Submission 63 - Neami National - National Disability Insurance Scheme (NDIS) Costs - Commissioned study

National Disability Insurance Scheme (NDIS) Costs

Productivity Commission Issues

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Contact us

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Background to Neami National

Neami National is a specialist community mental health organisation with 30 years' experience. We deliver a broad range of recovery oriented programs for people living in the community with a serious mental illness through a number of Commonwealth and State funded programs across Queensland, New South Wales, South Australia, Western Australia and Victoria. In all, Neami provides face to face support from 53 office locations across the five States.

Neami works with people across the full spectrum of need and is particularly committed to those who exhibit the most complex needs, including people who have experienced long periods of hospitalisation and have been assessed as requiring extensive support to develop life skills and embark on a recovery journey. Over 8,000 people are supported each year through a range of services encompassing community-based support, sub-acute services, residential rehabilitation support, homelessness support and service coordination services. All our services are actively integrated with public clinical Mental Health Services.

Neami has experience of NDIS in three trial sites – Hunter, Barwon and Perth Hills – and in the current roll-out area of North East Metropolitan Melbourne.

Neami has developed this submission based upon our experience as a national provider of specialist psychosocial disability services to the NDIS stemming from our involvement in the NDIS trial and ongoing business in Barwon and North East Melbourne (NEMA, Victoria), Hunter (NSW) and Western Australia. Our comments are drawn from our experience and consumer feedback and are specially focused on the needs of people with mental illness and related psychosocial disability.

Scheme costs

Are there any cost drivers not identified above that should be considered in this study? If so:

- *how do they impact costs in the short and long term?*
- *how and to what extent can government influence them?*

In the Issues paper, (Figure 2 on p.9) we identify *quality of service delivery* as a critical missing driver of cost. From the perspective of psychosocial disability we see quality impacting in both the short and long term.

In the short term the base rate of $42.79 per hour for a range of core and capacity building supports drives services to minimise costs in order to remain financially viable and this can inadvertently force quality of service provision to be relegated to a secondary concern. The price point necessitates the employment of staff with limited qualifications and experience in working with people with psychosocial disability to undertake support roles. These roles can appear on the surface to demand relatively low skills or limited experience. In many cases this may be sufficient and a reasonable quality of service will prevail to effectively meet the needs of a group of participants with psychosocial disability.

However, we believe the available quality of service will have negative consequences for a larger group of participants that will drive increasing costs of the scheme in the longer term. Higher level skills are required to work effectively with many people with complex mental health issues, irrespective of the functional support activities support workers are tasked to provide. These include relational skills (including working in a way that is trauma-informed), assessment of risk and functional capacity, and carefully calibrated provision of support. Delivering functional support activities with these higher level skills ensures support can be calibrated to build participant capacity and reduce dependence on support over time, and that safety of both the participant and provider is optimised. It is our experience, in delivery of psychosocial supports to people with complex mental health issues over 30 years, the need for service reduces over time if the right supports are provided by skilled and supported staff. Our experience also indicates that working with this group of consumers carries some risks, including self-harm, suicide, aggression, and assault and that negative outcomes for participants, staff and the community are an irregular but real part of the work.

The $42.79 per hour base rate determines that staff have very limited time to engage in activities related to training, support and professional development. This will eventually erode the skilled capacity and resilience of the workforce and undermine overall quality and safety of service provision. It may also negatively impact the capacity to maintain a workforce that is prepared to work with participants that have significant disability but also significant risk. It may take negative or dire consequences, for example the death or serious injury of a participant or provider, to illustrate the impact of this erosion of quality in the longer term. A less dramatic, but important factor in driving costs in the longer term of the Scheme, is the issue of creating dependence on supports and limiting capacity for independence. A base rate that maximises provider efficiency at the expense of support quality is expected to reduce the effectiveness of capacity building supports, leaving participants less independent than they otherwise could be, which in turn may increase the need for further NDIS-funded supports over the long term. The current price points also reduce capacity for providers to engage in research or to trial more innovative approaches to service provision. These activities necessarily require time out of direct service provision and front-end investment by providers. This will not be possible in this very lean business environment meaning that gains made in the past 20 years may stagnate or even decline, again with potential negative implications for cost and for participant outcomes.

