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PRODUCTIVITY COMMISSION

STUDY TO REVIEW THE COSTS OF THE NATIONAL DISABILITY INSURANCE SCHEME (NDIS)

Everyday Independence Pty Ltd

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Background - About Everyday Independence:

Everyday independence (EI) supports children, adolescents and adults living with disabilities to improve their independence in everyday life through the provision of:

- Occupational Therapy
- Physiotherapy
- Speech Pathology
- Psychology
- Allied Health Assistance

Everyday Independence has provided therapeutic supports within the NDIS for over 4 years, operating in Hunter, Barwon, Sydney and NEIMA.
To date we have supported over 2000 NDIS participants covering all ages and a broad range of disabilities.

Submission

This submission is based on our experience to date with the NDIA and draws on our 20 years of experience working with other schemes including TAC, LTCS, Workcover, ABI: Slow to Recover Program and FAHCSIA.

Our submission will focus on the sustainability aspect that the commission has been asked to address:

The sustainability of scheme costs, including current and future cost pressures

For the scheme to be viable and for costs not to "blow-out" we believe that there needs to be a strong and overt linkage between goal achievement and a reduction of core supports. This needs to be an overt conversation and a linkage that is shared by participants and their supporters.
It is our belief that through effective use of Therapy that the scheme can manage the objectives of assisting people to achieve their potential and remaining financially sustainable.
We believe that it is only through the intensive and time limited usage of therapy that an individual will be supported to realise a change in the nature and level of their supports. With therapy interventions, this reduction in paid supports will also allow for the natural development of informal and community supports.
We also highlight that schemes such as TAC and Life Time Care and Support have utilised Therapy to determine the most effective support model and level for a person and to coach and guide these resources toward an active model of support. This has managed the risk of support needs increasing overtime through dependencies. This approach has linked goal achievement to reduction in costs.
The use of Benefit and Support Services Assessments (recently changed to Framework Assessments) within the TAC scheme and the allocation of Case Management services in the Life Time Care and Support scheme are examples of the use of Therapy to improve the positive impact of support resources within a person's life.
In our experience with the NDIA there is not an overt link between goal achievement and the reduction of resources required by an individual. Therapy is not utilised as an enabler or facilitator of this change, it is common to see participants with high and multiple needs, with an allocation of less than 1% of funding for Allied Health. Often the identified use of therapy is very prescriptive and specific (e.g. Assistive Technology or "James needs a new mattress") and does not allow for therapeutic involvement in shaping outcomes using the resources of core supports. It is difficult to

see how these participants will be actively supported to achieve independence goals that will lead to a reduction in the NDIS investment.
In structuring this submission; we have identified a number of development opportunities for the NDIS where the effective usage of therapy, could enable and facilitate a positive change for the person.

The table below outlines these opportunities for change.

Current	Future
Focus on person's current needs	Focus on achieving a person's future potential
Risk averse approach	Positive and person-centred approach to risk
Service based model of therapy	Resource based model of therapy
Passive model of supporting participants	An active model of supporting participants
The prescription or delivery of Assistive Technology (AT) and environmental modifications as the outcome for the person	AT and environmental modification as a facilitator; along with other therapy resources; for the person to achieve an independence and participation goal

Each of these opportunities will be presented in further detail.

Focus on achieving a person's future potential
The NDIS does not overtly consider the person and their family in terms of their potential for growth, interdependence, and self-reliance. Services and supports provided are focussed on current needs only.
This is evidenced by the goals that we witness in participants plans. Goals are generally focussed on managing a person's current situation without any direct link to the supports that are being purchased.
People who have been living with disability and transitioning to the NDIS often have low expectations for future growth. Their families can be risk averse and cautious. They are accustomed to conversations or assessments about current needs, barriers, and solutions. They are becoming more accustomed to discussing goals but not linking goal achievement with current supports.
The linkage between future goals and future resource requirements needs to be overt and a shared commitment between the participants and providers. Therapy can support the implementation of this structure and provide an independent view on the achievement of this plan. This structure is a key component in the TAC and Lifetime Care and Support schemes which utilise Occupational Therapists to provide assessment and opinions regarding the best use of attendant care resources to achieve independence and participation goals.

Proposed Change	**Benefit**
Be overt about the linkage between achievement of future potential and future resource needs.	People will achieve their goals and become more independent and productive. This will achieve real reductions in a person's support needs.
Provide therapy input in the early stages of planning, using a collaborative approach	Families will collaborate in the future planning process with an acceptance that

with the person and their supporters, to determine potential and map out in detail the impact that realising this potential will have on the nature, type and level of support.	greater independence is linked to decreased resource requirements.

Encouraging a positive approach to risk

We need to know when to let go and when to take reasonable, prudent, and acceptable risks.

In line with the concept of realising potential, the current scheme does not focus on people finding their "just right challenge". We know that finding the right challenge often means taking some risks.

"In the past, we found clever ways to build avoidance of risk into the lives of persons living with disabilities. Now we must work equally hard to help find the proper amount of risk people have the right to take. We have learned that there can be healthy development in risk taking... and there can be crippling indignity in safety!" [i]

Historically the disability sector has taken a risk averse approach with a focus on the downside of risk. Traditional methods of risk assessment are full of charts and scoring systems, but the person, their goals and dreams seem to get lost somewhere in the pages of tick boxes.

A positive approach to risk embodies person centeredness, facilitates choice, empowerment and inclusion. Risk is therefore a concept that is closely associated with the balance between choice and control.

The effective use of therapy can support people and their families to develop a positive approach to risk. Whilst it should be an integral part of working with people in our daily work the sector is not yet mature enough to embed this culture without intent and focus.

