



---

**TRANSCRIPT OF PROCEEDINGS**

---

**THE HON RONALD SACKVILLE AO QC, Chair**  
**MR ALASTAIR McEWIN AM, Commissioner**  
**MS ANDREA MASON OAM, Commissioner**

**THE ROYAL COMMISSION INTO VIOLENCE, ABUSE, NEGLECT AND  
EXPLOITATION OF PEOPLE WITH DISABILITY**

**PUBLIC HEARING 25**

**THURSDAY, 14 JULY 2022 AT 10.04 AM (ACST)**

**DAY 4**

**MR PATRICK GRIFFIN SC, Senior Counsel Assisting**  
**MS AVELINA TARRAGO, Counsel Assisting**  
**MS REBECCA McMAHON, Counsel Assisting**

CHAIR: Good morning, everybody, and I welcome everyone to this, the fourth day of Public hearing 25 of the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability. This Public hearing, as I'm sure people following the hearing know, is concerned with the NDIS and First Nations people in remote and very remote communities. Before I ask Commissioner Mason to make the Acknowledgment of Country, I need to make this statement: Due to reasons that are quite beyond the Royal Commission's control, we will not be able to provide a live Auslan interpretation of days four and five of the hearing on our webcast.

Live captioning of the hearing will continue to be available, and an Auslan interpretation of days 4 and 5 will be added to the video of those days and will be available on the Royal Commission's website as soon as possible. The Royal Commission apologises for any inconvenience this may cause to any of those following on the webcast, but, unfortunately, this has been completely beyond the Royal Commission's control. I shall now invite Commissioner Mason to major the Acknowledgment of Country.

COMMISSIONER MASON: Thank you, Chair. Werte. We acknowledge the Arrernte people as the original inhabitants and traditional owners of the lands on which we gather today, Mparntwe, also known as Alice Springs. We acknowledge their ongoing spiritual and cultural connection to Mparntwe. We acknowledge and pay our deep respects to elders past and present. We extend that respect to all First Nations people. I acknowledge their enduring connection to land, sky, seas and waters.

Finally, we pay our deep respect to First Nations people here today and who are following this Public hearing online, on the mainland and on islands, including in the Torres Strait, especially elders, parents, young people and children, so -- with disability. Thank you, Chair.

CHAIR: Thank you very much, Commissioner Mason. Yes, Ms Tarrago.

MS TARRAGO: Thank you, Chair. As far as the program is for today, we will first hear from a lived experience witness, Paulette, and that will be followed by a number of witnesses who are First Nations people from community-controlled organisations. Lastly, we will hear from the NDIA. So our next witness is Paulette, and, unfortunately, she can't be here with us today. Instead, I will read her statement after watching a short video of her, which was produced by the ABC. Paulette has given a statement for this Public hearing dated 11 May this year. And her statement can be found at Hearing Bundle A, tab 14. Operator, can you please display the video doc ID ABC.9999.0001.0001.

**(Video plays)**

SPEAKER: It's been a few months since Paulette Pumata, moved away from her family in the remote community of Gunbalanya to Darwin, but she's already feeling homesick.

PAULETTE: It's very hard for me to stay without my family.

SPEAKER: For Paulette, it was a necessary move. She suffers from Machado-Joseph disease, a rare degenerative condition. In Darwin, she's able to access a range of supports under her NDIS plan that weren't available in Gunbalanya, including specialist disability accommodation, and multiple physiotherapy sessions a week.

5

PAULETTE: The carers from Darwin help me, come to my place, my house and to clean my house and to wash me and to wash my clothes and to wash everything.

SPEAKER: There are more than 1,700 NDIS participants living in remote parts of the Northern Territory. But many like Paulette struggle to access adequate care.

10

**(Video ends)**

MS TARRAGO: Operator, can you please also display the map of the Top End? So, Commissioners, as you will see, Gunbalanya sits between Darwin and Nhulunbuy. And just to provide more context into where Paulette will be speaking from.

15

*My name is Paulette and I am 52 years old. I'm originally from Groote Eylandt, but I was adopted when I was a baby in Darwin by my parents who lived in Gunbalanya. They are Manjoringunjg, and the main language around Gunbalanya is Kunwinjku. I have a sister who is also adopted. I speak Kunwinjku and English. I also understand a little bit of Groote language, Anindilyakwa. I know a few families from Groote, but I don't have my mum and dad there anymore. They have passed away.*

20

*I completed primary school in Gunbalanya and two years of secondary schooling. After school, I worked in a number of different jobs including as a receptive cleaner and teacher's aide. I worked until about 2008, when I had my youngest kid. I have four children. My first husband is from Gunbalanya, and he is the father of my two oldest sons, who are 34 and 37.*

25

*My second husband, also from Gunbalanya, is the father of my third son, who is 14 and my daughter who is 23. Three of my children live in Oenpelli. I started to get sick with Machado-Joseph disease, MJD, about 10 years ago. My father from Groote Eylandt had MJD and passed away. My brother, younger sister and niece also have MJD. My younger sister can hardly walk. They all live on Groote.*

30

*Because of MJD, I need help to do things like washing and mopping the floor. I get really tired. I started using a wheelchair a year or two ago. When I was in community, I use an electric scooter. I would use it to go to the clinic, post office, or the supermarket. I don't feel sick very often. There is a medical clinic I can go to in Gunbalanya. Recently, I had to go to hospital in Darwin due to a boil on my leg and a sore bladder. In February 2022, I also went to the hospital due to liver problems. They gave me medicine, and I'm feeling a lot better.*

35

*When I'm back home, I like to go fishing with other people in my community. Sometimes I feel like they don't want me to go with them. Maybe it's because they think they will have to look after me or don't know how to help me. Being on Country makes me feel happy, quiet and peaceful. I like fishing and looking for turtles.*

40

*When I'm back home, I like to go fishing with other people in my community. Sometimes I feel like they don't want me to go with them. Maybe it's because they think they will have to look after me or don't know how to help me. Being on Country makes me feel happy, quiet and peaceful. I like fishing and looking for turtles.*

45

5 There are a few bush medicines out at Gunbalanya. There are also some Marrgikbu, traditional healers, in Gunbalanya. I like to see them when I feel unwell. Sometimes this is better than going to the doctor. When I'm home, my family helps me wash my clothes, have a shower, cook my meals and make my bed. For a long time, we had no washing machine at home, but we do now. I didn't get any help or services before the NDIS. Only my family would help me. It would be easier for them to help me if they got paid.

10 Sometimes if my scooter breaks down, a man is called to come and fix it. It often takes a long time for the scooter to get fixed. I have to stay home and do nothing. I tell my daughter or husband to go and get my mail or go to the shops for me. It's not good when I can't use my scooter. Sometimes I have to help - I have to get help from aged care services. There are no services for people with disability in Gunbalanya, only aged care services.

15 I have heard of the NDIS. It means that people are meant to come in from Darwin to help me. Sometimes they can't get in because the road is closed during the wet season. Before I moved to Darwin, the therapists would come and help me do exercises at my home because it has rails. They didn't come very often. I talk to a NDIS planner sometimes, not very often. She talks about goals. She talks to me on the phone, and sometimes it's hard to understand her. She helped to fix my scooter and that's about it. She lives in Darwin.

20 Nine people live in my house back home, it's a four-bedroom house with two bathrooms, one inside and one outside. I love being with my family. The Machado-Joseph Disease Foundation organised for people to come to my house to put in rails and ramps a few years ago. Last year, a woman from the MJDF suggested I should move to Darwin. She said it would be better to be in Darwin for the NDIS, and I could get more services. I needed more help at home with mopping and washing. I couldn't get enough help with this in Gunbalanya.

25 She said my family could come and visit and that my 14-year-old son could stay with me in Darwin. She said he could stay all the time, but he wanted to stay on Country in Gunbalanya. I didn't understand it would be like this. I didn't realise that my family couldn't come and stay with me. I put my name on a piece of paper because I thought my family could come visit more. I've been here since August last year. I am here by myself in Darwin without my kids.

30 My son has come to visit once. It is very hard for me. I think I'm going to move back home. I don't want to stay in Darwin anymore. The people here want me to stay, but I don't want to because I miss my family. It makes me want to cry when I think of my family. I feel so sad being away from my family and Country. I know they miss me too. I want the rest of my family to come and stay with me, but they can't. They are not allowed to stay with me.

35 I have a house here, but it's an NDIS house so they aren't allowed to stay. My husband stayed with me for a while over Christmas, but he's not allowed to stay now. He has to sleep in the long grass if he comes to Darwin. I have missed out on ceremony while I'm in Darwin. I particularly miss all the regular things I do each day, like spending time with my family, walking around town with them, and speaking Kunwinjku. Speaking language is important to me. Sometimes it's a bit difficult to understand English.

40  
45

5 *When I wake up at the house in Darwin, the support workers help me get breakfast. Some days, they just want me to stay home, and other days I have community access. My community access involves either going to the bank or shopping. It's very boring. Sometimes I go to the MJDF office to chat with the staff. I don't do any fishing or hunting. A physio comes once per week, and I do a few exercises like standing up and sitting down. I also practice my walking. I used a walker before I started using my wheelchair.*

10 *I don't think there are any support workers in my community. No one else apart from my family helps me with things. My daughter used to get a carer's pension, but now it has stopped. My daughter stopped working to look after me. It is important in our culture that women looked after other women. If I was the boss, I would make the NDIS come to my community to help me with cleaning and cooking in my home. I would also want them to help me go hunting for a turtle, goose, pig, or buffalo and help me go fishing.*

15 *I miss the bush foods, and I need someone to help me cook the bush foods. I would like the doctor to come and see me to make sure I'm healthy. I would like the therapist to come and do my exercises with me at home.*

20 Commissioners, that's the evidence for Paulette. I will now hand over to Ms McMahon, who will take the next witness.

CHAIR: Thank you very much. Yes, Ms McMahon.

25 MS MCMAHON: Thank you, Chair. Commissioners, June Riemer is here in the hearing room, and Mr Damian Griffis is connecting by AVL.

CHAIR: Good morning. Have we got Mr Griffis on screen? Not yet. I have heard your name pronounced variously Riemer and Riemer. Which is correct?

30 MS RIEMER: Riemer. Riemer. Spelt Riemer.

CHAIR: Riemer.

35 MS MCMAHON: Perhaps while Mr Griffis is coming on, I will just let the Royal Commission know that you will now hear from June Riemer, the deputy CEO of the First Peoples Disability Network, and also Damien Griffis, the CEO of that organisation. If I could just point out, Chair and Commissioners -

40 CHAIR: I think Mr Griffis has now magically appeared on screen.

MS MCMAHON: Yes, he is.

45 CHAIR: Good morning, Mr Griffis. Can you hear us? Clearly not. I think we will just give it a minute to see whether we can connect with Mr Griffis. Can our IT people tell us whether connection has been made?

MS MCMAHON: Chair, would you like just to take a couple of minutes break to -

CHAIR: Yes, I think we should establish the connection. I'm sorry, Ms Riemer, to interrupt in this way. But let's take a couple of minutes just to make sure that we can contact Mr Griffis. Thank you.

5

**<ADJOURNED 10:22 AM**

**<RESUMED 10:27 AM**

10 CHAIR: Good morning, Mr Griffis. Sorry for the delay, but we had a difficulty in establishing the connection with you. As I'm sure you know, Ms Riemer is in the Alice Springs hearing room with us. Just to be clear, Commissioner Mason is with me in the hearing room, is on my left. Commissioner McEwin is on my right. And Ms McMahon, who will ask you  
15 questions in due course, is also in the Alice Springs hearing room. Thank you both for statement that you have provided and, of course, for all of the assistance that each of you has provided to the Royal Commission. We very much appreciate the contributions that each of you has made to our work. It has been very important.

20 I will ask you, if you don't mind, to follow the instructions of my associate who is in the hearing room who will administer the oath or affirmation as the case may be, first, I think, with Ms Riemer and then with Mr Griffis.

MS MCMAHON: I can indicate, Chair, that June will take an oath and Damian -

25 CHAIR: Yes, I understand that. And I think my associate is aware of that. Thank you.

**<JUNE RIEMER, SWORN**

CHAIR: Thank you, Ms Riemer.

30

**<DAMIAN GRIFFIS, AFFIRMED**

CHAIR: Thank you, Mr Griffis. I will now ask Ms McMahon to ask you some questions, that is, each of you some questions.

35

**<EXAMINATION BY MS MCMAHON**

MS MCMAHON: Thank you, Chair. June and Damian, you have provided a joint statement to the Royal Commission dated 23 June 2022. Damian, just firstly, you have not signed that  
40 statement but it's the case, isn't it, that you were involved in the preparation of that statement and have reviewed it?

MR GRIFFIS: Yes, absolutely.

45 MS MCMAHON: And is it the case, that the contents of that statement are true and correct?

MR GRIFFIS: Yes, they are.

MS MCMAHON: And, June, may I ask you, are the contents of that statement true and correct?

5

MS RIEMER: Yes, they are.

MS MCMAHON: FPDN have provided a submission to the Royal Commission, the *Promoting Inclusion Issues Paper*. May I just ask if those submissions continue to represent FPDN's position?

10

MS RIEMER: Correct.

MR GRIFFIS: Yes, they do.

15

MS MCMAHON: June, the Commission is aware of FPDN's work from the previous evidence at the hearings, but for the wider audience, could you explain who you represent and the work of FPDN?

MS RIEMER: Yes, I would. I would like to begin first and foremost acknowledging that we are on Country here today. But also I would like to acknowledge our founding member, Uncle Lester Bostock, a Bundjalung man, who, you know, was at the forefront of the disability rights movement but understood there wasn't a movement for First Nations people, so he was the founding member, as we said, for First Peoples Disability Network. But also our past chairperson, Aunty Gayle Rankine, a Ngarrindjeri woman. So they were great warriors and mentors to FPDN, and I would like to acknowledge them today.

25

In regards to FPDN's, work we are a national systemic peak representing the voices and narrative of First Nations people living with disability, their families and carers. For most of our work, it is policy, but we also, you know, collate the narrative and do some research in regards to making better outcomes for our First Nations people living with disability across this country and work closely with NGOs and the government sector.

30

MS MCMAHON: And you represent people in remote and very remote areas as well?

35

MS RIEMER: Yes.

MS MCMAHON: Thank you. Damian, FPDN has set out a 10-point plan for the implementation of the NDIS in Aboriginal and Torres Strait Islander communities. Why did FPDN develop the 10-point plan?

40

MR GRIFFIS: Just - I would also just like to acknowledge the traditional owners on whose land the hearing is being held today and acknowledge the Arrernte people as the traditional owners of the land there in Alice Springs. And also as Aunty - as June said, I acknowledge two of our founding elders, Uncle Lester Bostock and Aunty Gayle Rankin. We developed a 10-point plan for the successful implementation of the NDIS in First Nations communities

45

because we sadly anticipated that the establishment of the scheme was likely to not have sufficient focus on the needs of First Nations people with disability.

5 So, we decided back in 2013, when the scheme was first established, to clearly articulate 10 priority actions based upon some 15, 20 years of community consultation. And those 10 points were about giving a clear direction to the agency and to the scheme for how it could better support or most - support most First Nations people with disability, particularly those living in regional and remote Australia.

10 MS MCMAHON: Thank you. And, June, may I just confirm those 10 points - and it's included in your issues paper and your statement - are they applicable to First Nations people in remote and very remote communities as well?

15 MS RIEMER: Yes, definitely today and more so than ever.

MS MCMAHON: Now, in your submission, it also states that the 10 priorities in the plan should be developed using three pillars - and, Commissioners, this is at paragraph 22 of the statement. And I might just read those out for the wider audience. They are, firstly, building the capacity of communities and individuals to understand their rights and entitlements.  
20 Secondly, to invest to create a First Peoples community-controlled service sector. And, thirdly, to develop and support a First Nations workforce.

Now, I just want to explore some of those priorities and foundations now. Damian, the first point in your plan is to invest and create an Aboriginal community-controlled disability  
25 service sector to provide disability supports by Aboriginal and Torres Strait Islander people with disability for their communities. Can you please explain to the Commissioners what that sector would look like?

MR GRIFFIS: Well, firstly, it would be community-owned and community-led and owned by  
30 First Nations people and their communities. So, it wouldn't be an external service system, per se, which is the historical way that disability services have been provided to First Nations communities, if provided at all. The idea also is that communities themselves generate or create their own workforce, which, in many communities already exists, but perhaps in an informal way, and formalising that so that community members can be the ones providing  
35 support to their own community members with disability.

MS MCMAHON: And you've read, I understand, the evidence in this hearing from NPYWC and also Marnin. Are they examples of the sort of models that you speak of or that you  
40 recommend?

MR GRIFFIS: Yes, any are. Yes, they are examples, and the NPY Women Counsel in particular has the oldest First Nations owned and operated disability service system in the country, and it dates back to the 1990s. And the experience that they bring is invaluable and it has potential for transference, if you like, for want of a better term, into other remote and  
45 regional in the country, and the same work that's been done in the Kimberley region, particularly around fetal alcohol spectrum disorder.

That approach to disability service provision around that particular type of disability is also of great relevance, and we would see both of those organisations as models for service delivery in need to be rolled out across regional remote Australia.

5 MS MCMAHON: Thank you. And, Damian, in relation to the 10-point plan, has this been communicated, that is, your plan to the NDIA?

MR GRIFFIS: Yes, it has. And it was communicated as far back as 2013. It's a source of great frustration to us that we have really only experienced, in our view - and not just in our view;  
10 amongst the wider First Nations leadership - a tokenistic approach to the needs of First Nations people with disability by National Disability Insurance Agency. It's not sufficient to write a strategy document based upon a two or three-hour meeting.

15 What needs to happen is a genuine power-sharing co-design approach between experts from the First Nations communities and from community members in partnership with the National Disability Insurance Agency that clearly articulates what we want to achieve and the outcomes we are seeking for First Nations people in regional and remote Australia. We would also say that if you are to judge a society by how the most vulnerable are supported,  
20 miserably because we aren't providing meaningful support and opportunity to some of Australia's most vulnerable people, namely, First Nations people with disability, particularly our people living in regional and remote Australia.

25 So there's a very long way to go. We are ready, and we have been very, very patient, but it's long past time. We need a substantive standing committee approach that is about equal power sharing and genuine co-design. There has been some shift in the last six months by the agency, and we welcome that, but that work needs to progress - well, it should have progressed close to a decade ago now, to be frank. Thank you.

30 MS MCMAHON: I will come back to the standing committee issue you have raised in due course but in terms of having shared the 10-point plan with the NDIA, what, if any - has about there been a response in relation to the recommendations in that plan, including the creation of an Aboriginal community-controlled disability service sector?

35 MR GRIFFIS: Nothing of any substance, we would argue. One of the frustrations we've faced as the First Peoples Disability Network - we've probably had perhaps 10 different contract managers over the life of the National Disability Insurance Scheme, and that, to us, suggests a lack of prioritising, a lack of recognition on the part of the NDIA that to make meaningful change in the lives of First Nations people with disability across the country, and in  
40 particular those First Nations people living in regional and remote Australia, requires deep thinking, requires a strong strategic approach and a strong policy approach.

We have never seen any real evidence of that approach being ever really undertaken in any meaningful way. So we are prepared to start that process now, as long as it's done in a  
45 genuine, co-design, genuine power-sharing, genuine learning - two-way learning approach.

MS MCMAHON: Damian, you just mentioned having had in your estimation around 10 different contacts at the NDIA in the context of that question I asked about consultation. Can you just tell the Commissioners, firstly, how are you set up with the contact in the first place. And what was the purpose of that line of communication?

5

MR GRIFFIS: Well, it wasn't an approach that we were involved in. It was an approach that was sort of - we were told this is how it will be, if you like. One of our other frustrations is there really is a lack of First Nations people in any leadership roles within the agency. I'm happy to be proven wrong, but I believe that's still the case. And there should also be First Nations representation on the board of the - the agency, because we are not a fringe, small minority of potential participants in the scheme; we are actually a significant - a very significant cohort.

10

So it always felt, if I could be this direct, it was perhaps more around contract management than meaningful engagement on the part of the agency. I appreciate the scheme has been very busy and very demanding to get off the ground, but why we weren't utilised as experts in this area still remains a mystery, to be honest.

15

MS MCMAHON: June, I might turn to you now and ask you this question. From your observations and what you hear from people you represent, people with disability and their families, do First Nations people with disability and their families express a preference for First Nations community-controlled services? And if so, why?

20

MS RIEMER: Yes, they generally do. And we acknowledge that people have choice in their life, and, for some family groups, that may not be the priority. But, generally, they prefer to, because they are known and proven in community to generally work with community. So, you know, First Nations people with disability in community understand, you know, their local services in regards to acknowledging, you know, their local language, their local culture and other, you know, culture implications around that.

25

They also acknowledge when out on Community people understand the flexibility or other priorities might happen in Community. So when it's place-based in community, they know what business is happening on behalf of those families or the wider community. So it has to be in Community to support Community because they understand how that Community works, all those individual families and those associations.

30

35

MS MCMAHON: And when you speak of other priorities you mentioned business. You're talking about cultural priorities there, aren't you?

40

MS RIEMER: Correct, yeah, which is first and foremost for, you know, our communities, our families and our people with disability.

MS MCMAHON: Now, in the context of developing a First Nations community-controlled service sector, FPDN advocates for a whole-of-community approach. Can you please assist the Commissioners to understand what that means from your perspective?

45

MS RIEMER: Yes, so FPDN, you know, has talked about this whole of community approach for more than 10 years now. And the concept comes from developing countries, where there isn't a service system or where there isn't a welfare system to support communities. And what the concept is, is about going into those individual communities, with permission of elders and other people and language interpreters or families, and mapping that community.

What is already in the community, what can be developed, what are the skill sets already there? How can further skill sets be developed? What needs to be done to sustain that community for individuals to stay and live on Country and be backed by, you know, appropriate block funding or other funding mechanisms to support people to stay on Country.

MS MCMAHON: So you're talking there about local solutions based on unique strengths and unique challenges?

MS RIEMER: Correct, you know. And we have to look at different ways of doing business, you know, out in our communities. Particularly for, you know, our very remote communities, as we've seen over the last few days. There isn't a service system. There isn't, you know, appropriate equipment, you know, supports or other mechanisms for people to stay on Country and support their health and wellbeing, which is you know, foremost for our First Nations people and those living with disability.

MS MCMAHON: Thank you, June. Damian, I'm going to move on to the fourth point in your plan, and it is to recognise and value the existing knowledge, skills and expert within Aboriginal and Torres Strait Islander communities. What are some practical ways that this priority can be expressed as it relates to the operation of the NDIS?

MR GRIFFIS: Sure. Well, I think the first point to make is that First Nations communities, First Nations people, are thought leaders on inclusion. So, in fact, we need to flip it over the other way, if you like. We know that disability has always been part of the human experience in First Nations communities. We know that now because of a fairly recent archaeological discovery at Lake Mungo in New South Wales where a single footprint and the archaeologists believe also a stick with a single footprint, and the analysis has said that it's a male person with one leg using a stick and perhaps even moving at significant speed. And the theory is that they are participating in a hunt.