To address the issue of quality and thus a significant driver of increased cost in the longer term of the Scheme, the price point of support for people with complex psychosocial disability must be raised. We suggest a figure of $80 per hour is more appropriate to deliver supports to this group of participants with more complex needs (not all people with psychosocial disability). To maintain quality and reduce costs over the longer term, a more finely attuned scaling of costs is required that better accounts for the demands of roles and the complexity of relational work involved with some NDIS participants.

Additionally, there is a requirement that providers have some capacity to support their staff through training, supervision, and professional development, to ensure staff have capacity to deliver support that is of high quality and that both participant and worker safety is optimised. There is no capacity within current pricing to deliver this, so resolution will require some increase to the overall pricing structure. This will be a critical factor in maintaining a workforce that can deliver against the goals of the NDIS for this group of participants.

Eligibility

Are there other early intervention programs that could reduce long-term scheme costs while still meeting the needs of participants?

This question was grouped in a block of questions primarily in relation to the ECEI approach in relation to children with highest needs entering the scheme. We have elected to answer this question from a psychosocial disability perspective because of the relevance and importance of early intervention within the mental health domain and the opportunities that early intervention provides to reduce the long term psychosocial impacts and functional deficits that impact upon individuals' quality of life.

We consider it vital that the NDIS continue to include the clause "The impairments are likely to be permanent". We are of the opinion that this provides the scope for early intervention for individuals who are yet to receive a formal diagnosis but are experiencing mental health issues and would benefit from early intervention and a recovery approach. It is well documented in the recovery literature that early intervention and psychosocial recovery programs can reduce the long term impacts of and functional deficits associated with mental ill health. This is applicable to both youth and adult mental health. The benefits afforded by early intervention are not only the improved quality of life of the individual, increased life satisfaction, wellbeing and independence, but also the reduced dependence on and costs to the scheme.

We have outlined below three evidence-based programs that have demonstrated positive outcomes for people with mental ill health and psychosocial disability. These programs would not only benefit participants during early intervention but have also been demonstrated to benefit most people with a psychosocial disability.

The Optimal Health Program (OHP)

The OHP developed by Frameworks at St Vincent's[1] is an internationally researched and recognised self-management program that helps participants improve and manage their health and wellbeing. The programs utilise the "I can do" model that enables the person to identify stresses and vulnerabilities and how to manage these with clear strategies.

The Collaborative Recovery Model (CRM)

The CRM[2] is an evidenced based model developed by the University of Wollongong[2] based on research into the interventions proven most helpful for people living with mental illness and psychosocial disability. The CRM is essentially a person-centred, strengths-based coaching model that enables the participant to identify meaningful goals based on their values and to develop practical strategies to achieve these.

Flourish

Flourish is a recovery-focused self-development program designed for people who have lived with mental ill health and psychosocial disability and who are seeking to make improvements in their life. Flourish is a self-directed recovery program that seeks to support people to develop a renewed sense of purpose, identity and belonging. Flourish is often provided by peer support workers who have a personal lived experienced of mental ill health, psychosocial disability and recovery.

Planning

Is the planning process valid, cost effective, reliable, clear and accessible? If not, how could it be improved?

What are the likely challenges for monitoring and refining the assessment process and tools over time? What implications do these have for scheme costs?

Our experience as a national provider of specialist psychosocial disability services to NDIS participants stems from our involvement in the NDIS trial and ongoing business in Barwon and NEMA (Victoria), Hunter (NSW) and Perth Hills (Western Australia). Our comments are drawn from our experience and consumer feedback and are focused on the needs of people with mental illness and related psychosocial disability.

