supporting participants to:

- direct their lives, not just their services. including coaching participants, and working with participants to develop capacity and resilience in their network.
- build and maintain a resilient network of formal and informal supports
- develop their capacity to implement and manage their supports and network more independently over time.

Challenges

Inadequate attention to the capacity building elements of the role

In practice, most providers of Support Coordination work as case managers, linking participants to services and assisting them to negotiate entitlements in mainstream and community services. There is little or no attention to building informal support, developing personal safeguards or building the participant's capacity to redesign support let alone to direct their lives.

Lack of specialisation

Support Coordination is not differentiated by type of need or participant so it is often provided by Support Coordinators who lack the specialised knowledge, skills and experience to most effectively enhance outcomes.

Target group

The target group for Support Coordination may be unnecessarily restricted. The now obsolete Support Coordination Framework allocated Support Coordination according to a matrix of

capacity of participant AND complexity of plan. This provided Support Coordination to participants with significant disability with supportive families who wanted to avoid congregate services, use paid staff to facilitate relationships and become more independent. Without effective assistance (that could be provided by appropriately experienced Support Coordinators) these participants struggle to redesign their support and move from congregate to individualised services. Evidence from state and territory systems suggests that assistance to redesign support represents value for money contributing to participants being more independent, more safeguarded, with greater levels of participation and less need for paid support.

Registration requirements

Registration for Support Coordination does not require evidence of the knowledge, skills and experience required to deliver the capacity building outcomes. In fact, many Support Coordination providers do not appear to see it as their responsibility to provide the capacity building elements, advertising their services as case management.

Conflict of interest

NDIA policy, reflected in the 'Request for Service: Support Coordination', indicates that it is the NDIA preference that *The Coordinator of Supports should not be the provider of any other funded supports in the plan.* This preference however is usually waived: *The utilisation of First Plans means that the initial Support Coordinator may be employed by the same provider organisation as delivers other supports. Any potential conflict of interest must be managed by the provider and monitored by the NDIA.*

As a result, in practice, a participant's SIL or Social and Community Participation provider very often provides their Support Coordination.

Participant advocates argue the avoidance of conflict of interest is essential because most participants with Support Coordination lack the capacity to identify and understand conflict of interest, are not aware of opportunities they have never experienced and feel loyal to what they know. In addition, independent Support Coordination is a safeguard that mediates the pressures of: participants who doubt the reliability of mainstream opportunities and hence maximise funded support; and providers who subtly and even subconsciously protect their clients from the uncertainties of mainstream and community services.

National Disability Services (NDS) and the NDIA have argued that the market is not yet sufficiently mature and that a requirement for independence may deplete the market, leading to additional risks for vulnerable participants. The view is put that interests are ubiquitous: the issue is to declare them, recognise the potential for bias and manage conflicting interests, as occurs in the health sector.

Possibilities

Strengthen capacity building elements

Outcomes of Support Coordination are more likely to be achieved if the NDIA outlines the capacity building elements and reflects them in expectations and outcomes.

Specialisation

IAC papers including those of the Innovations Reference Group have argued that the NDIA differentiate Support Coordination by target group and life domain to ensure providers have the requisite knowledge, skill and experience.

The IAC has been clear that these requirements should be reflected in the registration process and recommended representations to the Quality and Safeguards Commission to ensure provider registration requirements for support coordination reflect the knowledge, skills and experience required.

Conflict of intertest

IAC papers have argued that the NDIA move toward requiring providers to avoid rather than manage conflicts of interest, starting with participants in closed system options of housing and support in major cities where thin market arguments are less relevant. Over time, such a move would generate data to underpin a fuller analysis of the role of independence in driving innovation and quality.

Elsewhere[4], the IAC has proposed that the NDIA:

- requires that the provider of Support Coordination is independent of the provider of SIL (or its affiliate) for participants who live in closed systems of housing and support in metropolitan areas, except where no other suitably qualified Support Coordination provider is available locally or the participant rejects the alternatives.
- actively assists participants to choose a suitably qualified provider of Support Coordination.

The IAC recognises the importance of transitional arrangements over a 12-18 month period to signal to the market the intent to move to independence for participants who use SIL and centre based programs. The IAC also supports the Intermediaries Review recommendation that NDIA planners retain discretion to grant exemptions based on operational guidelines.