So that's a modification that was made to enable that community member to participate in community life, and that single footprint has been dated at 25,000 years ago. So there has always been accommodations for community members of disability. We know that many traditional healers - it's not unusual for traditional healers to be blind or vision impaired, and there is also growing evidence of existing sign languages in many of our regional and remote communities that have been in existence for a very long time.

So, in that sense - and the other evidence we have is that there's no comparable word for disability in traditional community. So that's actually a wonderful thing. It suggests that, if you like, it's come as you are, and we will do what we can to provide the supports so you

can participate in community life. So, we want to change the conversation from medical model of disability to social model of disability to a culture of inclusion.

5 So, we also believe that most Australians with disability want the same sort of approach. So, it's a really important starting point to recognise the long history of supporting community members with disability that exist in our communities. And that, in itself, demonstrates that we are - we are thought leaders and we have an innate sense of inclusion and that we have those principles in mind and that we want to share that story, because it's a story that many Australians with disability would benefit from.

10 MS MCMAHON: Damian, you mentioned a few moments ago - I think you used the word standing committee or perhaps steering committee. Is that an expression of this fourth point, that is, using the skills and expertise of First Nations people?

15 MR GRIFFIS: Yes, absolutely. So we've called for a standing committee, steering committee - I guess we want to use the term "standing committee" because we want it to be - want it to have authority. Myself and June have been working in this area for a very long time and have been on many, many steering committees and many committees of different description, but what we mean is a committee that has authority. A committee  
20 that is made up of First Nations people that have expertise in this area.

In a similar structure to what the Royal Commission has been using, actually, in its First Nations Strategic Advisory Group, that is, that it's predominantly made up of First Nations people with disability themselves, but also other people like from Indigenous Allied Health  
25 Australia from NACCHO, the National Aboriginal Community-Controlled Health Organisation, from other community organisations that have an interest and understanding of disability.

30 But we don't just want it to be a steering committee that meets for a couple of hours and then something is signed off and before you know it, you've agreed to a strategy that perhaps hasn't been addressed adequately. It needs to continue to function. It needs to have authority, and it needs to be done in a co-designed way, which, in co-design, we mean by that equal power sharing, that is, about both parties learning from one another so that we can create the future we want.

35 But we have been calling that - for that for a very long time. It's well past time. In response to that in the past, I've had responses from NDIA officials which would be along the lines of, "But if we do it for your community, we have to do it for everyone." Well, my response to that is, "So? What would be so bad about that?" So, I think that's well past time, and we are  
40 anxious for that to happen - well, it should already be happening. Thank you.

MS MCMAHON: And just if you could just perhaps briefly assist the Commissioners to understand some examples of what the functions might be of such a committee.

45 MR GRIFFIS: Well, I think it would need to develop some substantive Terms of Reference. Obviously, it would be about the design of the scheme for its effectiveness in regional and remote Australia, but not just regional and remote Australia. It would need to include a

focus on urban and large regional centres. It would also need to recognise that the market-driven approach is a bit of a nonsense, if I could be that frank, particularly in regional and remote Australia.

5 That we need a - a service system which is about responding to what communities need and want. And it's as simple as that. That is the way it should be done. So it may look different in some parts of the country, and that communities themselves, as June outlined before, are the - the leaders in terms of how service systems should be designed. It also should include expertise in the cost analysis side of things. That's not something that - that's perhaps  
10 something the agency could bring to the table.

Our understanding of some of the barriers that many of our service providers face is - is a cost barrier. So we need to have an open and honest discussion about that also. But -

15 MS MCMAHON: And what - sorry, Damian. Excuse me.

MR GRIFFIS: No, you go, that's fine.

MS MCMAHON: I was going to indicate I will be coming on to local workforce and costs  
20 shortly. But please continue.

MR GRIFFIS: No, that's fine. So it would be Terms of Reference that's robust. I think the thing we are most anxious about is that it has authority.

25 MS MCMAHON: Yes.

MR GRIFFIS: Because, yeah, I sit on plenty of committees, as I'm sure others do, and sometimes committees are established as a way of perhaps - well, how do I say this - perhaps, you know, appeasing, I guess, but this is about actually doing some  
30 substantive design that is based on an equal power sharing relationship.

MS MCMAHON: Thank you. I asked you some questions earlier about consultation. But just at paragraph 63 of your statement, you indicated that FPDN were not asked to be involved in the thin market trials. June, perhaps if I can move to you. Was FPDN consulted in relation  
35 to the NDIA's 2017 Aboriginal and Torres Strait Islander Engagement Strategy?

MS RIEMER: Yes, we were. But as Damian said, there were, you know, only - my recollection, three meetings for that. And they were time limited. So it's not really hearing the voice and really bedding down, you know, what the - the issues are and what it should  
40 look like in a cultural framework on behalf of First Nations people living with disability. So we were involved, but it wasn't really a meaningful engagement, I would say.

MS MCMAHON: But were you involved personally in that engagement?

45 MS RIEMER: Correct, yeah.

MS MCMAHON: But do you recall whether or not your 10-point plan and its cultural underpinnings why discussed in that context?

MS RIEMER: No.

5

MS MCMAHON: Were you involved in the Strategies Progress update in 2021?

MS RIEMER: No.

10 MS MCMAHON: Were you consulted in relation to the NDIA's Rural and Remote Strategy?

MS RIEMER: Yes. But, again, they were six weekly meetings that I was asked to be a part of. But it kept changing the concept and who were involved in those, so it was more about supporting NDIS staff on the ground. That's how I felt about it. I felt like I was giving, you know, cultural awareness and disability awareness strategy rather than developing a strategy.

15

MS MCMAHON: And, again, were you personally involved in those consultations?

20 MS RIEMER: Yes.

MS MCMAHON: And was your 10-point plan and its underpinnings discussed in those meetings?

25 MS RIEMER: No.

MS MCMAHON: Now, I want to move on now to speaking about barriers. June, I just want to clarify something from your statement - or if you could please clarify from your statement. At paragraphs 45 to 50, it refers to a number of barriers but it's under the heading of Specific Barriers for People in the Torres Strait. Is it the case that the barriers in those paragraphs actually apply to remote and very remote areas generally?

30

MS RIEMER: Yes. And, you know, as we know, you know, different cultural groups have different, you know, individual barriers. But in respect to, you know, First Nations people, and Torres Strait Islander people, the barriers is still there. Their voice hasn't been heard. We haven't understood about, you know, two ways of doing business and collectively coming together and, you know, supporting those individuals in those regions to address the barriers.

35

40 MS MCMAHON: And I will talk about - sorry, I didn't mean to interrupt.

MS RIEMER: Yes, sorry, I was just going to say, one size does not fit all.

MS MCMAHON: Thank you. Damian, FPDN note in their statement about a lack of investment in Torres Strait. Do you have any examples or what are you hearing, your organisation hearing, about the issues in relation to the operation of the NDIS in the Torres Strait?

45

MR GRIFFIS: Well, we just don't see much or if any evidence of any substantive activity in the Torres Strait. And a couple of our staff have made a number of visits to the Torres Strait, resourced of our own - own back, if I might add, to try and better understand some of the  
5 often unique barriers that people in island communities face. Also our board member, Mr Sereako Trelloggen, who is a Torres Strait Islander man, is a good example. He has - he had to leave the islands at a very young age. He has significant disability. And had to move to Cairns.

10 And he doesn't have the same cultural connections that he would like to have because he can rarely travel back. We have to build a system that respects that people want and should have the right - or not should - actually have the right to live on Country. So, therefore, we need to design systems that make that - that enable that, and June's example before of the  
15 community-based rehabilitation approach that exists in many developing income-poor settings is the model that can be used.

There is evidence around many parts of the income-poor countries of the world where people with disability are supported to stay within their own communities, and we are often talking about systems that have no infrastructure; no, if you like, safety net on the part of  
20 government; little or no infrastructure, but communities come up with the solutions themselves. So it's not like we are reinventing a wheel here. In many ways, there's been substantive thinking done on how to approach these things for a very long time, and the standing committee approach could provide that advice to the agency on how things could work.

25 The other thing we would argue is, I think it is likely to be very, very cost effective. I would assume - in fact, I would be very confident - that it would be more cost effective, if we want to get down to that, you know, uncomfortable reality that it would be, I would be certain, more cost effective to enable a person to stay on Community but also the opportunity  
30 potentially to create micro-economies is very, very real. You could - there could be a workforce that stays within community and that in itself a little micro-economy, for want of a better term.

35 There needs to be someone to learn to drive the wheelchair-accessible bus. There needs to provide personal care support. There need to be someone to build and maintain, you know, footpaths so that wheelchair users can move around. All those things should be done within Community itself. I think we are missing opportunities here all of the time. And that thin market approach, if I may say so, that language troubles us a great deal.

40 Thin markets, to me - and I'm not an economist or a business person, but logically, to me, if you said a market was thin, it's hardly attractive to be active there, I would argue, given it's been labelled as a thin market. So I think we have to change the language significantly and get rid of these terms of, like "market", particularly in relation to regional and remote  
45 communities.

MS MCMAHON: I might just deviate for a moment, since you have dealt with matters of costs and solutions - local solutions. FPDN suggests that high cost of delivering services

could be reduced by employing and educating locally. Damian, I might just ask you to answer this question then I will move back to June for some barriers. But what would be required to do this?

5 MR GRIFFIS: So, I think we've seen evidence before of some of the effective ways that things can be done. I'm reflecting upon a program that I was familiar with in the early 2000s, which was the Aboriginal Mental Health Worker program. I think that was the correct title. But it was a pretty simple model where local community members were given access to training to understand how to provide support to other community members, particularly if  
10 community members were really struggling with very significant mental health.

It was about not waiting for an external system to fly in and fly out. It was about giving the skills to community members themselves. I'm not necessarily talking about long lists of TAFE diplomas though, to be honest. These are about on the, you know, community, two or  
15 three-day training sessions so the community members can be the support for their own community members. We should be applying the same model as it relates to disability.

There's no doubt there's - there's a lack of - I think it will be fair to say there's a lack of knowledge of some particular disability-related needs in some of our communities. No  
20 question. Because often what happens is when families go to hospital, perhaps, and they may have a child who has significant disability, often the family is given a brochure and sent home, if you like. What we need to do is investing in educating and informing community members so they can understand how to provide the best supports to their own community members with disability.

25 If we invest in that, then we are creating a potential workforce. We are keeping people on Country and in Community, and that to me - I'm not an economist, but I would love to see analysis because I would have thought it is far more cost effective than a fly-in fly-out approach which will only ever address needs in a very sporadic way. So you don't see - many  
30 First Nations people with disability in regional and remote Australia don't - particularly young people - don't get to progress through their life like a young person with disability in an urban community. Because they don't get the consistency of the allied health support.

35 So, they can't see a speech pathologist, for example, every two weeks. So, what we need to do is get local community members to become the - I guess you would call it informal but I'm reluctant to use that word informal, because I think it should be paid and I think it should be valued, and you get those local people to do those interim things, for want of a better term, while you wait for the expertise to come in. Which could be offered by indigenous allied health professionals too, I might add. So, we think that's -- way.

40 MS MCMAHON: I will come to that. I will come to that shortly as well. But I just wanted to move on to barriers for a moment. And, June, at paragraph 29(7) of your statement, you indicate that labelling is problematic for First Nations people. Can you explain how labelling creates a barrier to access?

45 MS RIEMER: Yes. So, what we need to understand here, the European concept of labelling and diagnostic tools and, you know, for our communities just does not work. Because as we

heard from Damian earlier, culturally in our communities, everyone is included. Other people may need to - you know, extra supports in their life. But when we go to the - you know, European concept that, you know, you have this diagnostic tool to say that you have autism or cerebral palsy, or whatever, it actually means nothing to our communities.

5

And, you know, I've done work with many programs, particularly in rural and remote communities, and what we heard from our families, you know, that rather than labelling is how they participate in community. How does culture affect - you know, them in their - in their community and, you know, how they - you know, work together with other families and other individuals. So, you know, a typical example, when I went out with Autism Australia, you know, we talked about, you know, what autism is in community.

10

You know, most of the community members, families and mothers said - and we asked them, you know, what did you want for your children, and they all just said, "We want them to be loved." They didn't talk about, you know, having an autistic labelling but how can we support them to stay in community, support them with their education. But, you know, first and foremost, you know, they're a cultural person that is loved and - and acknowledged within their community as a First Nations person first. Not a person, you know, living with a particular difference to participate.

15

20

MS MCMAHON: How are you seeing though that that - the labelling is actually leading to difficulties accessing the NDIS?

MS RIEMER: Yes. So, it's the lack of education and knowledge. It means nothing to community, that diagnostic label. You know. They may understand a bit about hearing impairment or vision impairment or certain physical disabilities, but what I'm trying to say, you know, culturally, that person is a cultural person first.

25

30

MS MCMAHON: Yes.

MS RIEMER: That disability label means nothing to them. So, then when they go into a government system that says that boxes have to be ticked and - about your impairment or what that labelling - culturally and language-wise, it doesn't translate. So, you know, people are not understanding what they are being spoken to and being asked to complete, you know, forms in regards to a government system because they have a certain label. That is not who they are as a person. And that's why this system doesn't work for most language groups, you know, in our communities.

35

CHAIR: Ms Riemer, what would you replace it with? Bearing in mind that if you have any government program that involves the allocation of public resources, there will need to be some form of eligibility criteria for those who are to participate, whether on an individual or communal basis. So, I understand what you're saying about labels but is it not necessary somewhere for criteria to be part of any scheme?

40

MS RIEMER: I would argue against that, because that's a colonial concept. You know, we're not - I understand where you're coming from, but for First Nations people, we are not about labelling.

45

CHAIR: Yes, I understand that.

MS RIEMER: I know. Let me finish.

5

CHAIR: I'm looking at it from a different point of view.

MS RIEMER: Yeah, I understand.

10 CHAIR: I understand that. But the problem we are faced with is a scheme -

MS RIEMER: Yes.

15 CHAIR: - that is currently in place. We've heard over this week the deficiencies of that scheme and many suggestions as to how it can be changed. But, inevitably, one would have thought, that whatever changes come about, there can't just be a scheme that has no boundaries. I mean, this may be -

MS RIEMER: I'm not saying that. I just -

20

CHAIR: - an unpleasant practical aspect but how do we deal with that?

25 MS RIEMER: We need to talk to First Nations people, which hasn't been done. So, the concept of the scheme originally was not about diagnostic; it was about how do you participate, how does - you know, how do you as a person with disability - how do you enjoy a life of good health and wellbeing? So those are the questions that we need to be asking, you know, in a cultural context. But, as Damian has said, we need a steering committee to co-design.

30 Because that will look different in every region, as we have previously heard. And that cultural and language navigation is different in every community. So, yes, there are certain elements, I totally understand, to be, you know - enable, you know, participation. But it has to look different, and we need to design that, that the voices and those impairments or those people living with differences are included within their language and cultural group.

35

40 So, how does it look for them? So, you know, it's about that - you know, interpretation of those languages, or those line items. How does that interpret in a particular language group or particular cultural group? And if we keep imposing colonial systems that have never worked for our communities, ever, you know, whether it's the education system, justice system, the NDIS system, we're not going to make change. As we previously heard, in all respect, we're just rolling out the same systems over and over again with no outcomes. And there is - you know, a saying around that, that definition.

45 CHAIR: The logic of your position - I'm not saying it is wrong or can't be implemented, but the logic of your position seems to be that the support for communities locally, culturally appropriate, providing for a life that is full and rich and has the cultural attributes that are essential to wellbeing shouldn't be structured by reference to disability at all.

MS RIEMER: Correct.

5 CHAIR: So, that means that we carve this out from the National Disability Insurance Scheme, on your approach, and have a completely different system that seeks individual and community wellbeing by entirely different processes.

MS RIEMER: And that's what FPDN have said from the beginning.

10 CHAIR: Okay.

MS RIEMER: It has to look different for First Nations people. Which, you know, as Damian has said, that can look different for many other, you know, cultural groups also. You know, because we - we said this is what the scheme is.

15 CHAIR: No, I -

MS RIEMER: And it's not working, so do we need to look at other ways of doing business?

20 CHAIR: Well, can I ask -

MS RIEMER: And it's two ways of doing business, your way and our way.

25 CHAIR: Okay.

MS RIEMER: And we need to come together.

30 CHAIR: Yes. I'm not - all right. Well, leaving aside our way and your way, does that mean that you see the NDIS as unfit for purpose for the communities we're talking about and incapable of remedy to achieve the results you want?

MS RIEMER: Yeah, and yeah, I would say yes.

35 CHAIR: All right. Okay. I understand that. Mr Griffis, do you have a view about that?

MR GRIFFIS: Yeah, no, I think now we are a decade into the scheme, and I think all the evidence that has appeared this week would show that it's failing. So, I think the key questions here and the critical things to understand is any assessment, if you like, for want of a better term, to enable a First Nations person to get into the scheme, the questions need to be functional ones. So, not necessarily do you have cerebral palsy, or - it is more, "Do you have difficulty getting around your community", for example, or, "Do you have difficulty hearing" perhaps.

45 We also need to recognise that there are particular barriers and I think the Commission - I know the Commission has heard about this throughout the week - to accessing - in accessing assessments anyway. So, again, that's another example of the current system not being realistic to enable First Nations people to access it. So, the cost barriers to an

assessment. You know, that's been a common theme. So, that's something that has to be understood.

5 I think the other critical question which June was touching on, I think one of the frustrations we still face, Chair, is a lack of understanding of the context. So, planners and LACs and local area coordinators, and particularly planners, we're just not seeing any evidence that planners really know the degree of poverty that exists in regional and remote Australia, for example. So, this is another reason why we are not seeing - well, the data is really poor in the Kimberley as came up the other day.

10 I think the participation rate - forgive me if I'm not quite getting this right, but it was a very low percentage in terms of people having plans done but not actioning them. The problem with that is, the scheme counts them as a participant, but we would argue that's not a participant. That's just someone who has had a plan done. So, what we need to understand is that to plan an outcome for a First Nations person with disability living in regional and remote Australia, we need to know that there are food security issues, as you would be aware, Chair, in many of our regional and remote communities. And getting worse.

20 There are - I still think it's the case in Wilcannia this week, there's no fresh - there's no water supply, for example. There are no footpaths in many communities. There are no accessible transport options in any regional and remote communities. I think it's still the case for our community members in Tennant Creek, for example, if you cannot access what you would call an informal transport option, as in what I'm saying getting a lift with someone down to Alice Springs, for your health appointment, you've got to wait for the Greyhound bus that comes through town I think at 4 am in the morning and is not wheelchair accessible anyway.

25 So you get carried up the steps of the bus into the - so a planner needs to understand all those things. And that's where it does look different. So, if we have planners who are First Nations people, who have an understanding of this context, then I think we have a better chance of this working. Does that look different? I guess it does, Chair, but in a way, it's - it's about following the principles of choice and control.

30 And I think the other question that June touched on, when we were in community we often asked the question what makes you strong. To the First Nations person with disability. We don't ask the question - but then a lot of Australians with disability I would argue, Chair, would love to be asked the same question. What makes you strong? What makes you - and what we mean by that is, what gives you the opportunity - what opportunity to participate in your own community and the wider community? That's a different question than what's your diagnosis? So, I guess, yeah, they are different starting points in a way.

40 CHAIR: Thank you both for those answers. Ms McMahon, I apologise yet again for the interruption.

45 MS MCMAHON: Not at all. Thank you, Chair. I might move back to some of the barriers we were speaking about earlier. And, June, I wanted to ask you, in response to the *Promoting Inclusion Issues Paper*, FPDN identified that the threat of child removal and engagement

with the child protection system has been a barrier to accessing the NDIS. Can you just explain this further in terms of what you hear and what you've observed?

MS RIEMER: Yes.

5

MS MCMAHON: From your representatives.

MS RIEMER: So, for most of our communities, you know, as we would know, have a fear of the welfare system and, more importantly, you know, for our mothers and families that may have - you know, children with severe disabilities, you know, they are afraid that they will be taken rather than be supported. So, an example I could give in a remote community in Utopia, we were well aware of nine families there that had children with severe disabilities that had never left the house.

10  
15 They were hidden from the community because there was a fear that the children will be taken and they would never be seen again. Because, as Damian said about transport issues, even if they were brought down to Alice Springs, you know, most of the families lose touch. So, you know, there is that fear across Australia, but more importantly in our rural and remote communities that when you identify your child as having some form of difference, it may mean the welfare will get involved or, you know, other elements will get involved in your life and not understand how you support that child culturally.

20  
25 MS MCMAHON: But are you hearing specifically from people you represent that that is affecting their decision to engage with the NDIS -

MS RIEMER: Correct yes.

MS MCMAHON: - or disability services.

30 MS RIEMER: Yes. Always. It's always been right from the beginning of the scheme. I have, you know, personal friends that don't connect with children - and family members with, you know, severe disabilities because they have already had, you know, touchpoints where they have feared about their child being removed.

35 MS MCMAHON: And you would have heard or read the evidence of NPYWC on Tuesday where a third of the children in their disabilities report indeed were taken off Country because of the lack of services. Are you seeing in other areas across Australia a situation where children are having to go off Country to get the services they need?

40 MS RIEMER: Yes, definitely. We've seen it, you know, with most of our work, you know, nationally than you know, particularly in rural and remote communities. There isn't a service sector. There isn't a will to build a service sector. Or as Damian has said, you know, develop a service sector locally that can support the families. But it's more about education with, you know, our communities, how, you know, they can support their families.

45

So, the concept that, you know, a child will get - and we understand that. There are usually more supports in, you know, metropolitan or higher populated regions. But that

dispossession of Country and culture is always, you know, foremost for our communities. You know, and, you know, families would rather their child participate, you know, in cultural activities, living in community, you know, learning language, than maybe having some of the, you know, allied supports.

5

MS MCMAHON: That are not on Country.

MS RIEMER: And that's an educational component too.

10 MS MCMAHON: Can I just ask also, June, for those families and children, if you have spoken to, who have gone off Country to get those supports, how - you can explain to the Commissioners the impact upon them personally, perhaps from a social and emotional wellbeing point of view and their families in community?

15 MS RIEMER: What normally happens, you know, anecdotally, you know, for most of our children, they end up in a mainstream service that doesn't understand their culture. You know, particularly those that may have, you know, quite high needs, whether that's language needs or communication needs. They don't understand maybe the local interpreting, you know, ways of doing business.

20

So, you know, I can - you know, I've seen it myself here in Alice Springs, with a child, you know, with quite physical high needs and has intellectual needs is left in a corner all day long, crying to their self because there is no interaction. And that's because the workforce doesn't know how to work appropriately, you know, with our First Nations children and appropriate engagement, whether that's in language or in culture. They try but there's not enough understanding.