Overall we have serious concerns regarding the planning process for people with mental illness and related psychosocial disability. Mental health is a specialist field of medicine with many unique, complex and challenging aspects that separate it from other disabilities. In psychiatry this is recognised and addressed via the biopsychosocial model which was developed in acknowledgement of the interconnection between the biological, psychological and sociological factors.

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[1] Gilbert, M. M., Chamberlain, J. A., White, C. R., Mayers, P. W., Pawsey, B., Liew, D., ... & Castle, D. J. (2012). Controlled clinical trial of a self-management program for people with mental illness in an adult mental health service–the Optimal Health Program (OHP). *Australian Health Review*, *36*(1), 1-7.

[2] Oades, L., Deane, F., Crowe, T., Lambert, W. G., Kavanagh, D., & Lloyd, C. (2005). Collaborative recovery: an integrative model for working with individuals who experience chronic and recurring mental illness. *Australasian Psychiatry*, *13*(3), 279-284.

A significant proportion of people with mental illness and related psychosocial disability experience conditions that can present as complex due to factors including the fluctuating and episodic nature of their condition, or can be difficult to engage in assessment or service provisions, or experience cognitive deficits that are not necessarily apparent. To ensure effective planning occurs, planners require specific knowledge, skills and experience in engaging and working with people with mental illness and related psychosocial disability.

Consumer feedback and our observations across several jurisdictions indicates challenges within the current NDIS planning process. We understand these as having two central causes;

1. Within the NDIS, planning is comprehended as a relatively simple process of information gathering and interpretation, with needs converted into actions through a plan that will last 12 months. This works for some but not all people with a psychosocial disability. For some people planning is a process, dependent on an interactive relationship developed over time, with needs revealed through this relationship, and required actions negotiated between the consumer and planner over time. This form of planning is best undertaken within the support coordination process of the NDIS, with the plan developed in an iterative manner. The current NDIS process does not accommodate this more iterative approach to planning that has been a strength of community provided mental health services, in particular in meeting the needs of people who are disengaged or marginalised.

2. Required system efficiencies are driving processes that undermine the strength of effective planning. For example, in North East Metropolitan Melbourne the majority of first plans were being undertaken over the phone. We were pleased to hear that a local decision last week will see most plans now developed in face-to-face interviews with consumers. Consumers report being taken off-guard by phone calls from LACs/planners and not fully understanding the assessment process. Some consumers have reported they were not aware that the phone call represented the full NDIS assessment/planning process. This leads to them not feeling they can express their needs effectively and feeling pressured to agree on plans they do not fully understand. We acknowledge the responsiveness of the region in ceasing this practice but wish to highlight it as a counterproductive and detrimental practice.

Rapid planning by LACs/planners without extensive experience in supporting people with psychosocial disability results in plans that attempt to replicate status quo in service provision without fully understanding the complexity of that service.

1. Consumers without English as their first language describe difficulties in participating in planning and in getting plans that they can fully implement on account of their language needs.
2. Our experience across 4 NDIS regions in 3 States reveals wide variation in plans for people we understand to have similar levels of need.
3. Primary health networks are well placed to understand the psychosocial needs of their communities. Ongoing data collection will build increasing understanding of need along the stepped model of care. Currently allocated resources limit PHN capacity to deliver across the full spectrum of identified need.

Recommendations to improve planning processes:

- Ensuring planners have specific knowledge, skills and experience in engaging and working with people with mental illness and related psychosocial disability. This could be achieved through a number of avenues including:
    - the employment of specialist planners with the requisite knowledge, skills and experience working with people with mental illness and related psychosocial disability

    - Training and supervision for planners
    - Ongoing professional development for planners
    - Regional/cross-regional forums to provide opportunities for planners to hear the experience of participants, carers and providers – this feedback could contribute to the iterative development of the planning processes.
- Developing a more iterative planning process for the group of people for whom single-event planning is challenging. This may involve short term plans for high level support coordination, with the goal of developing a longer term plan well aligned with the person's complex needs.
- There will be long-term efficiencies in ensuring well-resourced planners – skilled in understanding the needs of people with psychosocial disability and with adequate time to conduct most assessments face-to-face.
- That people from culturally and linguistically diverse backgrounds can fully participate in planning and can fully implement developed plans through adequate provision of interpreter funding throughout the process.
- Variation in planning across regions needs to be explored with efforts to identify areas of best/better practice and supporting dissemination of this practice more broadly across Australia.