Proposed Change	Benefit
The use of allied health professionals to empower people, their families, and paid supporters to develop a positive approach to risk within ordinary tasks. To then link the gains made with this approach back to the program for continual growth, downgrading or adjustment of supports.	People and their family will have a positive approach to risk which will enable growth, development and confidence. This will achieve reductions in a person's support needs.
Adopt a key worker model for participants with complex needs. The key worker can reinforce the positive approach to risk within all supporters and providers connected with the participant.	People, their family and service providers will have a consistent focus on goal achievement and understand the impact on resources required.

Adopt a resource based model of therapy – embed strategies into routines and linking achievements to support needs.

Currently the use of Therapy with NDIS input is very targeted and prescriptive, this approach is aligned with a service based model of therapy which describes practices primarily in terms of professional services. For example; John needs a new wheelchair or John needs a new mattress – OT 4 hrs. The limitations with this model is that there is insufficient funding to link these facilitators to the person's independence and participation goals. This model also directs services to work in isolation of one another.

A resource based model of therapy describes practices in terms of a wide variety of formal and informal supports within a community. Utilising therapy as a resource will support a person to embed progress into daily routines, to realise potential and then to gradually downgrade the nature and level of support.
Feedback from the NDIS and NDIA has been that the initial focus of the first plan is not on "change" and Therapy but on transitioning people into the scheme. Our experience has been that when supports and services are in place they are difficult to change, shape, or reduce overtime. This is not consistent with the philosophy of early intervention.

Proposed Change	Benefit
Using therapy input to introduce a therapeutic model into the person's support program, where supports are dynamic and continually adjusted to embed learnings into day to day and reduced when skill development occurs.	Using Therapy as a resource rather than an isolated service will lead to more efficient outcomes.
Any person who is provided with attendant care should have independent support to ensure that, this resource is used to achieve a person's goals.	Attendant care is viewed as a valuable resource in achieving a person's goals not simply a care resource. This will lead to accelerations in goal achievement and ongoing reductions in support needs.

Adopt an active model of person centered supporting participants

The current support model is often a passive, "do for the person" model which has the potential to negatively impact confidence and self-efficacy.
We witness many examples where supports are introduced without consideration given to how the person should be supported. The focus of support is on shifts, hours, times, days etc. Often support shifts are extended to make the shift more attractive to the worker, which results in the person being over-supported. Commonly the support workers are not aware of what the independence and participation goals are for the person and the specific strategies to achieve these goals. There is often no vision of a reduction in support overtime.
We believe that a more active model support is required. The components of an active model are outlined below:

Essential components of active support are:

1. Every moment has potential – using activities that need to be done (housework, gardening and shopping) and those activities that are available to be done (visiting friends, sport, education) as opportunities for supporting people to be engaged throughout the day.
2. Little and often – supporting people with shorter opportunities for engagement throughout the day rather than solely focusing on single lengthy events.
3. Graded assistance – providing the right amount and type of support at the right time.

4. Maximising choice and control – creating and looking for opportunities for the person to express their preferences and be listened to.

There are many examples of organisations using active support models in the area of recreation and community participation, but fewer examples in areas where independence in essential tasks is the goal. There are very few examples where active support models has led to a reduction in support hours as the focus of the support has been on facilitating choice, control and participation without a support reduction lens.

There is currently limited funding provision for Therapy input in plans to shift a passive model to an active model. Some organisations in the sector are creating this shift within their workforce but what is needed is an individualised approach which considers the person's goals and aspirations and specific routines. The table below outlines how therapy could be used to turn passive goals into more active statements.

Passive Model	Active Model
J will be supported within a 24/7 model	J will continue to have access to 24/7 support. J's level of support will change from direct 1:1 to a 1:3 ratio with inactive nights.
J will be able to attend social evenings and classes that will enable him to retain relationships with friends.	J will be attending social evenings and classes. J's supports will move from funded supports to support within his friendship network. J's informal supports will report that they are confident to support him to attend social evenings.

Therapy support can be used to implement the changes required in the support levels to achieve the goals outlined in the active model.

Proposed Change	**Benefit**
Introducing the concepts of "Person Centred Active support" with greater intention to create an enabling approach.	Existing core supports will be viewed as resources for goal achievement and realising potential.
Review of pricing structure to incentivise shorter shifts.	People will readily have access to support little and often.
The use of allied health professionals to create an enabling approach within individuals supports.	People will typically be provided with active support.
The term core and therapeutic supports should be reconsidered. There should be 2 types of supports those which are unlikely to change in the future (core) and those that are dynamic and will be used to realise potential (realising potential supports).	This will serve to create an expectation of change, downgrading and reduction as gains/confidence are made.

Assistive Technology (AT) and Environmental Adjustment/Modification

The current delay in the consideration of request, delivery or work commencing, or provision of equipment is:

There is no funding allocated for allied health to embed the use of AT or performance in a modified environment into routines and activities. There is also no allocation of funding or linkage to review the impact of AT and modified environments on core supports.

AT and environmental modification solutions are being introduced without budget realisation.

Proposed Change	**Benefit**
Funding allocation to therapy should be based on a functional outcome which also impact support needs – rather than just funding for assessment or prescription.	AT and environmental modifications will result in functional improvements.

[i] *Mental Retardation* and *Intellectual and Developmental Disabilities* (previously *Mental Retardation*) All articles are posted with permission from The American Association on Intellectual and Developmental Disabilities (formally AAMR), 503 3rd Street NW, Suite 200, Washington, DC 20001