25

MS MCMAHON: So, it's an impact of cultural incompetence.

30 MS RIEMER: Correct.

MS MCMAHON: I might just move on to a few issues with regards to planning. At [29] and [40] of your joint statement, you indicate that many people are unable to incorporate cultural connections to land and family into their plans. Perhaps I might just stay with you, June, for a moment. If you could just explain why that's so important and, secondly, if you can think of any examples, particularly with regards to men's or women's business where it may have been included in a plan?

35

MS RIEMER: Yeah, so, you know, this has always been an issue for our families that they haven't been able to, you know, implement or people understand what they mean by cultural business. And an example I would give - and this is not in all communities, but in some communities. So, a young man, you know, reaching teenage years needs to be able to participate in cultural business to become an adult. And that's a cultural protocols in particular, you know, family groups and cultural groups.

45

So if that young person, even as a person with disability, doesn't participant in that cultural initiation and programs, they remain a boy all their life and have to stay in the care of their

5 mother or their aunties, or other female groups. So, they're never seen as a man in that - that community. And that concept in the NDIS, in the planning development is not understood at all. You know, to support those children, to be able to participate in - out in Country. And that may mean for three months at a time. So, it's not adequately funded in regards to, you know, them being supported to do that cultural business.

MS MCMAHON: Without naming participants of course, but have you - is there an example where there has been that support provided?

10 MS RIEMER: Yeah, yeah. So, I'm quite aware of a few people that, you know, that happened to, particularly in Western Australia and here in the Northern Territory. And it was only the support of informal advocates, unfunded advocates, that understood this role, and fought with the agency for over two years for this to be enabled that one or two of these, you know, were supported to do that business out on Country.

15 MS MCMAHON: But apart -

MS RIEMER: It just didn't happen naturally.

20 MS MCMAHON: Apart from those couple of examples can you think of any other times where that sort of support has been offered through a plan?

MS RIEMER: Not really, no.

25 MS MCMAHON: All right. Now, you spoke earlier about under-utilisation of plans. Is that something that FPDN sees as a widespread issue?

30 MS RIEMER: Correct. Yeah. So, it's - you know, more so, lack of understanding, education and knowledge, what is in that plan. Even having the plan available. But the language barrier, you know, in regards to English and traditional language that means nothing to community. So, I personally have sat down in the Torres Straits and worked through plans with families for them to understand what the line item means and how they can utilise that, or the flexibility with that line item. So, none of those things are explained to individuals or the families who are supporting that person.

35 MS MCMAHON: And here you're also starting to talk about cultural safety and competence. What are your observations - and, Damian, perhaps if you would like to comment - of the cultural safety and competence of NDIA staff or what you're hearing and also mainstream services in remote and very remote areas?

40 MR GRIFFIS: Very poor. And the poignant examples that June has just raised, I think, demonstrate that very well. So, I think if I may relate that to the child removal issue. So, we need the agency to better understand that having conversations and talking to family members about their child is very loaded. Very risky. And to share and to ask the system for help is a risk for many First Nations people. Because the reality is - and we know that - I think I have this right - that across every jurisdiction in Australia now, we have increased removal of First Nations children.

45

I believe it's across every jurisdiction. I'm happy to be corrected there, but it's - if it's not, it's certainly close. And that's because the system isn't understanding of the power imbalance between First Nations communities and the system. So, I would say things like  
5 bureaucracies and stuff like that. So, if you are a parent of a child - a First Nations parent of a First Nations child with disability, to seek help comes with significant risk because the system may make judgments around you which are not contextual.

10 So, I can remember of many examples in the child welfare sector where - a fairly crude example, but an inexperienced child welfare officer - I don't know if that's the right term these days - but may walk into a house, open the fridge and not see any food in it and make an assumption that the family is not providing adequate nutrition to the child. The reality is, the family can't do that because they live in abject poverty.

15 So, the symptom is poverty; it's got nothing to do with love or neglect. And we need a system that better understands that. I think one way to do that is have Aboriginal planners. Now, I assume there are Aboriginal planners. I believe there are. But I haven't met too many and I don't know that June has either. So, that's something to me that needs to be  
20 immediately addressed because unless you have the contextual understanding that, you know, in regional and remote Australia, as Commissioners and I'm sure the Chair would be aware, that accessing fresh fruit and produce in regional and remote Australia is almost impossible.

25 Or, the last time I was out in far western New South Wales - and I imagine these prices are only going up in the context of, you know, the economy, the global economy - that the last time I was out in western New South Wales they were charging \$13 for a two-litre bottle of orange juice. So - so, you can't do that. If you have no means of income, or even if you - dare I say it if you are on the cashless - if you are on the cashless welfare card, then you may not be able to have the means to purchase things to maintain good nutrition.

30 So, unless you have the context, you're going to rush the judgment and make assumptions about - which sometimes assumptions based on a lack of understanding of the reality of the lives of many First Nations people living in regional and remote Australia. So, I think we need to invest in more training of NDIA staff - and we offer that sort of training at the First  
35 Peoples Disability Network. It's not training that is about white guilt, if you like. It's not about making the system feel bad about itself, I suppose.

40 It's more around giving a context so that people have better - you know, planners, local area coordinators, even the executive of the agency has some understanding of regional and remote Australia. The only other point I would make - and I think it's a credit to the Commission the Commission's held the hearings in Alice Springs. Now, I think that's really important. Because very few Australians, I think, have a real understanding of the lives of First Nations people in regional and remote Australia. I really believe that.

45 You know, largely urbanised country, living in big cities. You know, there's things that we see in regional and remote Australia that are deeply traumatising. I'm aware of families in some communities that every morning have to fetch fresh water. Go to a tap because they don't

have a means to do it themselves. I mean, these are things that you would hear of stories that come out of Africa, to be honest with you. And I think that's what probably, in a big picture sense, is lacking with the scheme, is really understanding the context of the lives of many First Nations people with disability in regional and remote Australia.

5

And if we can get the system to better understand that, but if we can also get communities themselves to be the solution, then we will come up with a response, I think, that is not only culturally safe and culturally appropriate, but I imagine more cost effective. And we also create an environment where we - if we can do this business, if we can do disability business well in regional and remote Australia, then why can't we do housing well, education well, health services well.

10

So I think we have an opportunity, and we don't want to - I guess the system, I think, sometimes reflects and thinks, "Gees, this sounds really hard", but I don't know that it is. And we're also not talking about millions and millions of Australians here. You know, we're not talking about half a million Australians. We're not talking about 3 million Australians. We're talking about a certain number of Australians. We're in a rich country like ours, full of smart people, we should be able to do better.

15

But the benefits could - could relate to a whole other areas of life for First Nations communities. Education, employment, transport, you name it.

20

MS MCMAHON: And, Damian, I understand that the solution - or one of the solutions that FPDN offers in terms of that context and understanding of context is First Nations representations at all levels of NDIA, and preferably those that are based locally for the provision of services? Is that right?

25

MR GRIFFIS: Yes, absolutely. Absolutely.

30

MS MCMAHON: Okay. Now, I'm conscious of time. So, I'm going to move on to ask you just one final question before moving to some structural reform questions. So, June, at paragraph 69 of your statement, you indicate that families should be supported by the NDIS to provide disability supports. Can you please explain to the Commissioners FPDN's position on that?

35

MS RIEMER: Sorry, can you -

MS MCMAHON: That families should be supported by NDIS to provide disability supports.

40

MS RIEMER: Correct, yeah. So, you know, as we know, you know, generally, for our communities, you know, first of all there's a fear of outsiders coming in to support. And there's a shame element to that, you know, for those that do gain, you know, some supports you know, within their context of a person with disability or in the home. So, you know, if we're talking about, you know, building resilience, building a workforce, you know, the families are the ones that know how to, you know, operate and - and support those individuals living in their immediate family or community.

45

They know the different cultural elements, you know, and that relates back to men and women's business. So, who can work with those particular individuals or different skin groups or different cultural groups. So, that is why it's important that, you know, we empower the families to do this work. And it needs to be, you know, moved from the  
5 agency plan manager arrangement to self-managing. Families self-manage their plans. But, in saying that, again, back to you Commissioner, they need educating and support in that.

You know it's not one size and how we - can we empower them and what it does it need to attain a certain level of understanding around brokerage models or, you know, accounting  
10 models or keeping receipts and that. But our families are resilient, and we just need to - you know, it might be a short-term proposal, one or two years, and then other family members, as we've heard yesterday with the other stories, learning from each other. Learning how a system works. But we haven't invested in that enough to educate and support individual families to know that they have options.

15 MS MCMAHON: And is it -

MS RIEMER: You know, and I think, you know, this scheme has not allowed our people to be independent of a welfare system. We are creating another welfare system into the scheme  
20 because we haven't allowed for choice and control with individuals and more importantly with that First Nations person living with disability. They do have a voice and we need to hear.

MS MCMAHON: Thank you, June. Now, just before we go on to questions from the Commissioners, I just have a couple of further questions about the future. June, your 10-  
25 point plan represents, does it, the ongoing recommendations of FPDN for First Nations people with disability in remote and very remote communities? Is that right?

MS RIEMER: Sorry.  
30

MS MCMAHON: Sorry, does your 10-point plan represent your ongoing recommendations to the Royal Commission -

MS RIEMER: Correct, yes, yes.  
35

MS MCMAHON: - in this hearing?

MS RIEMER: Yes.

MS MCMAHON: Damian, you've been appointed to the National Working Group of the Indigenous Voice to Parliament. What's your view about the significance of enshrining the Voice as it relates to First Nations people with disability in remote and very remote  
40 communities?

MR GRIFFIS: Yes. Well, I mean, that working group has now completed its work. But, yes, I was appointed to the National Working Group for the Indigenous Voice to Parliament. So, that is obviously another opportunity, and one of the recommendations we made through  
45

that process that there be a standing committee made up of First Nations people with disability who would provide advice to the Indigenous Voice to Parliament, and it was wonderful to see leadership - First Nations leadership endorse that approach.

5 So, with the hopefully successful passing of a referendum when that time comes, we would hope that that system, or that system - that approach of an Indigenous Voice to Parliament will have within it a standing committee on disability, which is another way to ensure we give voice to some of our most vulnerable Australians. So, yes.

10 MS MCMAHON: Now, before I ask Commissioners if they have any questions, June, is there anything else that you would like to say at this hearing?

MS RIEMER: I think, you know, for FPDN, you know, we were excited when the scheme evolved and it was you know, a lot of work of, you know, the disability rights movement to  
15 make change in Australia. And for FPDN, as I said, we were excited that First Nations people with disability would have the opportunity to participate and enjoy, you know, parts of Australia that, you know, whether that's employment or education that, you know, many other people, you know, are allowed to do. But we haven't seen that change.

20 And it saddens me, you know, that, you know, we're this far down the track and nothing has changed for many of our communities, for many of our individuals. So, you know, we - you know, we advocated for this Commission and so we would hope, you know, that strong recommendations come out of it. And people are actually listening. You know, as one elder said to me, you know, up in far north here, you know, if we're not listening, we won't hear  
25 them. And that - you know, I think about that every day. You know?

We need to be listening, you know, because they have the solutions. You know, they know what needs to be done, you know, in their particular communities. And, again, it goes back to one not - one size doesn't fit all. But I also - I would like to finish, you know, with the  
30 words of our founding elder Lester Bostock who wrote these words, you know, more than 30 years ago now, and he was talking about double disadvantage for First Nations people, "To be Aboriginal in Australia today is a disadvantage." And we still see it in 2022. And to be an Aboriginal person living with disability is a double disadvantage. So, when are we going to change that narrative? Thank you.

35 MS MCMAHON: Thank you, Chair. And just briefly, Damian, is there anything further that you wanted to add?

MR GRIFFIS: Other than to say that, like June said, communities themselves have the  
40 solutions, and they have always had those solutions. And it's almost about returning to the old way of doing things. So, disability has always been an accepted part of the human experience. We know that from the evidence that is at Lake Mungo. So, we are thought leaders on inclusion. What's lacking, though, is community infrastructure and opportunity, and we are missing an opportunity, I think, every day to create a – micro-economies within  
45 our communities, to create employment opportunities and to go back to the old ways of doing things, which is about people supporting one another to stay on Country.

MS MCMAHON: Thank you, Damian. Chair?

CHAIR: Thank you very much.

5 MS RIEMER: Thank you.

CHAIR: I shall ask first, if you don't mind, Commissioner Mason if she has any questions for you.

10 COMMISSIONER MASON: I just had one for June. You were talking and responding to the Chair's question about criteria in bringing people into the scheme. And you talked about it needing to be more a human process, really, a human rights process of what do you - what is your strength but also where do you need help. And it struck me as an interesting perspective around activating workforce, because family around actually see that every day,  
15 where people struggle as well as where they can do things in the community.

Do you think of that approach is a much more of a better platform to activate people to work within the NDIS scheme rather than the approach that's been taken now?

20 MS RIEMER: Correct, yeah. I think, you know, we know it's not working. So, we need to go back to the real principles about, you know, speaking to communities, what is needed in those particular communities and then starting from that essence of, you know, building a workforce. But, you know, supporting people to understand, you know, whether it's, you know, our own communities, our own, you know, ACCHO sector, our own service sectors.

25 What does disability mean, you know, in the perspective of, you know, different disability types. What is across disability. And there isn't an understanding about that. We know that. You know, people don't understand the CRPD principles and the rights of a person with disability. So, it's education and training for all of those, and it has to be a continuum. So,  
30 you know, I think we have opportunities there, as Damian said to, you know, economies of scales, to build markets, to build - you know, education is power.

And that's what, you know, it shouldn't be - you know, a system over here that doesn't support others to, you know, build their knowledge and strength. But we have to come from  
35 a cultural element when I say that. You know, like, as Damian said, when we go out in community, we don't talk about disability; we talk about what keeps you strong. So, people, you know, it's breaking down the language and, you know, and I think there's - you know, so much more work that needs to be done with all government agencies to understand our perspective, you know, and we all are equal partners coming to the table.

40 So I think, you know, in the end, it's a lot of work to be done but, you know, I think it can be done. We just have to, you know, take time, be flexible and bring everyone at the same time. And if that takes a while, it takes a while. I'm not sure if that answered it.

45 COMMISSIONER MASON: No, that's great. Thank you for your evidence this morning.

CHAIR: Commissioner McEwin, do you have any questions?

COMMISSIONER McEWIN: I have one question. Thank you, June and Damian, for your evidence. My question is around other models. What's your observation or experience of other models across other government systems, such as either Commonwealth or state and territory that - where you have seen culturally appropriate services work? So, for example, Damian, you mentioned very briefly earlier housing, education, etcetera. We will hear from NACCHO later, so perhaps putting health aside, the culturally appropriate health services aside, have you seen any other model across education or housing in Australia that has been culturally appropriate that have worked, and, if so, what could we draw from those? And I will direct it to both of you.

MS RIEMER: I will let you go, Damian.

MR GRIFFIS: Sure, June. So, Commissioner, I think a contemporary example I can give relates to a genuine co-design approach which was undertaken by the National Indigenous Australians Agency in relation to the Indigenous Voice to Parliament. So, the elements of that that were a unique experience for me professionally, having worked in this area now for more than 20 years and sat on probably hundreds of committees, this was about genuine power sharing.

It was about time. So, there was a lot of meetings. There was a lot of time taken. It wasn't a two-hour meeting. It was whatever it needed to be done. It was co-chaired between government officials - senior government official and senior First Nations leadership. And the NDIA, the NDIS is an outlier in relation to genuine co-design. So, they need to catch up in some ways with some other agencies that are doing this better.

Now, I'm not romanticising this. There's a very, very long way to go. There's still agencies that are - but we can also look to the Victorian experience around the treaty body and truth-telling approach down there, which is no doubt an evolution in this - it's an evolved approach, unique in Australian history. The Indigenous Voice to Parliament potentially is a unique moment in Australian history. The design of it, in my experience, was the best process I've been involved in professionally in terms of the level of commitment, the ability and genuineness of the system to listen.

And I think June's point before around listening is a skill set - is a skill that the system doesn't possess very well in relation to First Nations people. And the NDIA in particular has a very, very long way to go. We are prepared and willing and able to go on that journey with the agency in the spirit of making things better for our people, and the agency also needs to come to the table with that same starting point, as opposed to a starting point that might be about cost-cutting or cost savings or whatever. This has just got to be about what's the right thing that a civilised society does to support its most vulnerable people. I will leave it there. Thanks, Commissioner.

COMMISSIONER McEWIN: Thank you.

CHAIR: Ms Riemer, do you want to add anything?

MS RIEMER: No, thank you.

5 COMMISSIONER McEWIN: Thank you. And I also want to acknowledge the work that you and FPDN continue to do, and I acknowledge and pay tribute to Uncle Lester and Auntie Gayle, the founders, and I can see that you are honouring their work. Thank you.

MS RIEMER: Thank you.

10 CHAIR: Thank you.

MR GRIFFIS: Thank you.

15 CHAIR: We will be hearing a little later, as you probably know, from the NDIA, and we have some quite detailed information and statements that you may not yet have seen. In the statement of Mr McNaughton, he refers to the Engagement Strategy that the NDIA released in March 2017 and to a progress update report on that strategy in 2021. This is, I should say, at paragraphs 66 to 71 of that statement. He then goes on to say that:

20 *"The NDIA has recently commenced initial stakeholder engagement as part of the refresh of the strategy and that's expected to take 12 months to complete. The approach is detailed in the engagement framework 2022, and through this process, the NDIA expects to gain a deeper understanding about the experiences and challenges people from a First Nations background have in accessing and navigating the NDIS."*

25 My question is, are you aware of this process and have you been invited to participate in it? And then a further sub-question, do you have any comments about the process?

30 MS RIEMER: Yes. So, we had - yeah, we've had one meeting to date. We actually have another meeting next week, so the process is in place. The team they've built, I would - you know, we're positive about, that, you know, that they are listening, and they are hearing and have gone back, you know, and researched other evidence that we've told them to look at in regards to. I guess the point for FPDN is, we are engaged in, you know, a lot of these processes over many years, Commissioner, but our capacity is very limited too.

35 You know, so being engaged today or, you know, while I've been in Alice Springs, I've been working on other programs. You know, FPDN's capacity needs to be built. We need to be at all these tables because we know if we're not at the table, disability doesn't get discussed in regards to First Nations people. But, you know, enhancing our capacity and building, you know, our enablement to be that strong voice at every area and, you know, that's the issue for FPDN.

40 We know this is really important so we're investing in that refresh. But, you know, how it will look and how it will roll over the next year also depends on how much capacity we have. Can we be at that table, you know, to really instil, you know, and make those differences.

45 CHAIR: But do I take it from what you've just said that you regard the process as appropriate and promising?

MS RIEMER: As I said, we have had one meeting, so we will see how it goes from there.

CHAIR: So too early to say.

5

MS RIEMER: Yes. And we have the next one next week, yeah. So - but those involved at this stage are committed for change. And, you know, I think it is looking good.

CHAIR: That's what Zhou Enlai said when asked about the French Revolution. He said it was too early to tell. Mr Griffis, do you have anything to add on this?

10

MR GRIFFIS: Yes, just to add a little bit further to what Junie said. Yes, I think in my earlier testimony, I think I might have mentioned in the last six months or so, there has been - been a shift. Like June, we will wait and see. You know, it's not unusual for us to - to go down these sort of approaches and, you know, we will wait and see. But, I guess the other thing we will be keen to see - let's not call it a refresh because we would argue the first version wasn't that fresh, if I may say that.

15

So - so we want to almost start over, in some ways. And I think we've certainly made that clear to the - to the agency. So, yeah, the first meeting was positive. We've got another one next week. Yeah, let's hope we've turned over a new page.

20

CHAIR: Okay thank you. Just before we finish - sorry, you are about to say something.

MS MCMAHON: No, Chair, excuse me.

25

CHAIR: I was going to ask whether there is any application from any represented party to ask Ms Riemer or Mr Griffis questions? If there's no leaping up, I shall assume that there's no such request. Just before finishing, can I just take up something that Mr Griffis said. You indicated that it was important to hold this hearing in Alice Springs, and indeed it is. I do want to make the point that if we had not been subject to extraordinary interruptions through COVID-19, we were talking about and hopefully we could have had hearings actually in even more remote areas than Alice Springs.

30

That was one of the approaches that we were considering, and I do believe we would have done that. There are ways in which hearings can be held that don't necessarily involve a major convention centre and all of the trappings that go with it. With native title cases, as you well know, in the Federal Court, you can have hearings - indeed I had some - on hilltops and outside and so on. So, unfortunately one of the limiting factors for this Royal Commission has been the limitations on travel and the logistical arrangements that are necessarily involved in travelling to remote areas.

35

40

We, up to date, despite our best efforts, we haven't been able to hold a hearing in Western Australia at all. We will do so, unless there is further interruptions. But I just wanted to make the point that I agree entirely, and I'm sure my colleagues agree entirely, with what Mr Griffis said, and it's one of those limitations and a pity that we haven't been able to

45

ourselves as Commissioners - of course, Commissioner Mason has travelled to many of these areas, but that's just one of the limitations to which we have been subject.

5 I want to thank you both for not only your evidence and for the very stimulating conversations that we've had today, but also, again, for the contributions to the Royal Commission and for the work that you have done in - to use the language that you have used this morning, to support and improve the position of the most vulnerable people in this country. So, thank you very much indeed for your contributions.

10 MS RIEMER: Thank you, Chair.

MR GRIFFIS: Thank you. Thank you.

15 MS MCMAHON: Chair, we are running about five to 10 minutes over time. Perhaps we can have an adjournment now until say about 10 past 12. Will that suit?

CHAIR: Yes, we will do that. We will adjourn until 10 past 12. I would have thought 10 minutes before time is really almost punctual. We will adjourn until 10 past 12.

20 **<THE WITNESSES WITHDREW**

**<ADJOURNED 11:52 AM**

25 **<RESUMED 12:16 PM**

CHAIR: Yes, Ms McMahon.

30 MS MCMAHON: Thank you, Chair. Commissioners, you will now hear from Pat Turner, CEO of the National Aboriginal Community Controlled Health Organisation, who is here in the hearing room; and Jenny Bedford, the Chief Operating Officer of the Kimberley Aboriginal Medical Services, who will be appearing remotely; as well as Cassie Atchison, CEO of Broome Regional Aboriginal Medical Service. Ms Turner will take an affirmation, Chair, and Ms Bedford and Ms Atchison will take an oath.

35 CHAIR: Ms Turner, Ms Atchison, Ms Bedford, thank you very much for coming to the Royal Commission to give evidence, in one case remotely and in another in person. We are very grateful for the extremely detailed statements that we have that are very helpful to us, and we appreciate the work - the contributions you've made to the Royal Commission both for this hearing and in other ways. So, thank you very much and we are grateful for your  
40 willingness to give evidence today. If you would be good enough to follow the instructions of my associate who is in the hearing room, she will administer the oath or affirmation, as the case may be.