Assessment tools

A vital component of the assessment and planning process identified as an area for improvement for people with mental illness and related psychosocial disability is the area of risk assessment and collaborative risk management planning. The risks for people with psychosocial disability are well recognised and include, poor outcomes across all domains of health, self-neglect, vulnerability, self-harm, suicide and violence. Our experience with NDIS planning and assessment is that the area of risk assessment is not adequately addressed and that there is a perception that risk assessment is the responsibility of mainstream or specialist mental health services and is therefore separate from the NDIS disability focus.

We propose that the risk assessment and collaborative risk management planning is critical to NDIS planning and assessment. This will ensure that participants receive accurate and comprehensive assessment and plans relevant to their needs, including risk identification and recognition, resulting in services being enabled to work collaboratively and safely with the participants to achieve their goals. There is a duty of care to the participant, carers, workers and the community to ensure risks are identified and communicated. A failure to do so can result in catastrophic outcomes such as suicide, assault, and death.

Contemporary knowledge of risk assessment and management recognises risk as dynamic, contextual, and highlights the need to collaboratively engage the participant and their support network in the development of risk management strategies and plans. The ultimate aim of risk management planning is to engage and empower the participant to actively manage their own risk.

Effective risk assessment and collaborative risk management planning ultimately ensures better outcomes for participants, promotes self-management and reduces potentially tragic events impacting upon participants, carers, workers and the community.

Creating a support package

To what extent does the NDIA's budget-based approach to planning create clear and effective criteria for determining participant supports? To what extent does it lead to equitable outcomes for participants? What improvements could be made?

Are the avenues for resolving disagreements about participants supports appropriate? How could they be improved?

Our experience in relation to the creation of support packages and the resolving of disagreements about participant supports is inconsistent across regions and sometimes within regions. We can identify many instances where the budget-based approach and resultant support packages have been both comprehensive, clear, specific, and reflected the individual's wishes and goals. However, we can also identify instances where support packages do not adequately reflect the extent of the participant's needs, the range and extent of supports required, nor the participant's aspirations. The variance in support packages can often result in inequitable outcomes.

We are aware of many instances where participants with very similar needs have received markedly different support packages. The single most significant indicator of inconsistency relates to the distribution of the item Coordination of Supports (COS) as indicated in the table below.

Region	Packages	Coordination of Supports	Support Connection	Percentage CoS
Barwon	204	9	195	5%
Hunter	63	63	0	100%
NEMA	44	42	2	95%

We believe that the majority of participants with a psychosocial disability who have complex needs require active Coordination of Supports (CoS). CoS provides the capacity to actively manage and support individuals who experience fluctuations in mental state, crisis, are difficult to engage and have multiple provider involvement.

To ensure more equitable outcomes for people with a psychosocial disability we advocate for increased consistency in the allocation of Coordination of Supports. Improved consistency of support packages could also be improved through ensuring planners have the requisite skills, knowledge and experience in relation to people with mental illness and related psychosocial disability.

Our experience in relation to the resolving of disagreements about participant supports is extremely inconsistent across regions and sometimes within regions. As mentioned previously, we are aware of instances where we have successfully resolved disagreements and others where we have not been successful. We have experienced difficulties contacting planners and obtaining timely responses. We are unable to account for the inconsistencies.

To improve the inconsistencies experienced in resolving disagreements we advocate the creation of a timely formal review by an independent third party where disputes cannot be resolved.

Intersection with mainstream services

The ability of the NDIS to effectively interface with mainstream services is critical to ensuring both good outcomes for participants and the long-term sustainability of the scheme.

Is the current split between the services agreed to be provided by the NDIS and those provided by mainstream services efficient and sufficiently clear? If not, how can arrangements be improved?