[4] IAC (2018) *Support Coordination*

Table 2: Committed capacity building supports by domain by provider

This table provides information about the NDIA allocation of capacity building funds by domain and the type of supports participants are using

Domain	Committed CB as % of total CB	Committed CB per participant	% utilised	% Therapy support	% Non-Therapy support	% Self-managed
Choice and Control	1.9%	$854	77%	0	99.4	0.6
Daily Living	58.0%	$5,458	48%	51.4	26.2	22.4
Employment	11.6%	$8,309	69%	0.4	97.6	2.0
Health & Wellbeing	1.3%	$1,434	38%	11.2	57.9	31.0
Home	0.1%	$1,156	21%	0	95.1	4.9
Lifelong learning	0.0	$1,501	23%	0	68.2	31.8
Relationships	5.4%	$3,083	31%	0	85.2	14.8
Social Community & Civic Participation	5.5%	$2,725	32%	0.0	81.7	18.3
Support Coordination	16.1%	$3,099	53%	0.0	98.4	1.6%
Total	99.99%	$9,043	50%	28.9	56.5	14.6

Table 3: Committed capacity building supports by domain by disability type

This table provides information about the NDIA allocation of capacity building funds to participants with different disability by domain

Disability type	Domain of capacity building as % of all CB										
	Choice & control	Daily living	Employment	Health & Well-being	Home	Lifelong learning	Relationships	Social participation	Support Coord'n	SCPP[5]	Total
ABI	2.2%	47.2%	9.6%	2.3%	0.1%	0.0%	5.2%	5.8%	27.4%	$3,886	99.8%
Autism	1.7%	68.2%	7.7%	0.4%	0.0	0.0	7.5%	4.8%	9.8%	$2.549	100.1%
Cerebral palsy	2.0%	65.5%	7.1%	2.5%	0.1	0.0	2.5%	3.3%	17.0%	$3,684	100%
Developmental delay	0.6%	96.4%	0.3%	0.0	0.0	0.0	0.3%	0.2%	2.1%	$1,224	99.9%
Down Syndrome	1.9%	49.7%	21.3%	1.5%	0.1%	0.0	4.5%	6.8%	14.1%	$3,145	99.9%
Global developmental delay	0.5%	94.6%	0.2%	0.0	0.0	0.0	0.7%	0.3%	3.6%	$1,619	99.9%
Hearing impairment	2.3%	76.3%	7.0%	0.2%	0.0	0.0	0.8%	3.4%	9.9%	$1,882	99.9%
Intellectual disability	1.6%	41.8%	21.9%	1.0%	0.2%	0.1	7.5%	6.8%	19.2%	$3,485	100.1%

[5] SCPP – Amount committed for Support Coordination per participant with different disabilities

Disability type	Domain of capacity building as % of all CB										
	Choice & control	Daily living	Employment	Health & Well-being	Home	Lifelong learning	Relationships	Social participation	Support Coord'n	SCPP[5]	Total
Multiple Sclerosis	3.5%	66.7%	0.6%	6.9%	0.1%	0.0	0.4%	1.5%	20.3%	$2,730	100%
Other	2.1%	67.8%	3.9%	1.9%	0.1	0.0	2.6%	2.6%	19.1%	$3,148	100.1%
Other neurological	2.9%	62.1%	4.8%	2.6%	0.1%	0.0	2.1%	3.3%	22.2%	$3,123	100.1%
Other physical	2.7%	68.7%	5.8%	3.3%	0.1%	0.0	0.7%	2.6%	16.0%	$2,642	99.9%
Other sensory/speech	1.0%	89.8%	1.4%	0.1%	0.0%	0.0%	1.5%	1.3%	4.8%	$1,466	99.9%
Psychosocial	2.2%	33.0%	12.1%	1.3%	0.5%	0.0	5.1%	13.9%	31.9%	$3,376	100%
Spinal Cord Injury	3.9%	64.5%	1.8%	5.8%	0.0	0.0	0.5%	2.6%	20.9%	$3,257	100%
Stroke	3.1%	61.8%	2.3%	3.3%	0.1	0.0	1.3%	3.4%	24.8%	$3,194	100.1%
Visual Impairment	3.0%	66.6%	9.7%	0.9%	0.1	0.0	0.9%	5.5%	13.2%	$2,304	99.9%

Table 4: Disability type by utilisation by provider

This table provides information about the type of supports participants with specific disabilities use to delivery their capacity building supports