45 **<PATRICIA TURNER, AFFIRMED**

CHAIR: Thank you, Ms Turner.

**<CASSIE ATCHISON, SWORN**

**<JENNY BEDFORD, SWORN**

5 CHAIR: Thank you very much. Yes, Ms McMahon. Ms McMahon will now ask you some questions.

**<EXAMINATION BY MS McMAHON**

10 MS McMAHON: Thank you, Chair. Ms Turner, you have provided a statement to the Royal Commission dated 27 June 2022. Are the contents of that statement true and correct?

MS TURNER: Yes.

15 MS McMAHON: Ms Bedford and Ms Atchison, you have provided a joint statement dated 17 June 2022. May I please also confirm with you that the contents of that joint statement are true and correct?

MS BEDFORD: Yes.

20

MS ATCHISON: Yes

MS McMAHON: Commissioners, NACCHO have provided other submissions and reports, which you will find at tabs 85 to 89 in Hearing Bundle A, and they also include a final report of the NDIS Capacity-Building Project at tab 85. KAMS also provide two annexures which will be no doubt referred to in evidence this afternoon at tabs 81 and 82 of the bundles.

25

Ms Turner, could you please give a brief overview of NACCHO's work and your role in the key area - sorry, the key areas of NACCHO's work?

30

MS TURNER: Yes. Good afternoon, everyone. And thank you for inviting me here today to speak with you about disability, a critical issue for our people and our communities. Before I start, I would like to acknowledge the traditional custodians of the lands we are meeting on today. These are the lands of the Arrernte people, my people. I pay my respects to elders past and present and thank them for their continuing openness to have us live, work and meet on their land. I am the daughter of an Arrernte man and a Gurdanji woman. I was raised here in Alice Springs.

35

I am the CEO of the National Aboriginal Community Controlled Health Organisation, and the lead convener of the Coalition of Aboriginal and Torres Strait Islander peak organisations working with all governments in Australia to close the gap between our people and others. NACCHO is the national peak body representing 145 community-controlled health organisations across Australia. Our members deliver comprehensive primary healthcare from about 550 clinics across Australia. We deliver over 3.1 million episodes of care each year for more than 410,000 people. This includes 1 million episodes of care in very remote regions.

45

More than a third of our ACCHOS are located in remote and very remote communities. As well as clinic services, many ACCHOs provide home and site visits, medical, public health and health promotion services, allied health, nursing services, assistance with making appointments and transport, helping access childcare, or dealing with the justice system, Drug and Alcohol Services, and help with income support. Many are expanding into disability and aged care service delivery.

MS MCMAHON: Thank you, Ms Turner. Ms Bedford, could you please describe your role at KAMS and the services offered there?

MS BEDFORD: Yes. I would also like to start by acknowledging that I'm meeting - I'm here in Broome, on the lands of the Yawuru people, and that we are meeting today on the lands of the Arrernte people in Alice Springs. I would like to pay my respects to elders past and present and thank them for the opportunity to live and work on such beautiful country. If I can introduce myself, my father was a Kija man, and my mother was a Jaru woman I'm from Halls Creek in the East Kimberley region.

I work in the Kimberley Medical Services as a Chief Operating Officer. KAMS is a regional Aboriginal-community-controlled health service which was established in 1986 as a cooperative between the Broome Regional Aboriginal Medical Service and what is now the Ord Valley Aboriginal health service. And our role is to provide support to our members who are located in the towns and remote communities right across the Kimberley. KAMS is governed by a board of directors which is comprised of representatives from each of our eight member organisations, and our members include the Beagle Bay Community Aboriginal Corporation, the Bidyadanga Aboriginal Corporation La Grange, the Broome Regional Aboriginal Medical Service, the Derby Aboriginal Health Service, Milliya Rumurra Aboriginal Corporation, Nirrumbuk Environmental Health services, Ord Aboriginal Health Service and Yura Yungi Medical Service in Halls Creek.

We exist because of our members, and along with the support we provide, we also represent our members interests on critical issues that affect us. KAMS delivers primary healthcare from five remote clinics located in the communities of Balgo, Billiluna, Mulan, Beagle Bay and Bidyadanga. We also deliver dialysis care from renal health services - centres located in Broome, Derby, Fitzroy Crossing and Kununurra. And through our primary healthcare services in remote communities, KAMS and member services delivered over 169,000 episodes of care to more than 23,000 people in the 20-21 financial year.

MS MCMAHON: Thank you, Ms Bedford. And, Ms Atchison, if you could just explain what your role is at KAMS, please?

MS ATCHISON: Good afternoon. I would also like to pay my respects to elders past, present and emerging. I'm the Chief Executive Officer of Broome Regional Aboriginal Medical Services. BRAMS is an Aboriginal community-controlled medical services, and we have been caring for the Broome community for more than 40 years. When BRAMS opened our doors in 1978, we were the first remote Aboriginal medical service in Western Australia.

5 We provide comprehensive primary healthcare, social and emotional wellbeing services, aged and disability services to Aboriginal people living in the Broome region. We deliver more than 45,000 occasions of service each year, to over 7,000 people. BRAMS is also a registered NDIS provider, and we have become registered in April 2020, and we provide services to over 110 Aboriginal people in the Broome region.

10 MS MCMAHON: Thank you, Ms Atchison. Ms Turner, in relation to your 2019 capacity-building report - and this is also expressed in your statement - that Aboriginal and Torres Strait Islander people express a clear preference for access to community-controlled services. Why is that?

15 MS TURNER: Our people prefer to access services where they are confident in their cultural - that their cultural safety is guaranteed. Aboriginal community-controlled health services are highly visible, and trusted in Aboriginal and Torres Strait Islander communities. Many of our people will bypass mainstream services to access our services, where they are confident of cultural respect and cultural safety. ACCHOs provide embedded understands and lived experience and are a culturally safe place for all community members to access primary healthcare and other services free from stigma and shame.

20 ACCHOs often employ local Aboriginal community members who often have no formal qualifications but are essential to help bridge the gap between health professionals and families.

25 MS MCMAHON: Thank you. And, Ms Bedford, is that your experience as well in the Kimberley, in terms of an expression of preference for Aboriginal-controlled services?

30 MS BEDFORD: Yes, it is. I strongly agree with what Ms Turner is saying there. You know, the delivery of disability services and primary healthcare services in our region is a very personal thing because we are delivering services to our families and to our extended families. Our communities feel safe accessing our services because they trust and they respect us. ACCHOs and ACCOs across the region are culturally safe services, and by that I mean that we employ local Aboriginal people to deliver services to local Aboriginal communities.

35 We have a model of care which dictates that we walk side-by-side with our community in the delivery of our services. And so we engage with Aboriginal people and communities at their pace, and we work within a person and family-centred model. This is a critical point of difference between the ACCHO sector and mainstream services.

40 MS MCMAHON: Ms Bedford, if I could just pick up on something you said a moment ago, that you work in a person-centred and family centred. Can you just explain if there is any difference between those two approaches, from your point of view?

45 MS BEDFORD: The ACCHS model of care talks to a person-centred approach, but it also has some key principles included in it around family. And so when we're working with individuals we included family in conversations around, you know, a first diagnosis, for instance of a chronic disease, or, you know, in the terms of the way we engage. So, it's absolutely critical we have a person-centred approach so the individual can actually lead

clinicians in the delivery of care, but also that we're involving family in the conversations that we're having with the individual, around care and support.

5 MS MCMAHON: And can I just ask one further question in regards to the family-centred approach. Is that important or critical to First Nations people with disability accessing the NDIS?

10 MS BEDFORD: Absolutely. You know, our cultural obligations are very strong, and we have obligations within our families to look after everyone in our family. And so the ACCHS model of care talks about family being one of those key principles around the way we care and support for - for individuals. So, having - having access to the individual but also the family is a critical part of service delivery.

15 MS MCMAHON: And, Commissioners, Ms Bedford's referring to the ACCHS model of care. That's at tab 81 of your bundle if you wanted to refer to that. May I just also ask, in relation to family-centred, is that also important in relation to the engagement of First Nations people with disability in remote areas engaging in services - disability services?

20 MS BEDFORD: Yes. I believe so. I think we have dedicated roles that - that - and we will talk a little bit about that in terms of the Kimberley Supports consortium. But through the model of care and the way that we deliver, say, primary healthcare from our remote - our remote clinics, we make sure that we have local people working in our clinics, and there are designated roles like the Aboriginal Health Worker role. Within disability and particularly in our Remote Early Childhood Support Program, we have family support workers who are  
25 absolutely critical to the delivery of the program because they are able to connect non-Aboriginal allied health teams to local Aboriginal communities, families and individuals.

30 MS MCMAHON: Thank you. Now, Ms Turner, the second key issue in your capacity report, or one of the foundational issues is that you state that ACCHOs and ACCOs are best placed to provide supports to First Nations people with disability. And just before I ask you why that is, I just want to indicate to the witnesses if you could just slow down a little bit for our interpreters. That would be helpful. But why is it that ACCHOs and ACCOs are best placed?

35 MS TURNER: This is not just NACCHO's opinion. Research which is cited in our statement shows that ACCHOs are best placed to respond to the social and cultural determinants of health. Our people and our ACCHOs have a more holistic view of health. Everything connects. Your spiritual, mental, physical wellbeing is all connected. You cannot separate one from the other. And our people understand this. It's how we live. Our communities have a deep sense of heart for our people with a disability.  
40

We don't exclude people from cultural events or gatherings, just because they are disabled. We try to include people in everything that happens in community. We know that Aboriginal and Torres Strait Islander people continue to experience racism across the general health sector and that this impacts on their health outcomes. That is why ACCHO services are  
45 critical to the successful uptake and delivery of the NDIS to Aboriginal and Torres Strait Islander people with disability.

They ensure services for our people are culturally intelligent and appropriate. And this is why our people prefer to access community-controlled services.

5 MS MCMAHON: Thank you. And just some questions relating to data, Ms Turner. NACCHO cite in your statement the DSP and ABS data - and this is at paragraph 38, Commissioners - to identify that there's high rates of Aboriginal and Torres Strait Islander people with disability. What are NACCHO's observations of the rates of First Nations people accessing the NDIS?

10 MS TURNER: Well, there is limited data available on the number of Aboriginal and Torres Strait Islander people with disability. The ABS estimates severe and profound disability at 7.3 per cent for Aboriginal and Torres Strait Islander people, and the overall rate of disability at 23.9 per cent for our people. The NDIA forecasted that around 7.8 per cent of people on NDIS would be Aboriginal or Torres Strait Islander.

15 Currently, 7.2 per cent of participants - that's 37,345 people - who have an NDIS plan identify as Aboriginal or Torres Strait Islander. However, this is considerably less than the estimated number of Aboriginal and Torres Strait Islander people with a disability. While participation rates appear to be tracking to the NDIA forecast, we aren't seeing effective  
20 utilisation of those plans. There are significant underspends in NDIS plans, which demonstrate that even though our people are becoming NDIS participants, they can't access the services they need.

25 This is compounded in remote and very remote areas due to the thin markets. Many services are not available, or those that are may not be culturally safe for Aboriginal and Torres Strait Islander people. So, more data is needed on the prevalence of disability in Aboriginal and Torres Strait Islander people to ensure that we can make better informed decisions and direct funding to where it is most needed. Any nationally coordinated  
30 approach to data collection must adopt the principles outlined in Priority Reform 4 of the national agreement on Closing the Gap. And Priority Reform 4 relates to governments sharing data and information with only groups.

35 MS MCMAHON: Thank you, Ms Turner. I understand from your statement at 109 that NACCHO is engaging in some mapping work in relation to understanding the demand for disability services in remote communities. Is NACCHO funded to do this mapping work?

40 MS TURNER: Well, as I previously stated, there is limited data available to ascertain the true level of need of Aboriginal and Torres Strait Islander people with disabilities and, therefore, what resourcing our ACCHOs need to support them. NACCHO started undertaking work to better understand the levels of demand for disability services in remote communities. This work has only scratched the surface of what the ACCHOs are currently doing and what they need to support people with disability. Comprehensive mapping requires consulting across our sector to determine their capability and capacity to support community with disabilities.

45 MS MCMAHON: Thank you, Ms Turner. And I might now turn to you Ms Atchison - sorry, Ms Bedford first. You explain in your statement that there has been a partnership between

Kimberley ACCHOs and ACCOs and the NDIA. Could you just explain to the Commissioners how that partnership was initiated and how it developed?

5 MS BEDFORD: Yes. Representatives from the NDIA met with Kimberley leaders on their NDIS model of service delivery. And the Kimberley leaders at the time were very clear in saying to the NDIA that if you want to work in the Kimberley, you have to do it our way. And what "our way" meant was involving not just the Kimberley Aboriginal community-controlled health services, but also a number of Aboriginal community-controlled organisations such as Waringarri Aboriginal Corporation in Kununurra, Winun Ngari Aboriginal Corporation in Derby, Marninwarntikura in Fitzroy Crossing to develop a consortium to deliver disability services to our community right across the region.

15 So the Kimberley leaders developed the consortium. And the consortium, there are three elements to it. One is the Remote Community Connector Program, the next one is the Evidence and Access Coordination Program, and the last is the Remote Early Childhood Support Program. KAMS acts as the contract holder and auspices funds for the consortium. And consortium members such as those that I mentioned deliver programs such as is the Remote Community Connector program, and ACCHOs then deliver the Evidence and Access Program. The Remote Early Childhood Program is actually delivered by KAMS and also in conjunction with our consortium partners.

20 MS MCMAHON: Thank you, Ms Bedford. And, Ms Atchison, I want to turn to you now to describe to the Commissioners a bit more detail about each of the three programs. And I will start first with the Remote Community Connector program. Now, Commissioner, there's a very detailed explanation at 39 to 43 of their joint statement but if you could just give an overview, please, Ms Atchison, of the program, which I understand emphasises very much flexibility and a local approach.

25 MS ATCHISON: The Remote Community Connector program was designed to engage with vulnerable people living with a disability to engage with trusted, local community members to have discussions about their disability and how they can link into service providers. This program has been extremely powerful in our communities because we have engaged with a lot of community members who weren't aware that they had a disability or that they were eligible for NDIS or eligible for supports. So, there's been many people who have been able to be linked into services now who previously weren't having those services.

30 MS MCMAHON: And, Ms Atchison, one of the elements that's detailed in the explanation relates to the vulnerable participant check-in support in one of the communities. Can you just explain what that's about?

35 MS ATCHISON: It's about maintaining the connection with vulnerable people in the community who otherwise wouldn't have had that support previously. So, particularly in some of the remote communities where there - there aren't very many services for people with a disability, the Remote Community Connectors have been able to engage with vulnerable people and maintain and build those relationships.

MS MCMAHON: But what does it mean in terms of regularity, the check-in support? Is it something that's done randomly as people need it by local people on the ground? Is that the idea?

5 MS ATCHISON: Yes, that's the concept of the program.

MS MCMAHON: Do you see that - perhaps I'm asking a very obvious question, but do you see that that aspect of the program could be delivered by a FIFO, DIDO or zoom-in zoom-out type of model?

10

MS ATCHISON: No, it's a model that needs to be delivered for the community by the local community. You lose engagement by flying in and out and doing those types of services. It's really important to have local people deliver those services so the community know where they are, where you can access people, you don't have to put the burden on the local community to have to navigate phone numbers and Zoom and technology and all those sorts of things.

15

MS MCMAHON: Thank you. Now, the second program that Ms Bedford just referred to is the Evidence Access and Coordination Planning Program. Again - and this is at 45, Commissioners - what's the purpose and reach of this program?

20

MS ATCHISON: So the purpose of the Evidence Access and Coordination Planning Program is to assist people with disabilities to test their eligibility for NDIS and to help people gather all the information and go through the process of being approved for an NDIS plan.

25

MS MCMAHON: And have you been able to gather information or perhaps estimate the number of people that you've joined to the NDIS that otherwise may not have connected?

MS ATCHISON: Yes. So, since the program started in late 2019, the program has engaged with 470 people, and 361 of those engagements or people that have engaged with the program have met the criteria and now have an NDIS plan.

30

MS MCMAHON: Thank you. And the last program, the Remote Early Childhood Support Program, which I understand is relevant to Target 4 of the Closing the Gap targets, that is, children thrive in their early years, can you again, please, just explain the purpose of this program to the Commissioners?

35

MS ATCHISON: The purpose of the Early Childhood Supports Program is to assist children aged between 0 and 7 who have a developmental delay or a disability to access early intervention support. The team employs an allied health team with child health nurse, speech pathologist, an occupational therapist and physiotherapist. The program provides individual support with assessments, therapies, coordination of services, and access to other services.

40

A part of the program is that we also employ Aboriginal family support workers, who are the key and the linkages in engaging families and walking through that journey with families in accessing the allied health services.

45

CHAIR: Can you explain, please, your understanding of how the Community Connectors program was initiated and developed? Who was responsible for that in the first instance?

5 MS ATCHISON: It was the - from what I understand, it was the consortium. I - Jenny Bedford may be able to talk more to that because that happened pre - pre-my employment at BRAMS, but I understand it was the consortium members that come up with the concept for the program.

10 CHAIR: Ms Bedford, did you want to elaborate on that?

MS BEDFORD: Yes, I'm happy to. So, the Kimberley leaders that came together to form consortium developed the Remote Community Connector program. The ACCOs that I mentioned earlier, Waringarri Aboriginal Corporation, Winan Ngari, the Nirrumbuk  
15 Environmental Health, are responsible for the delivery of the Remote Community Connector program. And, you know, a lot of - a lot of the work that they do is also based around trust, and those organisations have been around for a very long time.

20 Waringarri, for instance, in Kununurra has been in existence since 1979, Nirrumbuk since 1983, and Winun Ngari in Derby since 1983. So, the work of the Remote Community Connectors are absolutely critical in terms of identifying local people who are living with a disability, connecting them up to the Evidence and Access Coordinator role, but also promoting - promoting the service within community.

25 CHAIR: This may be only significant as a matter of history, rather than anything else, but one of the statements on behalf of the NDIA describes the Community Connectors program as the NDIA's Community Connectors program, and the statement says that the NDIA has developed three Community Connector programs to support people with disability, these being the Remote Community Connectors, Evidence Access and Coordination Planning, and  
30 Remote Early Childhood Services. It may only be a matter of expression, but is that accurate, from your perspective?

MS BEDFORD: Look, I'm not quite sure if there were elements of co-design in the development of the program way back when the Remote Community Connector program was established, but I do know that the Kimberley leadership played a very key role in  
35 identifying the need for the Connector program to be operating within our remote communities.

40 CHAIR: Right. Thank you. Yes, Ms McMahon.

MS MCMAHON: Ms Turner, did you want to add something?

MS TURNER: Yeah, Commissioner, the idea came from the Aboriginal community representatives who know what works because of the years of experience. And when you  
45 look at organisations like Winun Ngari and so on that Jenny has referred to, they don't just service the community in Derby; they service all of the outlying communities, like up the Gibb River Road and so on. But, you know, these people have had years of experience and

they know what works and what doesn't. So, what we did was we asked the NDIA to fund it, and what they gave us was 12-month funding.

CHAIR: Ms McMahon.

5

MS MCMAHON: Thank you. Just briefly, Ms Atchison, just coming back to your Remote Early Childhood Support Program, can you just tell the Commissioners, firstly, the current caseload and, secondly, the role and importance of Aboriginal families support workforce to this program?

10

MS ATCHISON: Currently we have 157 children engaged in the program throughout the Kimberley region. And relating to the role and the importance of Aboriginal family support workers to this program, these roles are significant. They help identify potential children who may require help with their development. They assist the allied health team to navigate the community, contact them to engage with the child and the family.

15

And the family support worker helps the family and therapists completing intervention tasks and other related assessments, and they assist the family in accessing services and provide support throughout the whole process. So, the family support workers don't just engage initially; they go through and follow the family through their journey, which has been quite successful in maintaining the engagement.

20

MS MCMAHON: Thank you. Ms Turner, you're very aware of these programs and the work of KAMS and BRAMS, but having been reminded of the work that they are doing, is this a sort of model that should be rolled out or replicated in other remote and very remote communities?

25

MS TURNER: Well, it certainly worked in the Kimberley because the Aboriginal leadership in the Kimberley took the opportunity to form the consortium, take into account everybody's views and come up with solutions to, you know, the issues that were facing our communities. So, if we had the same process whereby we could give the initiative to the Aboriginal and Torres Strait Islander community leaders to come together to work out what will work best in their regions, I'm sure we will have very similar approaches, but there would need to be variations according to local conditions. So - but the fact that it is community-led is the most important.

30

35

And the lesson here for government is to learn from that and to trust what the local leaders are saying. There's been so much mistrust between the bureaucracy and Aboriginal people historically in this country, and those days are over. We've now got a seat at the negotiating table on Closing the Gap, and we have four priority reforms that are very important for all governments to implement right across the board in terms of shared decision-making between our peoples and government on all matters, building and strengthening the Aboriginal community-controlled sector to deliver services, reforming mainstream agencies to be culturally safe and respectful in their engagements with Aboriginal people - like police force, hospitals, out of home care, juvenile detention. All of those places.

40

45

5 So there's a lot of work there for states and territories, especially to do. But there is also Commonwealth agencies that need to smarten up their act. And the last one is, of course, the sharing of data and information. Now, we see these as microeconomic structural changes that need to happen in terms of changing the way governments work with our people right across the board. And if government agencies are not prepared to do that - in fact, this has been signed on by the Prime Minister, the Premiers and the Chief Ministers and the President of the Local Government Association, along with myself as the Lead Convener of the peaks, in a national agreement that is historical and that we have a lot of work to do. And these priority reforms absolutely underpin that structural change that must occur.

10 MS MCMAHON: And just speaking of structural change, does that include 'The Voice'? The Uluru statement?

15 MS TURNER: Well, the Voice has been a different kettle of fish. That's been an aspiration in relation to the people who were participating in the consultations that were held at the time. I think that, you know, there are - I mean, I'm having a lot of discussions in Canberra with the government in relation to the Voice and how they're going to take the referendum forward, and, you know, we will have to wait and see what comes of the referendum.

20 But the will looks as though it's there in the Australian people, among the Australian people, to support the creation of a constitutionally enshrined Voice. And the reason people are so strong about that is because every other mechanism we've had in the past, like ATSIC and, you know, the NAC and the NACC and the Aboriginal Development Commission and all of those structures that were created at the Commonwealth level were all done away with the stroke of a pen. Because they were only legislated and are not protected by the Constitution.

25 So if we do get a Voice, it will be something that will enable Aboriginal and Torres Strait Islander people to vet all of the legislation that impacts on us going through the Federal Parliament and having - and putting our perspective forward to the Parliament in their advisory capacity.

