Submission to the Independent Pricing Review 2017: McKinsey and Company

This is a joint submission from Community Mental Health Australia (CMHA) and Mental Illness Fellowship Australia (MIFA). We would like to acknowledge Neami National and Wellways Australia for their contributions to this submission. We would like to thank the National Disability Insurance Agency (NDIA) for the opportunity to comment on the Independent Pricng Review being undertaken by McKinsey and Co.

From the outset, we would urge the Board of the NDIA to make the full report and recommendations of the Independent Pricing Review publicly available. This will be important for the transparency of the review and to engender full confidence from the disability sector.

Access decisions, planning and delivery of supports must be founded on a solid, evidence-based understanding of what people with severe and enduring psychosocial disability need in order to maximise recovery, and ultimately reduce the level of support needed and increase community participation and contribution. The sector wants to work with the NDIA to better understand how a recovery approach can contribute to greater impact and cost efficiencies for people with psychosocial disability who are eligible for the NDIS. More grounded research of the impact of psychosocial support for this target group will inform the co-design of service-types and cost drivers that can be applied to the NDIS. This will assist the sector and the NDIA to develop price structures for psychosocial disability that achieve the objectives of the NDIS.

A central issue for including psychosocial disability in the NDIS has been that psychosocial disability support does not fit easily into the current pricing structures of the NDIS. The sector has developed responsive recovery-oriented models of support over many years, and has developed a workforce that is appropriately qualified and skilled to deliver this support. However, there is a mismatch between the supports people with psychosocial disability need and the types of supports provided in NDIS packages; and between the pricing of the supports and true cost of service delivery.

A recovery approach is aligned to the objectives of the NDIS. Supporting a person with psychosocial disability to build their resilience, strengthen their natural supports from family and friends, and develop their connections with the community, will lead to an increase in community participation and contribution, and a reduction in life-time support needs.

Developing a system of viable psychosocial support for people with severe and enduring mental illness within the NDIS requires an understanding of the key needs of people with psychosocial disability. These include:

- the need to take time to develop a comprehensive recovery plan;

- for capacity building, wrap-around support across many life domains and systems that can be flexible and responsive; and
- to have access to infrastructure and transport that meets their needs and be supported by well-trained and supervised staff.

Best practice in this space goes beyond the specific hourly price allocations, to a broader understanding of how supports to people with psychosocial disability are provided to ensure the best outcomes for people, and the ongoing viability of service providers.

Particular needs in psychosocial disability

A more responsive NDIS system is likely to be required for a range of disability groups accessing the NDIS. However, people with psychosocial disability require a specialised response due to the following:

- Significant disengagement with services, which may be due to a range of reasons, including stigma; low self-worth; lack of trust in service systems and previous poor experience with services; and/or a lack of awareness of their own condition. Functional impairments in psychosocial disability can include confused thinking, delusions and paranoia, which can significantly reduce a person's level of trust or engagement. This can result not only in disengagement from psychosocial support but all other mainstream services. It can also mean carers play an additional role in supporting people to understand their need for support, and a lack of insight from participants about the needs of their carers can mean carers are forgotten during individualised planning. Services must often engage with participants for months before enough trust is established for a participant to accept other services, including NDIS services.
- Ongoing interface with clinical care, support with medication adherence, and need for care co-ordination across inpatient, primary and allied health responses.
- Ongoing interface with 'mainstream' services such as housing, income-maintenance, employment, transport, physical health etc.
- Cyclic nature of mental illness and inherent inability to class any psychosocial impairment as permanent.
- Interface with guardianship and legal issues.

Implications of current pricing

The current price structure of the NDIS raises several central issues and implications for psychosocial disability support provision. The Reasonable Cost Model[1] fails to acknowledge the true cost of providing disability support to individuals with serious mental illness. The implications of the current pricing for psychosocial services are potentially:

- The exclusion of participants with higher needs that require higher levels of staff support from these services.

[1] NDIA and NDS (2014), *Final Report of Pricing Joint Working Group*. Available at: https://www.ndis.gov.au/html/sites/default/files/documents/final_report_of_pricing_joint_working_group.pdf

- The loss of existing skilled and qualified staff and a de-skilling of the workforce. Employees are more commonly employed on a permanent basis, however, the NDIS is leading to increased casualization of the workforce. Some providers have restructured their workforce already – meaning existing skilled recovery support staff have been retrenched and replaced by a lower skilled and more casualised workforce. Over time all providers may well opt to hire the lower-skilled staff they can afford to be able to offer NDIS services. Workers may choose to leave the sector altogether and move to clinically focused mental health support roles instead. This will impact on recovery-focused psychosocial rehabilitation supports, which will develop into generalist disability supports.
- Service providers may choose to only provide low-priced supports if the NDIS participant also purchases higher-priced supports from them, effectively aiming to some degree to offset losses on one support with profits on another. This limits choice and control and undermines the objectives of the NDIS.
- Without changes to either funding style or the pricing model to adequately fund centre-based service provision, some members report up to 90% of centre-based services for psychosocial disability may close.
- Withdrawal of service providers altogether from the market. Some service providers, particularly in rural and remote areas, are at the point of imminent withdrawal from the market due to unacceptable losses, which are drawing on already small reserves.