Is there any evidence of cost-shifting, duplication of services or service gaps between the NDIS and mainstream services or scope creep in relation to services provided within the NDIS? If so, how would these be resolved?

How has the interface between the NDIS and mainstream services been working? Can the way the NDIS interacts with mainstream services be improved?

How will the full rollout of the NDIS affect how mental health services are provided, both for those who qualify for support under the scheme and those who do not?

What if anything, needs to be done to ensure the intersection between the NDIS and mental health services outside the scheme remains effective?

The NDIS involves a transition in service delivery in relation to a component of peoples' disability support needs. Peoples' lives and needs are supported through an existing, often extensive, service system. While the delivery of disability support will shift for many people receiving NDIS supports, other elements e.g. acute care, health care, primary care, private psychiatry, housing, financial and education, employment supports remain in place. Changing this single element will have flow on impacts (as yet not fully recognised) across the entire spectrum of the health and social care system. Some change will be immediate and obvious, others will be a slower burn, with gaps and issues revealing themselves over time. This system level impact was not predicted or planned for during the NDIS trial.

Our experience is that relationships with mainstream providers must change as the NDIS results in less flexible service provision than was possible under block funding. This is most obvious in jurisdictions that have cashed out almost all community mental health sector support to the NDIS, such as Victoria. Existing relationships require active renegotiation through transition to NDIS, with all parties requiring clear information about eligibility and the scope or service provision under the scheme. In trial sites we experienced varying degrees of information provision and understanding by mainstream providers. Where the scope of the scheme was not well understood it contributed to tension between providers.

The current boundaried thinking about disability support and acute health care has potential to undermine the experience of participants with complex psychosocial disability and increase costs overall. When a participant requires hospital admission, no funded disability support is possible. This severs the relationship at a time when continuity of relationship is critical to achieving good outcomes for the person. On discharge, additional work will be required to re-establish the relationship with the participant. A similar issue occurs when participants move in/out of justice settings. For example, in preparation for discharge from a forensic mental health unit, extensive preparatory work and relationship building is provided through in-reach of community mental health disability support. This is not funded under the NDIS and will compromise the capacity of justice services to facilitate safe and timely discharge for people, again increasing overall cost pressures on the health and social care systems.

Our experience indicates there will be increased reliance on clinical services as there is less tolerance for, or capacity to manage, risk within the NDIS. For example, under the NDIS pricing structure there is no capacity for the close liaison and joint working with clinical services. Neither will community mental health sector staff be able to work two-up to manage risk during periods where consumers were more acutely unwell. In the NDIS there is less scope for interaction between direct service delivery staff and other agencies, with liaison roles undertaken primarily by support coordinators. The risk issue will require careful consideration as options to work two-up in this funding structure will be limited, potentially shifting burden of risk and decision making around risk on to service delivery staff who are unlikely to have extensive training in risk management. In these circumstances responsibility for managing risk and providing support will be pushed back to clinical services, irrespective of their capacity to manage this increased demand. If NDIS providers are unable to provide necessary disability and emotional supports during this period it may add to participant stress and further exacerbate their mental state. Whereas, under previous funding arrangements when someone with a deteriorating mental state would receive increased supports, in the NDIS there is potential for people to receive reduced support. This may lead to increased pressure on a range of mainstream supports – police, emergency services, acute mental health services, and justice – along with poorer outcomes for participants. There is also potential that those with the highest level of psychosocial disability will be the most financially burdensome for providers to service; in that providers will have obligations to their staff including ensuring a safe workplace and provision of emotional support. They will need to accommodate sick leave taken by staff in response to physical or emotional employment burden, while maintaining service to the participant. Unless packages fully accommodate participants' service demands, providers may opt out of service provision for participants with the most complex needs, compromising the integrity and goals of the scheme.

Will providers be ready?

Are prices set by the NDIA at an efficient level?