30 MS MCMAHON: Thank you, Ms Turner. We're coming close to lunch before we do, I would like to turn back again to Ms Bedford and Ms Atchison. At 64 of your statement, you advocate the strength of the Aboriginal Community Controlled Health Sector Model, which, again, is available in the hearing bundle. How do components of this model enhance the quality of support for First Nations people with disability in remote communities?

35 MS BEDFORD: I will start, Cassie, if that's okay. The ACCHS model of care and the - let me just go back. The Kimberley leaders framed the Kimberley consortium on the ACCHO model of care. The model is built around the delivery of comprehensive holistic and culturally safe primary healthcare services, but the principles that are contained within it are able to be applied to disability, to aged care, to any type of service delivery that ACCOs or ACCHOs wanted to deliver within our community.

At the top of the model, there is recognition that ACCHOs are more than just another health service. We put Aboriginal health into Aboriginal hands. And so there are some key domains within the model that talk about, you know, what are the things that make our community feel good and feel healthy. And they are things like, you know, culture, family, community.  
5 You know, it's not just about the physical health, it's about our spiritual health and our emotional health, and it's underpinned very strongly by cultural safety, because culture is our life.

And we give it the highest priority when we deliver services and programs to our  
10 community. Again, this is another unique characteristic of the ACCHOs and ACCO sector in the Kimberley, but particularly around the ACCHOs sector in delivery of primary healthcare in remote communities. The model also is person-centred and family-centred. It ensures that the delivery of primary healthcare is delivered across the life course, and it also talks to an Aboriginal health worker first model.

15 So, a key component of it is having a strong and confident Aboriginal health workforce. And so our primary healthcare services within our clinics are led by Aboriginal health workers.

MS MCMAHON: And is that to be achieved by building local workforce and  
20 capacity-building?

MS BEDFORD: Yes, absolutely. It's again that issue of local Aboriginal people delivering services to our community. The Aboriginal health worker workforce is absolutely critical to the way that we deliver primary healthcare in remote communities. And in much the same  
25 way Cassie spoke about the Aboriginal support worker workforce and the critical work that they do to bridge the cultural gap between our non-Aboriginal professionals, either within allied health teams from a Remote Early Childhood Program perspective or from a primary hilt care perspective where our Aboriginal health workers bridge the cultural gap between our doctors and nurses and the community.

30 Our Aboriginal health workers bring a skill set to our clinics that no other clinician has, and that is that deep knowledge of their community. They have lived experience, they are trained clinically, they understand community. They are members of kinship systems. They understand what's happening in community around cultural business, whether it be funeral  
35 time, or - or any other cultural activities that are happening in community. So, they have this intrinsic knowledge about how individuals and families are - you know, the issues that they're facing and the health problems that they may be presenting with at the clinic.

MS MCMAHON: Ms Atchison, did you want to add anything to what Ms Bedford has said?  
40

MS ATCHISON: Yes, just to expand on what Jenny has spoken about. One of the key elements of the ACCO model of care is that we treat and we value human rights. We treat our Aboriginal patients first and foremost as people, and we focus on the individual and the family and what they can do, not just focus on a medical condition or a disability. And our  
45 support focuses on achieving what the individual wants to achieve, if it - in regards to their healthcare goals, their aspirations, and the services we delivered are tailored to meet those circumstances.

And some of that person-centred approach and the model of care helps people to be at the centre of the service and we involve people in making decisions about their own lives. We take into consideration the person's experience, their age, their gender, their culture,  
5 heritage, language, beliefs and identity, and we support individuals and family units to build on their own capacities and their capabilities. And the model of care is strength-based and we support culture and cultural identity, and we encourage participation and belonging in the community.

10 And we are able to achieve that through what Ms Bedford said in regards to having a local Aboriginal workforce, we are culturally safe and having a multi-disciplinary team approach to providing services to Aboriginal people.

MS MCMAHON: Thank you. Ms Turner, I just had two questions for you, following that  
15 evidence. The first is, is the Aboriginal Community-Controlled Health Service Model the model that's used by your members, all of your members?

MS TURNER: Our aspiration is for every one of our health services, the 145, to deliver  
20 comprehensive primary healthcare. But we range from well-resourced ACCHOs to not-so-well-resourced ACCHOs. So, not every health service that we have operates a fully - a full suite of comprehensive primary healthcare. They operate what they are funded at this point to do. So, some are only very small clinics staffed by Aboriginal health workers and nurses in the main, with visiting specialists or appointments made with other services as  
25 required by the community.

They are small communities, obviously, where they exist and - but in areas like the  
Kimberley, we have a very well-coordinated arrangement between the eight health services, the other Aboriginal community-controlled organisations and - because everyone knows  
30 which organisation has responsibility for what areas of service delivery and who is best placed to be able to do that. And they can come to agreement like they have, for example, with the Community Connectors and - and so on.

So we're not expecting that it will only be our health services who will do the service  
35 delivery; we have - we try to have the most efficient and effective range of service delivery across areas. And in other parts of the country, it does operate in similar ways.

MS MCMAHON: So based on the strengths on the ground, in a particular community?

MS TURNER: Yes. Absolutely.  
40

MS MCMAHON: And that aspiration for your members to be implementing this model  
comprehensively, that's a capacity-building issue?

MS TURNER: It is a capacity-building issue. You did ask me earlier, if I might just go back,  
45 about whether we were funded undertake comprehensive mapping. So - and as I said, it requires - comprehensive mapping requires consulting across the sector to determine capability and capacity to support community with disability. This work has not provided a

full picture, because we were not funded to undertake comprehensive mapping of our sector. We are currently drafting a final report which is due at the end of August.

5 But prior to NDS Ready, 53 of our - of NACCHOs, 144 members, were registered to provide NDIS services. This program has made great strides in supporting the capacity-building of ACCHOs into NDIS provision. As per our last NDIS reporting period in January 22, an additional 71 ACCHOs have made meaningful progress towards NDIS service delivery, making a total of 124 of our ACCHOs, which is 90 per cent of our members delivering disability services.

10

And let me say, but there is no long-term commitment by government to build the capacity of the sector to become NDIS providers. I must say that I've had various clear arguments with NDIA about 12-month funding and how useless that is, because you recruit a whole bunch of Community Connectors, it takes time to get people engaged, takes them - takes time to get them up to speed with their roles and responsibilities and out there engaging with the community, and, you know, you can't have that done at the - at the start of the 15 12-month period and then, you know, their funding is up at the end of 12 months. So, they are anxious to get other jobs and move on.

20 I'm trying to get NDIA to understand we're not going to tolerate too much of this 12-month funding nonsense anymore, and if they want us to do the work, they have to fund us. They can't ring up, you know, at the drop of a hat and say, you know, "Have you done that comprehensive assessment?" No, because you didn't fund us to do it. And there's a bit of overlap at the moment between social security and NDIA, and it's a bit confusing. Who is 25 running the policy and who is running the program. So, I might just throw that in.

MS MCMAHON: And, Ms Turner, just one final question, you have just mentioned the NDIS Ready program, and you've indicated the members that you managed to become disability service provides for the NDIS. The funding for that program finished on 30 June 2022, I 30 understand. Has that -

MS TURNER: That's right. And the Department of Health has given us a further nine months.

35 MS MCMAHON: A further nine months. Thank you.

MS TURNER: Nine months funding. You see what I mean about this intermittent - you know, 12-month funding is absolutely useless. Now, I've been working with the Commonwealth Department of Health on ACCHOs base funding since I started at NACCHO in 2016. And we have now just been approved for four-year rolling funding for our services, which is a 40 massive break through, let me tell you, with indexation. So, you know, that will help in terms of the planning and the - and the manoeuvrability within those periods - within that four-year period, and give greater flexibility to our services to manage their budgets more effectively.

45 But this is where NDIA has to get real about wanting the Aboriginal and Torres Strait Islander people to have access and what it takes to do that in remote areas. And one of the reasons NACCHO encouraged our members to be involved in this area in the first place is

we're some of the - one of the few Aboriginal organisations nationally, with our distributed membership of 145 services, who have a presence out there, you know, who are actually working in remote and very remote communities.

5 MS MCMAHON: Yes.

MS TURNER: There's not have been many other service deliverers out there as we are. Even legal services and other services have been forced to concentrate in the cities, not in - not out in the communities where the needs really are.

10

MS MCMAHON: Thank you. And, Chair, this might be a convenient time to take a lunch break. Unless there's any question of the Commissioners?

15

CHAIR: Yes, what is your first bid for the lunch break? Your first bid for the time of the lunch break?

MS MCMAHON: Until 2 o'clock? Of course, it's a matter for you, Chair.

20

CHAIR: Yes. We will resume at 2.02 pm.

**<ADJOURNED 1:08 PM**

**<RESUMED 2:05 PM**

25

CHAIR: Yes, Ms McMahan.

30

MS MCMAHON: Thank you, Chair. NACCHO, KAMS and BRAMS have all identified a number of barriers to accessing the NDIS and these services. The evidence this afternoon won't detail all of those barriers, but we just wish to raise a few of those or focus on a number of them. The first is cultural competence. Ms Turner, if I may start with you. NACCHO's observations, if you could please tell the Commissioners, what are NACCHO's observations of the cultural competence and cultural safety offered by NDIA staff and mainstream service providers?

35

MS TURNER: Well, I think they're very minimal, really, in terms of cultural competency and understanding the difference in approach required to engage effectively with Aboriginal and Torres Strait Islander people right throughout Australia. So, quite often, we find ourselves in the position of having to navigate those paths with our clients to ensure they get a fair hearing.

40

But I think the assessment process is open to unconscious bias because of the lack of understanding of Aboriginal and Torres Strait Islander cultural beliefs and practices and - and - and I also think that, you know, change in an organisation to be culturally competent in their dealings with our people requires leadership from the very top.

45

MS MCMAHON: Yes.

MS TURNER: From, you know, the chief executive right through to, you know, the frontline staff, if you like, or the people at the coal-face who do more of the engagement. So, if you don't have that cultural respect and understanding throughout the organisation, you are not going to have the returns on the investment even the NDIA tries to make. And it's not going to come with a 30-minute online course either.

It's got to be a more comprehensive, cultural competency training and greater engagement - and listening to each other about their experiences and taking those learnings on board within the organisation. So, you know, I mean, I know a lot is expected, but I think it's had enough time to settle down and do its job, the NDIA. And it's the proper administration of the NDIS to make sure all Australians who are eligible have that access and are able to utilise their plans effectively.

MS MCMAHON: But you did mention - and coming from the point you've just made, Ms Turner, at 118 of your statement, the cultural competency does not exist only at an individual level through training, that it's an organisational mindset. Does that include representatives within NDIA itself of First Nations people and First Nations people with disability?

MS TURNER: Yes. And I understand that, you know, it's not easy, but it would certainly assist the organisation - and I believe that they do have Aboriginal and Torres Strait Islander staff and - but I'm just not sure how influential they are in the organisation when it comes to cultural competence of their colleagues.

MS MCMAHON: Now, speaking of cultural competence, what are the impacts of cultural incompetence as it relates to the delivery of NDIS services and disability services?

MS TURNER: Well, a complete lack of understanding of the circumstances that a person lives in, especially in very remote and remote areas, and the lack of services that exist in those communities, the lack of infrastructure. You know, most of the remote communities have very poor infrastructure, and that's across the board, whether it's technological, you know, IT, phone access, or quite often if we've got a clinic in a community, that will be the one place where we can sit down with our - our staff can assist a community member in contact with a third party and quite often have to interpret for them what the third party is talking about.

MS MCMAHON: So, is it your evidence that cultural incompetence by - where it exists - by NDIS staff affects access to the scheme?

MS TURNER: Absolutely it does. Absolutely it does. And I think that my colleagues in the Kimberley will be able to give you, you know, more concrete examples about how plans are - appear to be copied, individuals' names are wrong and so on. So, Ms Bedford and -

MS MCMAHON: Yes. I will come to plans shortly. But just before I do, Ms Bedford and Ms Atchison, at 72 of your statement, you refer to the requirements of cultural awareness training for staff within the Kimberley consortium for every community that they service. And you compare the approach of one community to be like a White Card for construction.

Can you please tell the Commissioners about this particular community's approach and your views on whether or not that should be rolled out to other communities?

5 MS BEDFORD: Sure. In - from July this year, it's now a requirement for any service provider seeking permission to enter and work in the remote Aboriginal community of Ardyaloon or One Arm Point on the Dampier Peninsula to complete a cultural induction course. The course itself lasts for about 30 to 45 minutes as an induction to the cultural beliefs specific to that community, and it's delivered by community elders.

10 So, it encourages service providers to work in a culturally safe way while they are in Ardyaloon community, and it also helps service providers to navigate community and link in with appropriate people that can answer the questions that they may have about cultural issues within community. So, once the - the training is completed, the person receives an accreditation card. They must have that card with them at all times while they are in  
15 community. It's valid for 12 months, and after 12 months a refresher course can be completed for the renewal of the cultural card.

This approach is a really good one because it will ensure that any service provider entering that community understands the cultural - the cultural imperatives of working in Ardyaloon  
20 community. It's community-led and delivered by local community elders.

MS MCMAHON: Thank you, Ms Bedford. Yes.

25 CHAIR: May I ask a question about the role of Kimberley Supports within the Remote Community Connector program. I judge from your statement at paragraphs 33 onwards, and particularly paragraphs 38 through to 43, that your view is that the Remote Community Connector program is actually working well in the Kimberley. Have I understood that correctly?

30 MS BEDFORD: Yes. Absolutely. It's working extremely well. Commissioner, the strength of the program is that you've got ACCOs and ACCHOs, so Aboriginal community-controlled organisations and then Aboriginal community-controlled health services working in partnership to deliver the program. You've got local Aboriginal people who live in those specific communities are working with their communities to connect them to the NDIS.  
35

And what we've seen before the Kimberley consortium was established was that there were only about 50 Aboriginal people in the Kimberley who had an NDIS package, and this was one of the major reasons why Kimberley Aboriginal leaders developed the consortium and the approach to the Remote Community Connector Program - excuse me - the Evidence and  
40 Access and Coordination Program.

And in the last two years since the consortium was established, what we've seen with the Remote Community Connector program is that it supported around 597 people - and, you know, it's still in its very early stages, but we've had 597 people supported through the  
45 Remote Community Connector program. There have been 361 access request forms lodged, and 309 Kimberley Aboriginal people have had their access met in the Kimberley.

CHAIR: The evidence that you've just given, which I follow, is a little difficult to reconcile with some of the evidence we've heard this week that rather suggests that the NDIS is not working in the Kimberley and is not fit for purpose. And I'm just trying to reconcile in my own mind your assessment of the success of the Community Connectors program with the other evidence we have heard about the Kimberley. Do you have any insights that can help me at least reconcile the evidence that we've heard?

MS BEDFORD: I think that one of the things that is prevalent is that the remote community program is not in every community. So, it's being delivered in towns where our Aboriginal community-controlled organisations who are members of the consortium are based, and also in remote communities where the Aboriginal community-controlled health sector has clinics operating. So, it hasn't had the opportunity to extend to all parts of the Kimberley.

I think the other part is that there are challenges within our communities to promote and raise awareness around the NDIS. Cultural safety is an issue and our teams are working extremely hard to get the messages out to our families around - around NDIS and the available services. So, we don't have full coverage of the Kimberley as yet, but that's not to say that we couldn't, you know, look at that in the future if we are funded appropriately to do so.

CHAIR: Do you have a presence in Fitzroy Crossing?

MS BEDFORD: Through Marnin, we do have - we do have a presence there, but there's no Aboriginal community-controlled health service as yet in Fitzroy Crossing. We are working alongside the community in Fitzroy to develop a new Aboriginal primary healthcare service in Fitzroy so there's a lot of work to be done. And I think Emily Carter in her evidence yesterday spoke about the absence of a dedicated Aboriginal community-controlled health service in Fitzroy.

CHAIR: Thank you.

COMMISSIONER MASON: Thank you, Chair.

MS ATCHISON: Excuse me, Commissioner, if I could add that BRAMS has been delivering some services to Fitzroy Crossing. We have around 15 participants who we've been doing support coordination for, and the reason we're working outside the Broome region is that there was actually the request, and participants contacted BRAMS directly and asked us to help deliver services to them in the absence of other service providers.

COMMISSIONER MASON: Yes, thank you. Just the Community Connector program, just to clarify, the Women's Resource Centre in Fitzroy Crossing, do they run that program?

MS TURNER: Marninwarantikura?

COMMISSIONER MASON: Yes.

MS TURNER: Are you talking about Emily's organisation?

COMMISSIONER MASON: Yes.

MS TURNER: Do they have the Community Connectors?

5

COMMISSIONER MASON: Yes.

MS TURNER: Jenny?

10 MS BEDFORD: My understanding is that they do.

COMMISSIONER MASON: Do you know how long they've been running that program for?

15 MS BEDFORD: The Kimberley consortium has been in existence for about two years, and Marnin is part of that consortium.

COMMISSIONER MASON: Okay.

20 MS TURNER: If I might add - sorry, Commissioner, I might add, I mean I saw some of the evidence given by people from the Kimberley, and one was where a lady had to go to the dump to find parts for the wheelchair. So, it's the appropriateness of what sort of wheelchairs in remote communities are most effective and, you know, what people are able to get in their packages that will cover that. And - so I think that there are a lot of issues like that.

25

It's - you know, it's an issue that I will be taking up, for example, with housing authorities under Closing the Gap about building appropriate accommodation with the necessary fixtures and design of the homes to accommodate people who have to use wheelchairs or who have great mobility issues. But there are other issues, like, you know, a bed-ridden patient and having the lifts to get them in and out of bed and into showers and things like that.

30

Very limited availability of that sort of program in remote communities. And, you know, I would have to wonder whether the houses were strong enough to be able to insert that sort of infrastructure such as the lifts unless they were the portable ones, you know, that were mobile. But I'm not sure whether Jenny or Cassie are aware of any examples similar to that, that's available to our families in the - in the Kimberley.

35

COMMISSIONER MASON: Because it seems to me that the model that we're talking about in the Kimberley, there is still that requirement to map locally what's needed with those local participants. And there are limitations, as you talked, about around an Aboriginal community-controlled health service in the Fitzroy. But there - it's identified there are plans now in train, and we heard that evidence around really practical helps failing.

40

45 And so, there's the evidence of the mapping and where the gaps are and what's needed. So, I know it's an iterative process but there's a structure to create the solutions. This is what's very positive about this model.

MS TURNER: Yes. Well, I would certainly agree with that and I think that, you know, if the organisations were funded to do the mapping over and above what they're doing - because we've gone beyond - above and beyond the call of duty in relation to supporting our clients with disabilities and their families who are critical to the care of many of our people with disability.

COMMISSIONER MASON: Ms McMahon, one more question because Ms Turner was talking about the Aboriginal community-controlled model and about First Nations people in the NDIA, senior levels. But Aboriginal community-controlled organisations, indeed health organisations, they are led by boards.

MS TURNER: Yes.

COMMISSIONER MASON: Can you give us the value of an Aboriginal community-controlled organisation member-elected board and what that means for the local community around service improvement but also in monitoring transparency and the way that that community operates for its members?

MS TURNER: So because the Aboriginal community-controlled health services are established by local communities and they have a formal governance process with an elected board and a report to members at the annual general meeting every year, along with the financial audited statements and any other, you know, information in their annual report about what they have been doing for the past 12 months and how things are going, that's an opportunity for community members directly, of course, to have an input and to give feedback as to how they feel about the service delivery and what can be improved.

And they certainly don't hold back. And the regular board meetings, people are always being lobbied in the streets about particular services and how, you know, people want that to respond, and those issues are brought to the board table and to the attention of the CEO. And, quite often, they are addressed as soon as it's raised within a board meeting context. So, you know, we are accountable to the communities where we operate.

And we take that very seriously while respecting the cultural protocols and ensuring good governance and meeting all the government requirements for accountability and - and the use of public funds, as well as having this cultural connect that is respectful and - and safe for our community to utilise.

COMMISSIONER MASON: Thank you.

MS MCMAHON: Thank you, Commissioner. Ms Turner, at NACCHO's statement at 63, it says that there is a failure at a system level to recognise reputational risk of ACCHOs engaging with the NDIS.

MS TURNER: Yes.

MS MCMAHON: Can you please just explain to the Commissioners what that means?

MS TURNER: Well, there's a high reputational risk for NACCHO and for our affiliates at the state and territory level and our ACCHOs to be associated with the NDIS. NDIS itself is not culturally safe for our people, and the key reason people use our service is because we are trusted, and this is especially true in our remote areas. So, association with the NDIS - with the NDIS risks undermining that trust.

And the current processes within the NDIS make it difficult for our ACCHOs to deliver services to the high standard both they and their communities are accustomed to. And, I mean, I could give an example in terms of where it's very difficult for our people to access the scheme and our ACCHOs to support them, if you want.

MS MCMAHON: Certainly.

MS TURNER: So, many Aboriginal and Torres Strait Islander people have significant complex traumatic histories which lead them to have chronic debilitating mental health conditions. Many have not had formal psychological assessments but, rather, see the GP. This leads them down a more difficult path where they cannot apply for NDS or DSP due to insufficient evidence or specialist support.

There - this is also further compounded by the larger burden of chronic disease they experience at an early age and - but, again, they cannot apply for the DSP or NDIS as they are needing substantial specialist supporting letters. And we've seen that arise in our services. And that was example from Wuchopperen Aboriginal Health Services in Cairns. But if I could ask Ms Bedford to elaborate from a KAMS perspective.

MS BEDFORD: Thank you. Some of the reputational risks that we are facing - so, there are no local support coordinators in the Kimberley. So, any NDIS participant's given a support coordinator at the level 2 or 3 level, and those support coordinators, we know, are the gateway into accessing NDIS-funded disability services and mainstream community supports. These roles aren't based in the Kimberley. So, they can be situated anywhere in Australia, and they do a lot of their work by phone and there's no requirement for cultural awareness training.

So, that presents a massive risk to us around cultural safety. The planning process also doesn't recognise the vast distances in the Kimberley, and so those distances that our staff are required to travel aren't recognised in the remuneration that's offered within NDIS packages. And, so, what happens as a result is that our community members who have a package be then don't get the best services because of the restrictions around travel. We also see a risk around support mechanisms for NDIS participants.

Now, through the Kimberley consortium, we've developed key positions which are identified roles that are, you know, placed in community, based in community, but also work directly with our community. And they are the Remote Community Connector roles and the family support worker roles. They - these types of roles need to be embedded across all planning activities to make sure that there's someone that's sitting beside participants to make sure that the plans meet the expectations of the participant.

Having a trusted person sitting alongside a participant will make sure that those planning - planning meetings and the plans themselves actually meet the needs and the expectations of the participant.

5

MS MCMAHON: Thank you, Ms Bedford. And I might just stay with you for a moment to explore the last barrier relating to - you've heard evidence in this hearing about negative experience with government agencies. Can you share your observations of the impact of distrust, if it does exist, in your community as it relates to how people with disability in the Kimberley interact with the NDIS?