Disability type	% of participant population	Committed capacity building support as % of total committed CB support	% utilised	% Therapy support	% Non-Therapy support	% Self-managed
ABI	3.2%	3.7%	48	30.4	62.8	6.8
Autism	29.0%	30.0%	53	31.4	45.6	23.0
Cerebral palsy	5.0	6.1%	51	40.0	43.7	16.2
Developmental delay	4.9	6.1%	57	26.3	56.8	17.0
Down Syndrome	3.8	4.3%	54	22.5	65.0	12.5
Global developmental delay	1.5	1.2%	59	27.8	54.5	17.7
Hearing impairment	3.0	1.6%	41	30.5	56.0	13.5
Intellectual disability	24.4	27.2%	49	21.3	71.8	6.9
Multiple Sclerosis	2.0	1.7%	50	45.5	37.5	17.1
Other	0.2	0.2%	51	36.9	40.9	22.1
Other neurological	4.6	4.5%	47	39.7	46.3	14.0
Other physical	4.2	3.1 %	46	39.1	44.8	16.0

Disability type	% of participant population	Committed capacity building support as % of total committed CB support	% utilised	% Therapy support	% Non-Therapy support	% Self-managed
Other sensory/speech	2.1	1.5 %	58	34.2	48.7	17.1
Psychosocial	7.5	7.4 %	40	17.6	79.4	3.0
Spinal Cord Injury	1.1	1.2%	48	36.0	41.1	22.9
Stroke	1.2	1.1%	52	47.3	42.4	10.3
Visual Impairment	2.4	1.6%	41	39.9	42.2	15.9
Total	100	%	50	28.9	56.5	14.6

Table 5: Age by utilisation by provider

This table provides information about the type of supports participants of different ages use to delivery their capacity building

Age	% of participants	Committed capacity building as % of total CB supports	% utilised (all CB)	% Therapy support	% Non-Therapy support	% Self-managed
0-6	13.4%	11.3	62	24.8	50.2	25.1
7-14	26.1%	24.5	54	42.1	33.6	24.2
15-18	8.4	8.4	42	37.7	44.6	17.7
19-24	9.5	12.9	47	17.9	73.0	9.0
25-34	9.5	10.7	48	19.8	72.5	7.7
35-44	8.8	9.4	48	21.1	73.6	5.3
45-54	10.9	10.9	48	22.8	72.2	5.0
55-64	11.5	10.2	46	29.4	65.1	5.5
65+	1.7	1.8	45	35.0	58.2	6.8
total	99.8	100.1	50	28.9	56.5	14.6

Table 6: Committed capacity building resources by age and domain
This table provides information about NDIA allocation of capacity building funds across domain and age

Age	Committed capacity building as % of total capacity building by domain										
	Choice & control	Daily living	Employ-ment	Health & Wellbeing	Home	Lifelong learning	Relation-ships	Social participation	Support Coordination	SC PP[6]	Total
0-6	0.6	97.4	0	0.0	0	0	0.3	0.0	1.6	$1,435	99.9
7-14	1.7	81.2	0	0.4	0	0.0	5.8	2.5	8.4	$2,100	100
15-18	2.2	58.1	5.6	0.9	0.0	0.1	9.1	8.4	15.6	$2,796	100
19-24	1.8	34.5	31.4	1.1	0.2	0.1	6.8	9.1	15.0	$3,583	100
25-34	2.2	38.5	19.4	1.8	0.2	0.0	7.8	9.5	20.6	$3,680	100
35-44	2.2	38.5	18.9	2.2	0.3	0.0	5.8	7.8	24.4	$3,640	100
45-54	2.1	40.4	17.6	2.2	0.2	0	4.9	6.4	26.2	$3,480	100
55-64	2.5	46.6	12.1	2.4	0.1	0	3.7	5.1	27.4	$3,184	99.9
65+	2.9	52.4	6.3	3.1	0.1	0	2.7	3.8	28.8	$3,075	100

[6] SCPP – Amount of Support Coordination committed per participant

Table 7: Utilisation of capacity building resources by age and domain
This table provides information about the **lack** of utilisation of capacity building funds by age by domain

	% of committed capacity building underutilised by domain								
Age	**Choice & control**	**Daily living**	**Employ-ment**	**Health & Wellbeing**	**Home**	**Lifelong learning**	**Relation-ships**	**Social participation**	**Support Coordination**
0-6	17%	38%	0	58%	0	0	44%	62%	**57%**
7-14	24%	44%	81%	66%	0	81%	**67%**	70%	**51%**
15-18	27%	44%	**64%**	60%	96%	78%	**70%**	**71%**	**47%**
19-24	26%	**63%**	**41%**	60%	**82%**	80%	**68%**	**65%**	**44%**
25-34	22%	65%	26%	39%	73%	78%	**67%**	62%	**44%**
35-44	22%	65%	33%	62%	79%	81%	**71%**	68%	45%
45-54	21%	65%	21%	60%	78%	98%	**72%**	70%	46%
55-64	79%	64%	22%	65%	84%	100%	**75%**	73%	48%
65+	20%	62%	19%	65%	60%	100%	**73%**	74%	47%