As previously stated we hold genuine concerns about our and other providers' capacity to deliver quality services within the price structure set by the NDIA. We believe greater consideration to the varying needs and complexity of participants is required and the consequent varying skills and experience required by staff to effectively meet those diverse needs. Funding those with more complex needs at a higher rate will enable quality service provision to the majority of people with psychosocial disability at the lower rate, while allowing for quality, more-complex service provision for those who need it.

What is the capacity of providers to move to the full scheme? Does provider readiness and the quality of services vary across disabilities, jurisdictions, areas, participant age and types/range of supports?

What are the best mechanisms for supplying thin markets, particularly rural/remote areas and scheme participants with costly, complex, specialised or high intensity needs? Will providers also be able to deliver supports that meet the culturally and linguistically diverse needs of scheme participants, and Aboriginal and Torres Strait islander Australians?

Providers will struggle to deliver a financially viable and sustainable service into remote areas (in particular remote regions WA, SA, QLD and NT) under the current pricing structure. The 18% loading indicated in WA will not come close to the known additional costs of providing services in these regions (in some cases up to 220% higher than metropolitan delivery). This will likely result in no services, and certainly no choice in services, being available to meet the needs of people in these regions.

While Neami is interested in providing services into these remote regions, the bottom line of financial viability will drive our decisions; only significantly increased price caps will make provision in these markets more likely.

Effective provision of services to participants with diverse linguistic needs requires skilled staff, training and specialist support through interpreters. Lack of NDIS funding for interpreters, and in some cases lack of availability of interpreters, compromises participant capacity to gain appropriate plans or to fully utilise plans. While employment of support staff who speak a language in common with participants would be ideal, gaining staff with the right values, skill/experience mix, language capacity and availability to meet the needs of individuals is likely to be uncommon in densely populated metropolitan areas, let alone in rural or remote regions.

Culturally relevant services for participants from diverse cultural backgrounds and Aboriginal and Torres Strait Islander Australians can only be delivered by staff with adequate and ongoing training and support to build their skills in culturally relevant service provision. Employment of staff with a shared cultural background with participants will bring benefits however, culture is understood as uniquely experienced and culturally relevant practice requires a willingness to go beyond a worker's own perspective to hear an individual's unique perspective. This will include an ability to take time to interpret together how services can be provided in a way that meets their cultural needs. The training, ongoing professional development and supervision, and opportunity to negotiate cultural understandings with individuals, all take time that is not accounted for within the lean NDIS funding structure. Without an ability to engage in culturally relevant practice, participants from culturally and linguistically diverse backgrounds are unlikely to have their needs fully met within the NDIS.

How will the changed market design affect the degree of collaboration and co-operation between providers?

A major driver of continual improvements in expectations and outcomes for people living with mental illness and psychosocial disability in the last 20 years have been strong mental health sector and inter-sectorial collaboration and cooperation. For example, capacity to work across sectors – mental health, primary care, housing, welfare, alcohol and other drugs, and justice – has driven improvements in service delivery and outcomes for people who use those services. The lean and competitive market structure of the NDIS has seen collaboration eroded in some areas, with lean management structures, and business models requiring that 85% of staff time is in face-to-face service delivery, have resulted in few opportunities to liaise, share with, or learn from other providers. In some regions former collaborators in service delivery, research and sector contribution have been reduced to competitors without time to share experiences or work together to address concerns.

Notably, where a large number of plans have adequate provision for support co-ordination, such as the Hunter and some of WA, collaboration and cooperation have thrived. In these regions individual plans that incorporate service coordination have enabled time for continuing communication between services. This individual plan-driven opportunity for collaboration has had flow on effects for service collaboration more generally. In these regions where there has been time for maintaining relationships between services, strong leadership and direction from the Local Health Districts and NDIS has further built on opportunities for effective sharing and cooperation; for example the communities of practice in the Hunter. In regions without adequate allocation for support coordination or strong NDIS leadership around collaboration, we have witnessed increased competitiveness between providers and decreased opportunity to work together to optimise outcomes – effectively compromising the scheme's goals of a better life for people with disability.