10

MS BEDFORD: Yeah, so there's a couple of examples that I could give, and I will go back to the access requirements. So, when access isn't met, the NDIA's National Access Team often don't provide adequate feedback. Yes, they send a letter and, yes, they quote the relevant sections of the Act where disability - sorry, where access wasn't met. But often times, you know, a phone call to the Evidence and Access Coordinator could actually result in additional evidence being gathered so that the participant can meet access.

15

And I will use an example that we got from one of our member services, and this was a client of theirs that - that only had one arm and didn't - didn't meet access because there wasn't enough evidence to state when the loss of limb occurred. So, this information was really critical because the definitions around the significance of the disability and - really related to when - whether the person was born without a limb or whether they lost their limb in their 20s. You know, it's a very different sort of state of play.

20

And that wasn't explained to the participant. It was just a letter that came that quoted relevant sections of the Act. And so, the reputational risk for the ACCHOs themselves was that there was a lot of distrust, not just of NDIS but also of the ACCHOs themselves in terms of making this person go through a really detailed and complex process with no - no result. And it could have been alleviated by a phone call to say, "Hey, we need a little bit more evidence around this" and it could have, you know, been a very different outcome. So, they're some of the risks that we have sort of identified.

25

MS MCMAHON: Thank you, Ms Bedford, and thank you for sharing that example. I might move to you, now, Ms Atchison. Firstly, are you seeing NDIA information or material to help participants understand the system being explained in culturally appropriate ways?

30

MS ATCHISON: No. We have very little evidence to support that the information is being communicated to our participants in a way that they can understand. And we have lots of examples of where the information and the planning process isn't aligning to the individual, their circumstances or the decisions or goals that they would like to make. And that's reflected through the plans that people present to BRAMS with.

35

MS MCMAHON: And what about in traditional language? Have you ever seen NDIS information translated or interpreted in traditional language?

40

MS ATCHISON: Not to my knowledge, no.

MS MCMAHON: Now, I just want to move on to planning. Ms Turner earlier had indicated under-utilisation of plans. From your perspective, Ms Atchison, on the ground, is that something that you're seeing with your clients as well?

5

MS ATCHISON: Yes. We are. So, there's a mixture of line items that we find people are utilising, and then there's other line items in people's plans that aren't being utilised to their full capacity.

10 MS MCMAHON: And I understand that BRAMS has undertaken some auditing in relation to plans. Can you tell the Commissioners what you've done and what you've found?

MS ATCHISON: Yeah. Sorry, I'm just going to go to my notes to make sure I've got the correct information here. So, BRAMS is obviously an NDIS provider, and a part of being a provider is we have compliance obligations in respect to internal auditing. So, every six months, we go through a process where we do an internal audit of all of our participants' files, and that includes reviewing and scrutinising the NDIS plans.

20 Our most recent audit was undertaken in May and June, and what we found was that 60 per cent of our participants had duplicate goals on their plans. So, it looks and appears that some of the goals have been copied and pasted and they don't reflect the individual. And then furthermore, we found that 10 per cent of the files, 10 per cent of our participants with plans, actually had names incorrectly recorded on them.

25 So, the participant's name at the start and details were correct, and then as you get further down the plan, we found that the NDIA have actually referred to other people or a different participant in that participant's plan.

MS MCMAHON: I see. Ms Turner, I wanted to explore a paragraph of your statement now, and that's at paragraph 60. Sorry, not of - where you quote in that statement from a submission to the Royal Commission and you say this:

35 *"The needs, situation and cultural of Aboriginal and Torres Strait Islander people were not taken into consideration when developing the NDIS, resulting in a system that creates accessibility and service gaps at best, and exploitation at worst for Aboriginal and Torres Strait Islander people."*

In what ways does NACCHO consider exploitation has or may occur?

40 MS TURNER: Well, part of the problem is that the NDIS is structured as a business. And this is how the department first pitched it to me when they came to see me. "A great business opportunity", they said, "Pat. You can make a lot of money out of this. And charge people to provide services for their plan - from their plans." But our model of care and the way our ACCHOs operate is to respond to the person and their families and do what's needed to get them to a better space. It's not about making profits.

45

Any money, of course, that we do get in terms of Medicare revenue that we earn is reinvested in the delivery of comprehensive primary healthcare, which is all-embracing, as we have explained. So, we don't accept - and our services don't accept that the NDIS - the NDIS as a money-making proposition. We're not interested in making money; we are  
5 interested in providing the right level of service at the right time to each person. And if our services make any money, as I said, we reinvest it into expanding our services to community.

But for mainstream providers, they're focused on service delivery as a business, it appears, which means cultural safety is viewed through a cost lens rather than being seen as critical  
10 to ensuring clients can access the support they need. Our observation is that little monitoring of cultural competency of existing providers for Aboriginal and Torres Strait Islander people on plans occurs, and it's certainly not a compulsory KPI within the regulatory environment for providers.

15 The current model devalues the rights of Aboriginal and Torres Strait Islander people with a disability, and this permeates through the organisations who they are entrusted to support them. So, that's been our observations and experience to date.

MS MCMAHON: Thank you. Now, just before I move on to matters looking to the future, I  
20 just wanted to ask - and I might go, perhaps, to Ms Bedford. What's your view in relation to funding family members to provide disability supports by the NDIS?

MS BEDFORD: Look, I think a lot of our families are actually providing the support through  
25 our relationships and our cultural obligations. You know, families will provide the support and not be paid for it. So, from a KAMS perspective, we are very supportive of that happening. I think there needs to be greater supports embedded. When we look at the model of care, we talk about a family and a person-centred approach. So, it makes sense to us that families are supported and paid for the work that they are already doing.

30 MS MCMAHON: What about NACCHO, Ms Turner? What's their view on -

MS TURNER: Absolutely. Absolutely, NACCHO supports family members who provide  
35 support to disabled people in their families. They have to be paid. Their support is taken for granted and so much of what they have to do is taken for granted. It's hard enough, living in poverty, as most people are reliant on income support, let alone have the additional work and effort that has to be put into caring for a person with disability, in whatever form that comes.

40 So, it's always falls back on the family and there will be, you know, particular people within the family that will fulfil that responsibility and that role, and they should be paid. It's a job. And it's got to be recognised as such. Especially when we've got so many of our people reliant on income support.

45 MS MCMAHON: Do you see any challenges with regards to the funding of family members by the NDIS?

MS TURNER: I would think that the benefits would outweigh the negatives.

MS MCMAHON: All right.

CHAIR: What are the negatives?

5

MS TURNER: Well, it could cause jealousy among the family members, who's - one's getting paid and other's not. But that shouldn't be a reason not to pay for the work being done.

CHAIR: There would have to be rules, wouldn't there?

10

MS TURNER: Well, you pay the person who's doing the work.

CHAIR: Yeah, but there have to be rules, don't there, as to how much work they do, how much work they're going to be paid, what accountability there is, and that creates the risk, doesn't it, of intervention by outside authorities, not necessarily First Nations authorities.

15

MS TURNER: Sure. Sure. Well, I'm sure that - if people are on the payroll, they're answerable, you know, to their employers. There could be a system developed whereby they've got a network of staff who are family members, with an organisation assisting them to do the proper, you know, time of hours worked recorded and so on, and monitoring their support to make sure that they're coping and they're able to continue to provide that intimate support within the family.

20

MS MCMAHON: Now, just moving on to issues of reform and change, Ms Turner. If I could ask you first, NACCHO has set out 22 recommendations in their capacity-building report that was commissioned by the DSS, I understand.

25

MS TURNER: Yes.

30

MS MCMAHON: Has NACCHO been consulted in relation to those recommendations or informed as to which, if any, are to be implemented in any formal or informal discussions?

CHAIR: Ms McMahon, are we able to find those recommendations?

35

MS MCMAHON: It's in the capacity-building report in the final pages of that report.

CHAIR: And that's tab -

MS MCMAHON: Just give me one moment.

40

CHAIR: Yes, 85. Thank you.

MS MCMAHON: Thank you, Commissioner Mason.

45

CHAIR: Right.

MS MCMAHON: Yes, please, if you can -

MS TURNER: So, the NDIS Ready program was a result of the capacity-building report. That was done in 2019. The Department of Social Security cherry-picked four recommendations out of the 22 to fund through the program. NACCHO has not been consulted about the remaining 18 recommendations and funding of these from either NDIA or DSS.

MS MCMAHON: Thank you. Ms Bedford and Ms Atchison, and perhaps Ms Turner as well, is it fair to say that your organisations agree that it's critical that the NDIS must support flexibility, local solutions, and building of First Nations workforce?

MS TURNER: Well I might go first, if that's already all right. Yes, an effective Aboriginal and Torres Strait Islander workforce is essential to underpin the strong community-controlled sector. And our Aboriginal health workers and health practitioners are the heart of our ACCHO workforce, and they are skilled valued and trusted members of our teams and in local communities. And they have accredited training.

Already, they are caring for clients with disability who in, many cases, are older Australians. This is especially true in remote setting where it is already difficult to find specialised workers. To effectively support growing demand, we need to leverage the current ACCHO workforce and draw from local communities to build the multi-disciplinary care workforce that includes both cultural and clinical experts.

So, upskilling, retraining and utilising the existing workforce and creating workforce pathways to build capacity is the key to success. However, it must be remembered that ACCHOs are foremost comprehensive primary healthcare providers. In addition to frontline workers, we need to build the workforce capacity of our sector to become leading providers of NDIS services for our people.

MS MCMAHON: Thank you, Ms Turner. Ms Bedford or Ms Atchison, are there any specific reforms that you would like to tell the Commissioners which are key to your services?

MS BEDFORD: Can I just - if I could go first, I would just like to strongly agree with Ms Turner's comments and just say that Kimberley consortium, in developing our Kimberley Supports programs right across the region, used the ACCHS model of care to frame the services, but also to ensure that our services are delivered in a culturally safe way. Critical to cultural safety is Aboriginal workforce, and what we see with our Remote Community Connectors, with our Aboriginal health workers, with our family support workers is that their lived experience and their intimate knowledge of communities makes sure that they are able to walk alongside members of our community who are living with disability and - and frame the service delivery approaches to support our community living with disability.

Investment is needed into the ACCHOs and the ACCO sector, and what we see where we're delivering services in thin markets is that the ACCO and the ACCHOs sector, as framed in the Kimberley Supports consortium, needs to have its potential realised through long-term rolling funding contracts.

MS MCMAHON: And I just wanted to ask you, Ms Bedford - and it's probably self-evident, but is it the case that many of the communities that you're working in have thin or failed markets?

5 MS BEDFORD: Yeah, we - you know, in a lot of the remote communities that we have a - we have a presence, you know, the clinic is, you know, one of the only service providers that operate within community. You know, the fly-out fly-out - fly-in fly-out model doesn't work in remotes because it doesn't allow service providers to develop relationships built on trust. We have to have service providers here in Kimberley delivering services to our community,  
10 and that ensures that those surfaces and programs are culturally safe.

MS MCMAHON: Thank you, Ms Bedford. And, Ms Atchison, was there anything further you might tell the Commissioners this afternoon in terms of issues or recommendations?

15 MS ATCHISON: I would just like to add that the NDIS program has made a significant difference for our participants in Broome, and it does come with its challenges. And I guess, just from our journey, we started to be a registered provider in 2020. Our board of directors invested some of our own funds that we generated through our primary healthcare clinic to becoming a registered provider and to cover our start-up costs.

20 And, from our perspective, we've had a really - made a really good effort into delivering a really good NDIS program. We employ 14 full-time staff. We have over 110 participants. But given all of the work that we do and everything else, that we still don't operate in surplus, we actually operate in a deficit in our NDIS program. And we put money into our NDIS  
25 program to keep it operating. And that again is a commitment from our board of directors to fill that gap.

But given how big the scheme is, and all the different sort of modelling work, I think that further work does need to occur around the funding model, the price guide, the line items.  
30 Because, currently, there's sort of no flexibility in some of those line items, whereas we find we need a level of flexibility, and there is some things that we provide that are outside of our scope. There are some strengths with the NDIS and it has been a really good program, but there's further work that needs to be undertaken to encourage and empower ACCOs to be able to deliver the service without having to constantly having to worry about how we're  
35 going to cover costs for certain things in the organisation.

MS MCMAHON: Thank you, Ms Atchison. And, Ms Turner, just - I want to ask you about the National Closing the Gap agreement, but before I do, I just wanted to ask you - give you the opportunity for any particular recommendation or changes that you think should be made.  
40 If you could please tell the Commissioners?

MS TURNER: Well, I think that further engagement between NDIS and our sector, and recognition of the fact that we're subsidising the delivery of their program and responsibilities, and we can't continue to do that. You know, we've got so many demands in  
45 terms of managing chronic patients and with multiple illnesses, and so many other areas, because comprehensive primary healthcare enables our services to advocate across the

board about the overall living conditions for our people and to bring those, you know, facts to the attention of government to try to get an improvement in the living circumstances.

5 And we just can't keep on subsidising these new programs to ensure that they're getting the reach that they should. But the reach certainly needs to be improved. So, there has to be cooperative work. We've run yarning circles. NACCHO has organised for our people and our staff and who work in the field in these areas to come into a central location like they did in Darwin. We invited DSS and NDIS - NDIA to come along and listen, and they were very grateful for the opportunity to hear first-hand from the people in the field about their experiences and how things could be improved.

10 So that's been our initiative. And it's something that we do very well. We are very conscious, as a national body, that we have constant interaction with our membership base. And so we know what's going on within each of our services around the country and what's important to them. So, I'm hoping that there's a more productive relationship between NACCHO and the NDIS. And I would like the Social Security and the NDIA to sort out their roles and responsibilities so, you know, we are not having to answer policy questions for this mob and then, you know, program questions to that mob.

20 They can sort out their own internal communications. Our job is to represent the interests of our clients, our people, and we need to negotiate much better funding arrangements.

MS MCMAHON: Thank you. And as I said, just finally, I wanted to ask you how could the National Closing the Gap Agreement be strengthened to improve outcomes for First Nations people with disability in remote and very remote communities?

30 MS TURNER: Yeah, sure. Look, I think it is important to say, when we're talking about Aboriginal and Torres Strait Islander people, that you remember that our people have been learning and implementing cultural practices successfully and had highly functioning societies well before there was a western construct of a department or a policy. The transference of power to Aboriginal and Torres Strait Islander organisations and communities is required to enable our people to take the lead in decision making and the design and delivery of programs and services to meet our people's needs.

35 Genuine partnership and self-determination need to be at the forefront when designing new policies and programs and services to support the development of Aboriginal and Torres Strait Islander people to truly acknowledge us as the First Peoples of this modern nation and to build on and recognise our strengths. The National Agreement signals a new direction and is a commitment from all governments to fundamentally change the way they work with our community, organisations and people.

The government has got to give as much effort and investment to the National Agreement in its first term as it does to the work it's doing on the Uluru Statement from the Heart.

45 MS MCMAHON: Thank you, Ms Turner. That completes the evidence, unless there is any questions from the Commissioners.

CHAIR: Thank you very much. Commissioner Mason, do you have any questions?

5 COMMISSIONER MASON: Yes. Ms Turner, I was interested in the questions you flagged about the - about DSS and the NDIA and the running of policy and the running of programs and working that out. Can you give the Commission an example of what you've experienced or seen in relation to this situation?

10 MS TURNER: Well, just where DSS is ringing up asking us, you know, whether we've done a comprehensive assessment. "No, you haven't funded us to do that." And so on. I mean, they should already know that, as far as I'm concerned, what we've been funded for and what we haven't been funded for. So, there's been a bit of a scramble of late, I think, in DSS to catch up. Maybe with evidence that's coming out of the Royal Commission, I don't know.

15 But, generally, when you've got an agency, a statutory body like the NDIA, that has a particular remit to provide services to the Australian people who are eligible for those services. And you have a portfolio department that handles all the policy and advises the government directly. So, there has just been a bit of confusion about who are we answering here of late, with some of the questions that have come from the department or - you know, in the main, I think it's been from Social Security rather than NDIA.

20 COMMISSIONER MASON: In the previous session, we heard from the First Peoples Disability Network, and the CEO Damian Griffis often referred to power sharing, and you've mentioned that in your evidence this afternoon, transfer of power. Can you give the Commission a sense of what this word means, how it's - why it's being used now in relation to the NDIA and the way that it could potentially work better with First Nations organisations and leaders and the population, actually. What does that really mean? Because it's a word that hasn't been used in the Commission in terms of hearings to date. So, I'm really interested in why it's being used in this context.

30 MS TURNER: Well, you know, I was pretty cross that we weren't consulted in the first place about the NDIS and the special needs of Aboriginal and Torres Strait Islander people. And then to be approached by, you know, the Department of Social Security, senior officials from the NDIA, senior officials from Health Department and NIAA, coming into my office and say, "We've got a profit-making proposal for you and your sector, and we know that you're the best placed sector to deliver on the NDIS, and you can make a lot of money out of this."

35 And I said, "No, that won't work. That's not the way we operate. That will not work. This is what will work, is if you, you know, co-design the service delivery with us, in genuine partnership and we work out together, utilising our local services like KAMS and BRAMS, as an example, to bring their expertise to the table and say, 'This will work in the Kimberley. This will work in the Pilbara. This will work in Central Australia.' You know, and so on and so forth."

45 I think that they're catching up now. They realised that consultation has to occur through us, and I'm pleased about that. But, you know, I'm not really in favour of too much consultation. I want to negotiate an outcome that is going to improve the life circumstances of our people. So, we're interested in the implementation of the four priority reforms I spoke

about earlier. And when I talk about the transference of power, I mean, you know, bureaucrats have a responsibility to deliver the programs they administer.

5 And those programs are supposed to benefit everybody who is eligible for them. If our people are eligible for them, they shouldn't have to jump through hurdles - as many hurdles as we have had to get access to the programs. We've to make it as smooth and as assessable as possible, and we know all the extras that you've got to put in to get that access. But it's important that our people do have that access. Therefore, the power sharing that Damian referred to or the transference of power has to occur in those negotiations  
10 between the NDIA and, say, for example, NACCHO.

Because we will bring our members in and we will have a fully informed view - and work through overcoming the barriers and to get a much better outcome for the daily lives of our people on the ground. Even things like, you know, how do we get more prompt repair of  
15 wheelchairs in remote areas? You know, we've got to think about practical - practical barriers that our people are facing every day and how to overcome them. And we're capable of doing that if we're given the time and the respect of the engagement and, of course, you know, a fair share of the budget to deliver services in a very high-cost environment in remote and very remote.

20 COMMISSIONER MASON: Thank you.

CHAIR: Commissioner McEwin?

25 COMMISSIONER McEWIN: Thank you. I wanted to ask either - or all of you about technology. You made the point earlier that platforms like video conferencing, Zoom and so forth, cannot replace the critical importance of face-to-face. Putting that to one side, what investments would you consider important to improve the way you do your work when we consider things like telehealth and other emerging, I suppose - you know, technology-based  
30 solutions. Is there anything that would help you in particular in the work you do in the remote communities?

MS TURNER: I will answer that and then I will go to Jenny, if also that is right. So, we used telehealth during COVID, and we had to talk to the bandwidth pride providers to broaden  
35 the bandwidth to enable us to have the access because of the poor access for telecommunications in remote areas. So, we did that ourselves, and we utilised telehealth very effectively during COVID. There are some mechanisms now that are being adopted by KAMS, and I can get Jenny to explain them. With the NDIS it's a bit more complicated, I think. But I will ask Jenny to give her views first and, if I need to, I will add after Jenny.

40 MS BEDFORD: Thank you. Look, I think face-to-face is always the preference, but as Pat mentioned, what we saw during COVID was an increase in telehealth consultations. And they seem to work pretty well. Community seemed very comfortable using telehealth as a means to see doctors that were Broom-based but also, you know, saving a trip down to the  
45 city for specialist appointments. The challenge that we have is that, in some remote communities, they don't have access to the internet.

5 So Balgo Community, for example, has only got access to 3G, whereas the other two communities in the Kujungka region, the other two desert communities of Billiluna and Mulan, have access to 4G. So, in terms of, you know, the delivery of primary healthcare and emergency care in particular, we really struggled to increase our emergency telehealth service, for instance, in Balgo because we don't have access to, you know, the necessary internet which would support that.

COMMISSIONER McEWIN: Ms Atchison, did you want to add anything to my question?

10 MS ATCHISON: I would support Pat and Jenny's comments about telehealth. And specifically last year, BRAMS had a telehealth project which was for primary healthcare. But it should be noted that telehealth, even when we do a telehealth consultation, we still have an Aboriginal health worker with a patient to engage over the telehealth. So, although telehealth concept is really good, you still need to attach a local person with the individual  
15 so they can help the person people feel comfortable, they can help interpret and those sorts of things.

20 So if they are thinking about the infrastructure from an IT perspective, that is good, because there's sometimes where services can't come up, all the specialist services and things like that, but you still need to have that face-to-face person to help the individual navigate the telehealth process.

COMMISSIONER McEWIN: Thank you, all of you, and thank for the important work you are doing for your community. Thank you.

25 CHAIR: Ms Turner, much of what we've been talking about this week and much of what we've been talking about during this session involves resources and support from, presumably, the Commonwealth and maybe states and territories. In the document that NACCHO produced "*Core Services: An Outcomes Framework*", page 3, it talks about the revenue sources for ACCHOs, saying they're diverse, including block grants from Health, Medicare billings and so forth. Where does one find a comprehensive analysis of sources of  
30 finance and what the expenses are? Is there a consolidated set of accounts for all NACCHOs, or is each NACCHO - does it produce separate financial statements?

35 MS TURNER: Yes.

CHAIR: They each produce separate financial statements.

40 MS TURNER: Every - the 145 Aboriginal community-controlled health services funding - funded directly by the Commonwealth Department of Health. They are legally incorporated organisations, and they all have to produce an audited financial return. And - so, that would be held by the corporation governance body as well as the department. There was a bit of a scare - for me, anyway - a couple of years ago when the Department of Finance wasn't going to require audited financial statements from organisations anymore.

45 And we certainly raised our concerns with them and the Commonwealth Department of Health because, in my experience, checking the audited financial returns is an early warning

sign if there are problems starting to emerge in an organisation. So,, I have always regarded it as a safeguard to have that in place. But every ACCHO is funded individually. The Commonwealth Department of Health, the Indigenous Health Program would have a record of the revenue that they provide.

5

In some instances you will have input from State Governments but, you know, that is - that has not been the norm. Only when they want something particular done. And - although Victoria seems to be extraordinarily generous, the Victorian Government. I can't say the rest - the same for the rest of them. And, yeah, so that's - and, you know -

10

CHAIR: So, does that mean that each ACCHO makes an individual application to the relevant funding body?

MS TURNER: Yes, yes.

15

CHAIR: So there are 150-odd applications.

MS TURNER: 145.

20

CHAIR: 145.

MS TURNER: Funding agreements.

CHAIR: Each individually assessed, presumably?

25

MS TURNER: Yes, yes.

CHAIR: And what's your role, in determining, if there is any - if there is any role, in determining allocation among NACCHOs. Presumably - ACCHOs - no role.

30

MS TURNER: No.

CHAIR: And so you get funding for, as it were, the national activities directly to you?

35

MS TURNER: That's right. So, what we get funded for is our core business, which is to support or membership base and to encourage, you know, the development of full comprehensive primary healthcare service delivery to our people to encourage good quality control. We have developed the Core Services Framework which we are now costing with our members. That will give us - because we've been having this funding needs debate with the department since I've been at NACCHO.

40

We had a major breakthrough with the four-year rolling funding this year, but we need to get needs-based funding, and we have just recently commissioned a report from Equity Economics that showed that the funding for the Aboriginal community-controlled health sector is \$4.4 billion underfunded. 2.8 of that comes from the Commonwealth, and 1.6 from the states and territories, who should be contributing - given the level of chronic disease

45

that we carry and - and the service - and the funding that's provided for mainstream primary healthcare compared to us, there's a \$5,000 gap per head.

5 CHAIR: Thank you very much. I will just pause for a moment to see if there is any application to ask any questions. Normally, the pause is very brief, as it is in this instance. In that case, thank you very much, everybody, for giving your evidence and for your contributions in writing. And also I echo the comments of Commissioner Mason and Commissioner McEwin thanking you for the work you do, in particular, in the remote areas that we're concerned within this hearing. So, thank you very much. We very much appreciate your contributions to the work of the Royal Commission. Thank you.

10 MS TURNER: Thank you, Mr Chairman.

15 MS ATCHISON: Thank you.

MS MCMAHON: Chair, Counsel Assisting would be assisted by a five-minute break.

20 CHAIR: Yes, it's now nearly - or 10 past, so let's be generous and come back at 20 past. Shall we?

MS MCMAHON: Thank you, Chair.

CHAIR: We're going to start with the panel from the Commonwealth, the NDIA.

25 MS MCMAHON: That's right.

**<THE WITNESSES WITHDREW**

30 **<ADJOURNED 3:09 PM**

**<RESUMED 3:22 PM**

CHAIR: Mr Griffin.

35 MR GRIFFIN: Commissioners, I call Scott McNaughton and Kitsa Papadopoulos to give evidence. Both are present in the witness area. Commissioners, can I indicate that a statement from Ms Papadopoulos dated 14 June 2022 appears in Hearing Bundle B, tab 18, and associated documents in Hearing Bundle B, tabs 19 to 30. For the record, the statement bears the identification number STAT.0552.401.001. Mr McNaughton has also provided a statement to the Royal Commission, dated 15 June 2022, appearing at Hearing Bundle B, tab 40 1, with associated documents at Hearing Bundle B, tabs 2 to 17. For the record, the identification number is STAT.0553.0001.0002. As you will be aware, Chair, the witnesses will be giving joint evidence, and I ask that they be sworn or make an affirmation.

45 CHAIR: Yes, thank you. Thank you, Mr McNaughton, for returning to the Royal Commission. I'm sure you very much enjoy your repeated journeys to the Royal Commission.

MR McNAUGHTON: Thanks for having me back, Chair.

CHAIR: Ms Papadopoulos, thank you too for coming to the Royal Commission to give evidence. Thank you both for the detailed statements we have received. If you will be good enough to follow the instructions of my associate, located around the corner there, she will administer the oath or affirmation, as the case may be.

**<SCOTT McNAUGHTON, AFFIRMED**

10 **<KITSA PAPADOPOULOS, AFFIRMED**

CHAIR: Thank you, Mr McNaughton. Thank you, Ms Papadopoulos. And now I will ask Mr Griffin to ask you some questions.

15 **<EXAMINATION BY MR GRIFFIN SC**

MR GRIFFIN: Mr McNaughton and Ms Papadopoulos, do you mind if, from time to time, I refer to you by your first names?

20 MS PAPADOPOULOS: That's fine by me.

MR McNAUGHTON: Yes, fine

25 MR GRIFFIN: And can I indicate my approach to asking you questions will be to try to nominate who the question is directed to, but on the basis that if the other person wishes to add further comment or an answer, please feel free to do so. Don't wait for me to come back and ask individually the same question.

MS PAPADOPOULOS: Sure.

30

MR GRIFFIN: Firstly, Ms Papadopoulos, this is the first time you've provided evidence to the royal commission; is that correct?

MS PAPADOPOULOS: Correct.

35

MR GRIFFIN: And, as I mentioned, you've provided a statement. Is that statement true and correct to the best of your ability?

MS PAPADOPOULOS: Yes, it is.

40

MR GRIFFIN: And, Mr McNaughton, as the Chair just indicated, you are a frequent flyer before this Royal Commission. In respect to your statement, is that true and correct?

MR McNAUGHTON: Yes, it is.

45

MR GRIFFIN: Can I come to you first, Ms Papadopoulos. You say in your statement at paragraph 9 that you're the Branch Manager, Market Intervention and Commissioning, for the NDIA. What does this job involve?

5 MS PAPADOPOULOS: The Market Intervention and Commissioning Branch is part of Provider and Markets division at the NDIA. The division is responsible for the markets stewardship of the NDIS market to ensure that there is effective supply of supports for people receiving NDIS plans. My branch in particular looks after a few areas. One of the areas that we are responsible for is market development projects.

10 So we monitor markets across the NDIA on a geographical basis and we identify markets where it appears that participants are not receiving the supports that they need, which might be because of low supply or it could be because of other issues in that particular place. We prioritise markets for what we call market intervention, which is a process of going in and understanding the issues that might be at play in that particular place and designing a response and implementing a response to lift utilisation of plans and ensure that people are receiving the supports that they need.

15 In addition to that, I lead markets stewardship of the support coordination markets. So, that means that I monitor the overall support coordination market in Australia, and I also lead market stewardship of the plan management market.

MR GRIFFIN: How long have you been in your current role?

25 MS PAPADOPOULOS: Close to two years now.

MR GRIFFIN: And what relevant experience and qualifications did you bring to your current job?

30 MS PAPADOPOULOS: So I have a Bachelor in Economics - Social Science with Honours and a Master's of Business Administration. I have worked in State Government in New South Wales for most of my career, a long time in New South Wales Treasury, mainly working through customer-focused service delivery-type of work, also in regulatory reform. After New South Wales Treasury, I worked in the Department of Communities and Justice in New South Wales, and for quite a few years I had a focus on commissioning of services which - which really means how can we drive a more customer-focused approach to service delivery in government.

35 MR GRIFFIN: Mr McNaughton, can I ask you similar questions. Can you briefly outline your current position and what that entails?

40 MR McNAUGHTON: Yeah, sure. My current role is the General Manager of our National Service Delivery division. So, I look after all of the state and territory office networks. I also look after our Access and Eligibility Branch, as well as our Complex Support Needs Branch, and I also have responsibility for our Connector Program.

45 MR GRIFFIN: And how long have you been in this position?

MR McNAUGHTON: Approximately two-and-a-half years as well, coming up just over two-and-a-half years.

5 MR GRIFFIN: And were you at the NDIA prior to this position in another role?

MR McNAUGHTON: Yes, I was. I have been in the NDIA for approximately eight years and have undertaken various roles at both the branch manager level and now a general manager level.

10

MR GRIFFIN: And very briefly, in terms of qualifications and experience prior to joining the NDIA, what did you do?

15

MR McNAUGHTON: Academically, I have a Master's of Business and also a Master's of Public Administration. Prior to joining the NDIA, I was with other Commonwealth agencies and departments, such as Services Australia, Department of Social Services, Family Community Services, and Indigenous Affairs.

20

MR GRIFFIN: Ms Papadopoulos, in paragraph 40 of your statement, you provide an overview of what's called the Modified Monash model. Can I ask that a map be brought up on screen indicating the various categories under that model. Do you have that map on the screen which is in your statement?

25

MS PAPADOPOULOS: Yes.

MR GRIFFIN: You will see that there are different colours on the national map. Broadly speaking, are there seven categories under the Monash model, from 1 to 7?

30

MS PAPADOPOULOS: That's correct.

MR GRIFFIN: And is category 6 a remote area?

MS PAPADOPOULOS: Yes.

35

MR GRIFFIN: And category 7 is a very remote area?

MS PAPADOPOULOS: Yes.

40

MR GRIFFIN: In terms of that map, a light off-yellow colour is a category 7?

MS PAPADOPOULOS: That's correct.

MR GRIFFIN: And the grey area, which is either in the middle of that colour or at its perimeter, is category 6?

45

MS PAPADOPOULOS: Correct.

MR GRIFFIN: Do you know how many communities in total within very remote and the remote area the NDIS deals with?

5 MS PAPADOPOULOS: I think it's between 100 and 200, but I'm not quite sure of the exact figure.

MR GRIFFIN: And in your time at the NDIA, have you visited any very remote community?

10 MS PAPADOPOULOS: No, I haven't.

MR GRIFFIN: Have you visited a remote community?

MS PAPADOPOULOS: I have in my previous roles.

15 MR GRIFFIN: What was the extent of your visitation of remote communities in the previous roles?

MS PAPADOPOULOS: It was in my role at the Department of Communities and Justice in New South Wales, and I visited Broken Hill and Wilcannia.

20

MR GRIFFIN: But you haven't visited a remote community as a result of your current employment with the NDIA?

MS PAPADOPOULOS: No, unfortunately, travel has been hard during COVID.

25

MR GRIFFIN: Mr McNaughton, can I ask you a similar question. In your time at the NDIA, have you visited any very remote communities?

30 MR McNAUGHTON: Yes, I have, Counsel. I had the fortunate opportunity to visit quite a few communities. Palm Island in East Arnhem Land. I have been to Galiwin'ku, Yirrkala, Nhulunbuy. I have been out to Hermannsburg up in the Central West. Stretching my mind here. Some others in South Australia - Yalata. Yarrabah, out of Cairns. So, a few. Can I just say, mainly I visited as a visitor, daily. I haven't lived or immersed myself in those communities, but I have visited many and had the privilege to do that.

35

MR GRIFFIN: You pre-empted my next question.

MR McNAUGHTON: Sorry.

40 MR GRIFFIN: When was the last occasion you visited a very remote community?

MR McNAUGHTON: Pre-COVID, obviously, unfortunately, my last. And that was a trip out to Hermannsburg. And before that, I was in Palm Island in May 2021 in the middle of lockdowns.

45

MR GRIFFIN: Can I ask you both in turn, have you had the opportunity to read the statements of the witnesses that have given evidence in this public hearing this week?

MS PAPADOPOULOS: Yes.

5 MR McNAUGHTON: Yes, I have. And I've been here for most of the hearings so been able to hear them firsthand too, which has been really insightful.

MR GRIFFIN: I can tell you have been before the Royal Commission before, Mr McNaughton, because, once again, that was my next question.

10 MR McNAUGHTON: Quite.

MR GRIFFIN: You've either been here in person or otherwise followed the evidence this week?

15 MR McNAUGHTON: Yes, I have. I arrived Monday.

MR GRIFFIN: And Ms Papadopoulos?

20 MS PAPADOPOULOS: I arrived on Wednesday afternoon and have been, yeah, watching the hearings since then.

25 MR GRIFFIN: Ms Papadopoulos, at paragraph 86 of your - sorry, Mr McNaughton, at paragraph 86 of your statement, you say that all staff and NDIS partners are required to complete a mandatory E-learning module called Celebrating Diversity: First Nations Cultures. Firstly, can I understand what is meant by the term "NDIS partners"?

MR McNAUGHTON: They're our local area coordinator partners and our early childhood partners.

30 MR GRIFFIN: And can you describe briefly to the Commissioners what that educational module which I just referred to involves?

35 MR McNAUGHTON: It's an online learning module. It's based on an introductory module into cultural competency - cultural awareness it's often referred to also. It's built on the back of the SBS program and contains a lot of insightful videos around the history of First Nations people since colonisation, goes through Stolen Generation, the impacts of those, and the consequential impacts that many First Nations people have suffered. They are very insightful videos.

40 And then it talks about - the videos have a whole series of interviews with First Nations people and their own experiences in community, at work, at sport, and, yeah, so it's a good program. I think, as Pat Turner said earlier, you don't do a 45-minute E-learning program and you become culturally competent, and we all certainly agree with that. But it is a really good first introductory learning activity for all of our staff.

45 MR GRIFFIN: And do I take it that all staff of the NDIA are required to undertake that education in that module?

MR McNAUGHTON: Yes. It's what we - we have a series of E-learning modules. Some are mandatory and some are non-mandatory. And we make that one, like many others, mandatory.

5

MR GRIFFIN: I appreciate your observation that, in my words, it's a first step. Do you, within that module, have a way of testing the understanding of the people that have viewed it?

MR McNAUGHTON: Well, the actual E-learning itself has an online survey at the end that you have to complete to successfully pass it. But - so that's the way in which you self-identify that you've been able to pass that as an E-learning concept. Other than that, there isn't any follow-up necessarily that we do specifically around that.

10

CHAIR: What happened to the 10.5 per cent of staff that haven't done the compulsory course?

15

MR McNAUGHTON: Chair, they are the ones that we continue to chase down to make sure they do.

CHAIR: What do you threaten them with?

20

MR McNAUGHTON: We just try and encourage them strongly that they should do it within a reasonable time.

CHAIR: So it's sort of semi-compulsory?

25

MR McNAUGHTON: Well, it is something I go back to - well, the agency goes back to all their managers and we've - there is a range of other mandatory learnings that's we also get them to do.

30

MR GRIFFIN: It's not a huge commitment in time.

MR McNAUGHTON: Well, as I said, it's the start. It's the start. It's actually quite a new product, and we have been thinking about what's next and what might be more of a curriculum that's more role-specific for people. So, for our remote planners, who are out in community all the time, we expect a higher level of cultural competency. So, what's the next level of curriculum for people in those roles in the agency, versus someone who might be in an enabling team or a corporate team who may have less involvement with First Nations people or communities.

35

MR GRIFFIN: So if somebody was in a back room in Geelong doing data processing as a purely clerical job, there would be less urgency, in your mind, to make sure they have undertaken the work?

MR McNAUGHTON: What we would like them to do is complete the mandatory module, and part of what the mandatory module does is, essentially, hopefully start a journey - a

40

45

learning journey that individuals will continue to self-service and knowledge, and that's a really important flavour for it as well.

5 MR GRIFFIN: How does the NDIA satisfy itself that the partners, referred to in the statement, have also undertaken that training?

10 MR McNAUGHTON: So as part of that partnering in the community contracts, any mandatory training, whether that be E-learning or face-to-face delivered project, the partners have to report their progress against the completion of that, and our contract managers follow that up with the partners.

15 MR GRIFFIN: You also indicate in your statement, Mr McNaughton, that you have a role of Indigenous Champion within the organisation. Am I correct in understanding that in order to be eligible to assume that role, you have to be at a certain level of seniority within the organisation?

20 MR McNAUGHTON: Counsel, we have three Champion roles in the agency. We have the Indigenous Champion, we have a Disability and Inclusion Champion, and we have the LGBTIQ+ Champion. They are all SES or senior executive service levels to do that role, and, primarily, that's to give the role a sense of - I guess status, importance. It brings with it other activities on top of my general manager role. So, I will champion our NAIDOC Week activities, our National Reconciliation Week activities. It also allows me, within my general manager role and with my SES colleagues, to be able to champion their cultural awareness and inclusion within their groups.

25 MR GRIFFIN: And your role extends beyond - within the NDIA, it also involves dealing with other agencies and organisations in an almost network of such people. Is that right?

30 MR McNAUGHTON: That's correct. There's a network of Indigenous Champions across Australian public sector agencies.

MR GRIFFIN: Someone who hadn't had the benefit of that explanation might ask the obvious question: Why isn't an Indigenous person in that role?

35 MR McNAUGHTON: It's a very good question. When I was first asked to take the role on two-and-a-half years ago, I thought long and hard about it, given I don't - I'm not Indigenous, I don't identify as being Indigenous. We don't and we didn't at the time have any senior executives who identified as First Nations in the agency. I was asked to do it because of my role in managing service delivery and the Connectors branch, but also, I have some background and quite a lot of interest in Indigenous affairs. So, it was a bit of a passion of mine as well.

40 MR GRIFFIN: Does the NDIA have any process in place at the moment to try and encourage the representation of First Nations people in senior management of the organisation?

45 MR McNAUGHTON: It's an area that we need to do more in. We've got a strong First Nation employment program for non-SES levels. In fact, we're about to announce our new strategy

that's been developed - co-developed by our First Nation Employee Network. But, at this stage, we haven't successfully been able to recruit recently any First Nations people into senior roles, but it is something that our executive team are looking very hard and deeply at.

5 MR GRIFFIN: It doesn't quite answer the question I think I was asking. Do you have a process in place to try and get First Nations people into senior management?

MR McNAUGHTON: Do you mean in - identified measures like - and specifically roles?

10 MR GRIFFIN: I will give you a particular example. You can endeavour to achieve more diversity simply by advertising and seeing who makes application. You can also endeavour to do it by trying to identify and target people you believe might be of great use to your organisation with sufficient support and training to achieve senior management level. Given those sort of spectrum of approaches, I understand you to say you're keen to have more  
15 diversity. My question is what are you actually doing to achieve it?

MR McNAUGHTON: It is definitely an area that we have to probably do some more targeted recruitment to, as you suggest. We recently did that as part of an affirmative measures position for our inclusion - Disability and Inclusion Champion, where it was an identified role  
20 that the person had to be a person with disability. So, it is something we've done recently in other roles. It's clearly an area that we need to do more in to get more senior people in as First Nations executives.

MR GRIFFIN: Before I leave this topic, has the NDIA considered removing the barrier of SES status in order to get a First Nations person into that Champion role? In other words, it  
25 could be someone at a lower level of the organisation in terms of its structure?

MR McNAUGHTON: Yes, we have. In fact, we've got two or three incredibly strong, passionate and intelligent First Nations people coming through our ranks at the executive  
30 level 2, or the director level, who I think are very, very close to being able to take that mantle, but actually to grow through the agency and become SES officers in their own rights anyway. So, there are some fantastic people coming through the ranks that I think are very close to that.

35 CHAIR: Is the LGBTQI Champion - does that person identify as such?

MR McNAUGHTON: Yes, they do.

CHAIR: It would be a bit silly, wouldn't it, to have somebody as a LGBTQI champion who  
40 didn't identify as such.

MR McNAUGHTON: Yes.

CHAIR: It sounds a bit silly to have a First Nations Champion who's not First Nations. This is  
45 not directed at you. It's - your answers suggested that the limitations on the process where it had to be a senior person. Why? Isn't it more important - and this is not directed at your qualifications, but isn't it more important to have a person who fits the bill?

5 MR McNAUGHTON: Yeah, Chair, in fact, just last week when I did a presentation at NAIDOC week, I said my role is to do myself out of this role and to see one of the First Nations people take it over very soon. And it won't stop me being a Champion. I will just continue to support -

CHAIR: I'm not suggesting it should.

10 MR McNAUGHTON: I mean that as a role, but - yes.

MR GRIFFIN: In listening to or viewing evidence of witnesses this week, do you accept an overarching proposition that for people of First Nations background in remote and very remote communities that the NDIS systems and processes are complex?

15 MR McNAUGHTON: I think certainly what we've heard throughout the course of the week is that there is a need for more flexibility. There is a need to make the scheme easy to understand and the need to make the scheme more community-led. And - and I thought the presentations from KAMS and BRAMS recently and how they're working with their local community to do that is - is a great flagship across the country of how that's been done. So, 20 certainly, there is more to be done to make it more flexible and easy to understand. I absolutely accept that through the week's evidence.

MR GRIFFIN: I wonder whether you accept my proposition that the system and processes for those groups are complex? 25

MR McNAUGHTON: We - we also have to be mindful, I guess, that what the scheme has been able to deliver over the last three or four years.

30 CHAIR: Sorry, is that an answer, yes, comma, but?

MR McNAUGHTON: It is a yes, comma, but. But because I think, Chair, it's important to say whilst there are some complexities, there has been a lot of good work over the last few years. And we've seen that with our Remote Community Connector network. We've seen that with the growth of the number of First Nations people joining the scheme and getting supports for the first time in their lives. 35

MR GRIFFIN: I'm not questioning that at all, Mr McNaughton. But I'm trying to focus on the fundamental principle that, in my words, a theme of a lot of the lived experience witnesses from those communities was that they didn't understand what it was all about. Hence, my suggestion that the scheme and its processes are, for those people, complex. 40

MR McNAUGHTON: I think there is more to be done to make it easier for people to understand how the scheme works, how they can use their plans more flexibly, and some of the infrastructure that has been put in place needs to be reviewed to make it more culturally appropriate into remote. 45

CHAIR: Mr McNaughton, I do think the question was pretty clear and straightforward. Do you agree with counsel's proposition that the scheme and its processes are, for those people, complex?

5 MR McNAUGHTON: And I think, Chair, I have agreed that more needs to be done to simplify it.

CHAIR: No, no. Could you answer the question, please?

10 MR McNAUGHTON: I think what we have heard this week that there are elements that it is complex for some people to understand. And there's more to be done to make it more simple.

15 MR GRIFFIN: I want to come to you, Ms Papadopoulos, if I could, on the question of thin markets. As Counsel Assisting, we accept the identification of a thin market can be a complex economic exercise. Do you agree with that?

20 MS PAPADOPOULOS: I'm not sure what you mean identifying it is a complex economic exercise.

MR GRIFFIN: Well, in order to examine a market and determine whether it comes within the concept of a thin market, requires some degree of sophisticated analysis. Does it not?

25 MS PAPADOPOULOS: There is a lot of data analysis involved and a lot of qualitative analysis as well. So, some background in markets, yes, is helpful for that.

MR GRIFFIN: So the answer to my question is yes?

30 MS PAPADOPOULOS: Yes.

MR GRIFFIN: Thank you. Do you accept the basic proposition that a thin market refers to a situation where people's needs are not being met because of a lack of availability of services?

35 MS PAPADOPOULOS: I think that's - yes, that's one explanation of a thin market.

MR GRIFFIN: Yes. And I appreciate in your statement you go into much more detail, and we thank you for that. But I was just trying to get a working definition that people listening to this hearing could understand without any specialist background.

40 MS PAPADOPOULOS: Yes, certainly. So, I - I avoid the term myself, thin market. But it is an established term that has been used in a lot of the material around the NDIS. I heard a witness earlier say it's - it's a negative term and it kind of suggests why would someone want to come and work in that market if it's a thin market. So, my team and I tend to use terms such as "underdeveloped markets" or "struggling markets" or "markets where there are gaps". And so our analysis in identifying the markets that we want to prioritise, and we

45

think we would like to send our team into, we base those decisions on where we see participants' needs not being met.

5 MR GRIFFIN: Indeed, to use the "struggling" or "gaps" would on its face appear to be far more expressive of what you're talking about.

MS PAPADOPOULOS: Yes, is that - are you saying that that's a better way of describing the markets?

10 MR GRIFFIN: I'm suggesting to you that the terms that you've said you prefer to use are indeed much more expressive about the concept you're talking about.

MS PAPADOPOULOS: I think so.

15 CHAIR: It's actually a term that's been imported from economic analysis, one way or another.

MS PAPADOPOULOS: Yes.

20 CHAIR: One of the witnesses during the week said they didn't like the term "markets" for reasons they gave. But one of the reasons for not using a term like "thin markets" is that it doesn't in any way convey the real problem. The real problem is very simple. There's nobody there to provide the services that people want and need. Whether you describe that as thin markets, absence of service providers, gaps in the NDIS, a fault in the structure of the  
25 NDIS - but whatever it is, thin markets doesn't convey it, does it?

MS PAPADOPOULOS: The NDIS, yes, relies on healthy markets for people to receive the services they need and so, yes, you're right. Where we see people not receiving services, a lot of that comes down to supply of providers not being available. However, when we  
30 analyse what's happening in these markets, we look at demand side as well. So, we go - we look at the particular participants in that place, we analyse their plans very carefully, we work with their support coordinators and the people around them to understand their personal circumstances.

35 And - so what we see is where you have participants who don't understand the NDIS in the first place, who don't understand how to use their plan, who have personal circumstances that make other things in their life a higher priority than accessing disability supports, that demand is not being expressed in the markets. So, it's not visible, and an opportunity is not being seen by providers to - to enter that market, potentially.

40 So a lot of the work we do is called market facilitation and it's about trying to systemically address both those issues on the demand side, as well as looking at what is preventing providers from offering services in those markets.

45 COMMISSIONER MASON: I have a question. The Aboriginal and Torres Strait Islander community-controlled sector started well before the '67 referendum, but there became a mechanism for Aboriginal and Torres Strait Islander people and their communities to have

access to resources and funds. And the primary approach has been through community development. And even today with the evidence from NACCHO and for the leaders from the Kimberley, those models are driven not - not from looking at market opportunities.

5 It's actually by looking at it from a community development perspective. And I'm just interested to know if community development is missing in the way that the lens is put over First Nations communities and families and individuals, or is it seen from a market perspective? Because I've not heard that term in the NDIS, the approach of community development.

10

MS PAPADOPOULOS: Yes. There - in my team, our responsibility is around markets. However, as I've talked about, we - when we go into a market - which is really a place - we get to know the people, the participants, the providers and everybody in that network and understand what's going on in that place. My team has levers that pertain to markets. We call them levers. We have things that pertain to markets. We can work with the provider side, we can share data, we can encourage people, we can create networks.

15

We - we then have a look at the participant side. We work with teams such as Remote Community Connectors and remote planners and community engagement and other teams also within the NDIA then to try to bring a more holistic approach and to help those teams contribute to the project and address the range of issues that might be going on in that place. What we've learnt is I think we could do better to bolster that approach and to work more closely with all those other teams so that we're all individually contributing to - to change and improvement in those markets.

20

25

So we are learning and it's - it's definitely causing us to have some conversations about, as you said, community development and a whole of community approach.

30

COMMISSIONER MASON: Because in that answer - I'm just listening for community development principles or experiences, and it's not there. You are in an environment here in Alice Springs where there's many, many languages being spoken, First Nations languages. And, Scott, you will understand this. And a term that I quickly learnt about when I came here to Central Australia was listening to people who could speak five, six languages is the ability to code switch.

35

So someone who can - who's talking to someone in English, and they see someone coming to them and they might be a First Nations Warlpiri language speaker or Arrernte language speaker, and they code switch to that language. And it feels like in your response that that code switch is not there in the NDIA around community development as a ground-up approach, which is the natural way leadership happens in the First Nations community-controlled sector. It's a community development approach.

40

45

Because we heard the examples from First Peoples Disability Network around looking at community development in overseas countries. There's that natural leaning towards that approach. So, is that - I will leave it there. I'm taking time here. But I've not made that connection until you started talking about - and the Chair's questions around thin markets, and it might be something of some more unpacking around the language. Because the

fearfulness that Aboriginal people have towards the NDIA is that the language or the code switching is not community development; it's thinking about markets and demand. Supply. Supply chains. So, thank you, Mr Griffin.

5 CHAIR: If I may say so, I think the very important point being made by Commissioner Mason is that community development has nothing necessarily to do with markets at all. I think that's the point. Of course, you've got to have resourcing. Of course. And it will normally be governments one way or the other, but if you wanted to develop a community, there are - no doubt a variety of ways in which that can be done, depending upon the  
10 characteristics of the community. But if what you want to do is to harness the culture, the wisdom, the experience of a community, doing it by a process of engaging with and co-designing, if you like, with that community, may have absolutely nothing to do with the market.

15 It may just be a question of funding an organisation that's got the requisite experience, skill, empathy, cultural affiliation and providing the resources to do so. I think that's, as far as I can work it out, that's the dissonance that we've been hearing during the week. But anyway, that's just a thought. Carry on.

20 MR GRIFFIN: Ms Papadopoulos, you make recall Ms Beth Walker, the Public Guardian for the Northern Territory, gave evidence earlier this week, and she drew a distinction between a thin market and a market failure. That's a well-recognised distinction, isn't it?

MS PAPADOPOULOS: A market failure in economics has a very, very narrow definition.  
25

MR GRIFFIN: What's the definition for an economist of a market failure?

MS PAPADOPOULOS: I think there are three - three particular situations where it can arise. But it's associated with public goods. So, that is one - it can get quite technical. I used to  
30 have the Productivity Commission definition stuck up on my wall when I was in Treasury. But public goods, for example, such as electricity are not - would not be economical to be provided through a natural market because they're a natural monopoly; therefore, it's a market failure. Therefore, you - you - the government or the community provides something like electricity in a different way. Pollution, I think, is another example of a  
35 market failure.

MR GRIFFIN: But if there's been a complete market failure, you are dealing with a much more complex problem than a thin market in terms of the options available to you?

40 MS PAPADOPOULOS: Yeah, that's correct.

MR GRIFFIN: Chair, I note the time, and I'm intending to move on to another topic.

CHAIR: Yes. It's flying by, Mr Griffin. Perhaps, given when we started, we could continue for  
45 a little while -- you had in mind.

MR GRIFFIN: Yes, I'm in your hands.

CHAIR: As long as the staff doesn't show signs of rebellion, let's continue.

5 MR GRIFFIN: I don't know how one identifies that. But anyway. In your statement, Ms Papadopoulos, at paragraphs 24 to 26, you explain the thin market trials that have been initiated by the NDIA. I understand that they arose out of a meeting of Ministers in 2019 in particular.

10 MS PAPADOPOULOS: The decision to undertake trials? Yes.

MR GRIFFIN: And the Ministers, as I understand, agreed that a more flexible approach, including targeted market interventions were needed to address certain market gaps?

15 MS PAPADOPOULOS: Yes.

MR GRIFFIN: Have you read or are you aware of the 2011 Productivity Commission report entitled '*Disability Care and Support*'?

20 MS PAPADOPOULOS: Was that the original Productivity Commission report that argued for the NDIS?

MR GRIFFIN: Indeed it was.

25 MS PAPADOPOULOS: Yes, I've read it.

MR GRIFFIN: The Productivity Commission report does not appear in the Hearing Bundle and it comprises two volumes of approximately 600 pages. It was accessible online, Commissioners, but for the purposes of my questions, it seemed that there were three primary conclusions in that 2011 Productivity Commission report. And they were, firstly, the disability support services in remote communities were either non-existent or limited to basic care and allied health programs.

35 The second principal finding seemed to be that those services cannot provide adequate support for people with complex needs. And, thirdly, they concluded it was highly unlikely that any disability service would exist in remote communities in the absence of block funding. Let's assume for the purposes of my questions that that's a reasonably accurate summary at least of those findings. Did you understand that that was one of the documents which led to the creation of the disability scheme?

40 MS PAPADOPOULOS: Yes.

MR GRIFFIN: And can I assume that when the scheme was established, those problems identified, or characteristics identified by the Productivity Commission were still relevant and present?

45 MS PAPADOPOULOS: I - I assume they were, and I - the - I guess, are you - are you concluding that they weren't taken into account properly with the design of the scheme?

MR GRIFFIN: Can you tell the Commissioners what is meant by the term "block funding"?

5 MS PAPADOPOULOS: Block funding is a way of funding usually a non-government organisation to provide services to the community. It refers to - to, usually, a contracted arrangement for a number of years or a period of time, and the funding is attached to certain deliverables or outcomes.

10 MR GRIFFIN: So does block funding provide a precise amount of money and some security that that funding will be available for a designated period of time?

MS PAPADOPOULOS: Yes.

15 MR GRIFFIN: How prevalent is block funding within the scheme today?

MS PAPADOPOULOS: The scheme is largely a model of individualised funding through plans. However, the NDIS model of individualised funding is complemented by a range of block funded programs. Remote Community Connectors is one example, EACP, the RECS program. We also have ILC grants and state and territory government programs as well. So, all of those block funded programs wrap around individualised funding and are there to complement and support the operation of the NDIS.

20 MR GRIFFIN: And are you or Mr McNaughton able to give a ballpark figure of what percentage of total funding can characterised as block funding?

25 MS PAPADOPOULOS: Very minimal.

MR McNAUGHTON: I can - not as a percentage, but I can tell you, Counsel, we spend around \$23 million a year in funding for Remote Community Connectors, Evidence Access and Coordination of planning and Remote Early Childhood grants. The ILC grants are managed by the Department of Social Services now. They were 400 or \$500 million previously. I don't know what they are exactly now.

30 MR GRIFFIN: Can I ask you and those that advise you to take on notice that question, to see if you can provide a more precise answer - and there's no criticism in that comment.

MR McNAUGHTON: Yes. No, absolutely, we can do that.

35 CHAIR: Would you mind explaining briefly, if you can, how the block funding for the Community Connectors program works? Where does the money come from? Who gets it, pursuant to what authority?

MR McNAUGHTON: I will take that, Chair. Yes. So, we have a series of individualised contacts with - they are usually all ACCHOs or Aboriginal medical services across the country. There's about 40 or 50 head contracts and they cover around about 309 community remote communities across the country. It started with a bit of a trial in East

Arnhem Land and then up to the Kimberley as a way of - I think the first nature was a disability navigator to help people understand the NDIS in local language.

5 And it proved incredibly successful and so now we continue that grant program. We've moved from annual grants to two- or three-year grants now to try to lock in some surety for workforce and we are still expanding. We're just about to announce - I won't announce it here, but we're about to announce a contract up in the Torres Strait and Far North Queensland for an extension of the early childhood program up there as well. So, it's something we continue to -

10 CHAIR: So these are funds that are provided to individual organisations, ACCHOs or whatever, to perform particular services in particular communities?

15 MR McNAUGHTON: Yes. That's correct, Chair, yes.

20 CHAIR: And are the funds made available as the result of applications by ACCHOs or do you seek them out? How does it - how does it work? And where does the funding come from? Is there some special fund within the NDIA that can be used for this purpose? Or is there some other mechanism for obtaining the moneys?

25 MR McNAUGHTON: Yes, Chair. The funding for it comes out of the agency's operating budget rather than scheme costs. So, that it actually comes out of my - my division's budget. So, we allocate that funding. It's a bit of - going to the other question about how we do it, it's a bit of a combination. Sometimes we get approaches from communities who say we have heard of this, or some communities might have .5 of a funded Remote Community Connector and they think they would like to expand that.

30 And other times we might hear from local stakeholders or others that says, "We need a local person here. We need someone in the Torres Strait, or we need someone in Weipa, or we need someone in Fitzroy Valley." And then we will work with the local community, it's usually the Aboriginal medical service or the ACCHO that we'll go to first off and work with them about their ability to take on those contracts.

35 CHAIR: We've heard a lot this week about the importance of flexibility and this, I take it, you would regard as a mechanism for ensuring that the scheme has a degree of flexibility in the way in which it provides services, supports communities and interacts with those communities.

40 MR McNAUGHTON: Yeah, most definitely, Chair. A lot has come up this week about different language groups. For argument's sake, our Remote Community Connectors out in Galiwin'ku in East Arnhem Land have done all of their products in Yolngu language, and their videos and those sorts of products. There's no use us doing that from national office. We need to invest locally in community to do those things.

45 CHAIR: Yes, thank you.

MR GRIFFIN: Mr McNaughton, how many Community Connectors are there nationally?

MR McNAUGHTON: There's 209 Remote Community Connectors. And they service just over 300 remote communities.

5 MR GRIFFIN: And when you say "remote", does that include very remote?

MR McNAUGHTON: Yes, sorry, remote and very remote. It does.

10 MR GRIFFIN: If they service 300 remote communities, are there any communities that don't have a Connector?

MR McNAUGHTON: Yes, there would be. There would be some who aren't covered.

15 MR GRIFFIN: What percentage of remote or very remote First Nations communities would not have a remote connector?

MR McNAUGHTON: I will have to take that on notice and give you an accurate answer, Counsel.

20 MR GRIFFIN: I think you indicated that it usually involves ACCHOs or ACCOs?

MR McNAUGHTON: Yes, or Aboriginal medical services.

25 MR GRIFFIN: Yes. Is there a policy within the NDIA that it has to go to that category of organisations?

MR McNAUGHTON: No, there's not a policy. It's more a practice that we like it to go to those organisations.

30 MR GRIFFIN: And why do you have that practice?

35 MR McNAUGHTON: I think, really, as, you know, what Pat Turner just said about the trusted local organisation who are in community, who have a presence, who employ local people. Obviously - sorry, who often speak the local language, and it just makes a lot of sense for us to engage with that network for the delivery of that support.

40 MR GRIFFIN: If a community doesn't have the benefit of such organisations, what, if anything, does the NDIA do to try and build such organisations so that, in the future, they can get the benefit of this program?

45 MR McNAUGHTON: Yeah, it's a very good question. And we often work where there is a - a remote community not too far from the other very remote community, we might ask them to start servicing those communities. We might extend their grant and ask them if they can go out there and do some visiting of those communities. There's sometimes often a natural tendency where people in communities who don't have access to an ACCHO or an AMS might connect with someone who does, and then we try to engage with those communities to reach into those more - more remote, very remote communities.

MR GRIFFIN: How long has this program been running?

5 MR McNAUGHTON: We started as a very early pilot in 2017, just to test it. And - and it built up really quickly and to where it is today.

MR GRIFFIN: How many communities in 2017 had no such organisation but in 2022 do have an eligible organisation?

10 MR McNAUGHTON: Can I answer that by saying I think we started with two communities and now we are at 309 communities. Does that answer the question? So we -

15 MR GRIFFIN: No, it's a useful answer, but it's not an answer that I was trying to get at. Presumably, in 2017, a number of communities had organisations in place already which turned out to be quite eligible. I'm wondering, due to your program, whether you've facilitated the creation of organisations in communities that didn't previously have them, that are now eligible for this program?

20 MR McNAUGHTON: Moreover, they were all existing organisations who've been able to expand their workforce into delivering the Connector model. Some also Evidence Access and Coordination and Planning and also Remote Early Childhood. So, it's been an expansion of their existing services they provide in the community.

25 MR GRIFFIN: For all intents and purposes, that's a very positive development. But how, in the communities that don't have such organisations, can you build capacity so that they can reach that point?

30 MR McNAUGHTON: Yeah, this is the work we continue to do with our own community engagement staff working with Aboriginal-controlled organisations who might service those communities to see if they can do some local recruitment. We have tried - sometimes it doesn't always work - that we engage someone, and that role isn't something that they are interested in doing so that they might opt out of it. But it is something - we - we are often looking at the map, Counsel, saying where aren't we and where do we need to go? How many participants are there? What can we do about that.

35 MR GRIFFIN: How long has your engagement unit been working on that particular project we have just been discussing, that trying to build capacity?

40 MR McNAUGHTON: Yeah, probably in the last two years when we really resourced up our Connector branch, and they started having a look - based on the success of the model in the Kimberley and East Arnhem that we really started investing heavily in that more community development - community design of Remote Community Connectors across the country.

45 MR GRIFFIN: Mr McNaughton, that is to be applauded, but can you point to any successes where a community has gone from not having an eligible organisation, to use my words, to the position today where they do?

MR McNAUGHTON: I think I'm getting confused with your term of "a not eligible organisation".

5 MR GRIFFIN: When I use that term, it's on the basis that there's a preference or a policy within the NDIA to use those types of organisations. So, I'm not meaning it as a precise term.

10 MR McNAUGHTON: Yes, so we don't see any organisation would be ineligible to do that. So, the - the remote community connector in Fitzroy Valley is Marra Worra, and they are not, as I understand it, an ACCHO but they are an Aboriginal-controlled organisation who does other things, the CDP program and so forth. So, we have been engaging with them to be able to deliver a remote community connector and they have now got 2.4 remote community connectors that they are engaging. So, that's probably an example - one who wasn't a traditional ACCHO, in a sense, but was still an Aboriginal controlled organisation locally.

20 MR GRIFFIN: Can I now move to a slightly related area. If the Productivity Commission reached certain conclusions in its 2011 report, then the NDIS is established and rolled out, then in 2019 the ministers have the meeting which we've been discussing. Can I take it that when the NDIS was created and rolled out, the NDIA was aware at that point at what the Productivity Commission had identified? And then my question is, between 2015 of the rollout and 2019, when the minister's made certain decisions, what did the NDIA do to address the issues which had been identified by the Productivity Commission in these communities?

25 MR McNAUGHTON: In relation to the thin market piece?

30 MR GRIFFIN: In relation to the three matters I identified earlier when I referred to the commission. I'm happy to -

35 MR McNAUGHTON: No, that's okay. I guess going back to the Productivity Commission which helped inform the creation of the NDIS, which then led to the drafting of the approval of the NDIS Act, and, you know, so the NDIS clearly sets out how we need to administer the scheme and fund the scheme and roll out the scheme. Through that period there was a series of bilateral agreements with state and territories about the rollout, place-based, age-based timing over - over periods. WA has just finished their full rollout based on their bilateral. So, there was a period of getting the scheme's basic fundamentals in place, and I think throughout that time there have been some aspects of trying to learn - around in 2017 with the remote community connectors and other options - we've seen attempts of pooling funds in some communities done throughout the course of the journey, and through 2019 where it was becoming quite evident where some participants were getting their plans and not able to access services what were the other things we needed to do. Hence the market intervention work that's now in place. So, it has been a journey along the way in terms of administering the scheme and rolling it out to where it is today, you know, 520,000 participants, I think is the latest figure. So, I think, counsel, what we've learnt is better understanding the data, where there are gaps in utilisation of people's plans by support type and what are the options, we can do to make sure those participants can access those

supports. What are the different levers, as Kitsa mentioned, we can use. Whether that's pooling funds, commissioning those supports, looking at different ways.

5 MR GRIFFIN: Mr McNaughton, the Commission acknowledges that the rollout of the NDIS was a massive exercise. It is self-evident.

MR McNAUGHTON: Yes.

10 MR GRIFFIN: What - was any action taken in relation to thin markets as identified by the Productivity Commission prior to 2019? Ie, between 2015 and 2019. And, if so, what was that action?

15 MR McNAUGHTON: I'm not sure if Kitsa wants to jump in here, but from my - my understanding of what was known as more over around trying to work on the rollout into those remote communities to get people into the scheme, to get service - support coordinators signing up to deliver services, to try and get more providers registered to deliver supports. It was, as you acknowledge, a very big transition where providers had to enter the - the marketplace to deliver - sorry about the language, but that was the approach. We had to get support coordinators, we had to get disability support workers  
20 signed up as registered providers to deliver that. So, a lot of effort went into the development of the provider market, as best we could at that period of time, but I think we've learnt that we do need to do things a lot differently in those markets.

25 MR GRIFFIN: I understand from part of your answer that there was a need to prioritise certain things. It does seem that if the organisation knew about thin markets when it was being rolled out, why didn't it address that problem during the rollout?

30 MR McNAUGHTON: Well, I - as I just answered, I think the challenge was for us to make sure that, a, we were getting people access to the scheme, getting them on their plans and getting their supports - their plans in place, and then trying to work through different models of getting more support workers and support providers in there. We didn't start probably doing different market conditioning until 2018-19 because we were - we were so focused on making sure people could get their plans, get their supports, get some early intervention supports that they needed as well as some of the other activities that were  
35 going on.

MR GRIFFIN: Ms Papadopoulos, are you able to add to the discussion we have just been having?

40 MS PAPAPOULOS: The only thing I would add so to say that I'm aware that there was some risk management placed around certain remote communities. So, for example, in the APY Lands the South Australian Government was providing the majority if not all disability services in the APY Lands. And the South Australian Government did not transition their service out of the APY Lands until my branch had assisted to put new providers in place to  
45 take over the service delivery that used to be provided by the government. And so my assumption would be that that similar process of risk management would have been in

place certainly where other state or territory government services needed to - needed to move out but be replaced by alternatives.

5 MR GRIFFIN: When you refer to risk management in that context, what do you mean?

MS PAPADOPOULOS: I - I mean managing the risk around people with disabilities not receiving the supports that they require.

10 MR GRIFFIN: So in lay terms, going from a system perhaps run by the state to ending up with nothing if it wasn't transitioned very carefully?

MS PAPADOPOULOS: That's correct.

15 MR GRIFFIN: Is that an appropriate time?

CHAIR: I think so. Thank you. So, we resume at 10 or earlier?

20 MR GRIFFIN: 10. I know how long my questions will take, I'm not sure how long the answers will take. But based on what's transpired today and the very responsive and cooperative approach of the witnesses I will be confident we can finish in accordance with the general schedule you are aware of.

CHAIR: If we start at 10?

25 MR GRIFFIN: If we start at 10, yes.

CHAIR: In the expectation that your answers will be commendably brief tomorrow, we shall start at 10 am. I will adjourn until then.

30 **ADJOURNED 4:23 PM UNTIL FRIDAY, 15 JULY AT 10 AM.**

<b>Index of Witness Events</b>	<b>Page References</b>
JUNE RIEMER, SWORN	P-225
DAMIAN GRIFFIS, AFFIRMED	P-225
EXAMINATION BY MS McMAHON	P-225
THE WITNESSES WITHDREW	P-251
PATRICIA TURNER, AFFIRMED	P-251
CASSIE AITCHISON, SWORN	P-252
JENNY BEDFORD, SWORN	P-252
EXAMINATION BY MS McMAHON	P-252
THE WITNESSES WITHDREW	P-283
SCOTT McNAUGHTON, AFFIRMED	P-284
KITSA PAPADOPOULOS, AFFIRMED	P-284
EXAMINATION BY MR GRIFFIN SC	P-284