A mental-health responsive, recovery-oriented NDIS approach

A review of the line items or types of services provided needs to be undertaken to see how closely they match with the actual needs of people with psychosocial disability. The following approaches would provide more effective and efficient support for people with psychosocial disability in the NDIS.

Developing a comprehensive recovery plan

People with severe and enduring mental illness experience a high level of disengagement with services. Building trust through prolonged engagement is a core requirement of any psychosocial support. The NDIS must support participants to access the NDIS, and once access has been granted, support is required for a planning response over time.

Successful recovery-oriented support services have embedded planning and goal-setting within the support process. Current best practice recognises that for many people with psychosocial disability understanding the barriers and their strengths, and exploring and activating a future-oriented goal planning process takes time. A period of building trust, understanding the person and their needs and aspirations, and understanding what is possible for recovery, gives a person and their support worker the best chance of identifying a plan, which maximises recovery, and therefore achieves the objectives of the NDIS to reduce the level of support and increase community participation and contribution.

This typically occurs over a period of 6-8 weeks, and requires the worker to initially take the lead and use assertive approaches, such as outreach, to engage the person. Over time, the participant becomes more actively engaged and takes the lead. This process includes involving others and developing a collaborative plan, and exploring issues such as early warning signs

and desired responses. This needs to be carried out by skilled mental health recovery professionals.

There must be capacity in the NDIS support provider for providers to deliver this element. This could be funded on an hourly basis for many participants, for example, 20 hours to deliver a Collaborative Recovery Support plan. This could be outcome oriented funding with providers required to demonstrate that the plan was person led, involved family/carers, and collaborated with other providers. The plan could clarify the supports required in the Individually Funded Plan going forward, and establish communication protocols among providers and other parties going forward.

Capacity building for mental health

The NDIS is designed to support people to participate in everyday life, which is the goal of many people with psychosocial disability. The NDIS is not intended to provide health interventions to enable this, but rather provide supports to assist the person to overcome barriers that prevent participation.

Current planning methodology focuses on whether a person can or cannot perform the activity, whereas in psychosocial disability, barriers around motivation, meaning making, self-efficacy, side-effects of medication, co-occurring substance use issue, for example, impact on whether a person engages in the activity or not. No amount of having people into the home to do that activity, or provide assistance will change that. Physical support does not address the barriers that prevent the person from participating. The current NDIS approach favours core supports over capacity building supports. Furthermore, the current pricing structure does not allow providers to employ appropriately skilled staff.

Psychosocial disability support that addresses the underlying barriers, and seeks to build underlying strengths is the most effective approach. Supporting someone with psychosocial disability is rarely about physical support or a lack of capability. Rather than lacking inherent capability (as may be the case for some physical disabilities), a person requires support to overcome psychosocial barriers. For example, a person may require support to perform household tasks, not because they do not know how to manage the task, but because a combination of cognitive, social and motivational factors means they do not. The most effective approach here is to understand these barriers and use a coaching approach that addresses the underlying barriers, rather than a support approach. This approach will build capacity resulting in shorter term support, and requires people skilled in these approaches. There is evidence to support this approach:

- Wellways and NEAMI data demonstrates that with appropriate psychosocial support, needs decrease over 12-18 months.[2]

[2] Muir, S et al (2016) Evaluation of outcomes for Wellways Australia, Recovery Star and Camberwell Assessment of Needs data analysis. Swinburne University of Technology, 21 October 2016, https://media.wellways.org/inline-files/External%20evaluation%20for%20Wellways%20Draft.pdf

- Evidence based interventions address participation barriers at a psychosocial level. For example, peer support is known to enhance self-efficacy and self-management skills, address self-stigma and build a vision of recovery and possibility.[3]

The current approach, with an over-emphasis on core support hours, is inefficient. Adopting an approach that works in physical disability results in an approach that supports people to address discrete participation goals and can inadvertently lead to dependency creation. Addressing the underlying barriers that restrict participation, and building life skills, on the other hand, builds self-management skills that enable participation across multiple life domains, which is more efficient and effective and builds independence and recovery over time.

Support across life domains and systems

People with psychosocial disability are often highly disengaged from and distrustful of services. Services specifically for people with mental health issues span primary health, public health, community, and legal sectors; these sectors are also highly siloed. People with mental health issues are also significantly disadvantaged in a huge range of other "mainstream" domains of life.[4] They need support to connect with a range of services and co-ordinate clinical and social supports. Care coordination or case management as currently provided by the sector includes functions that are currently split across several line items and areas of the NDIS system (recovery planning, support coordination, capacity building, & broader Local Area Coordination work including 'case-finding,' assertive outreach and mainstream service coordination).

The scope of coordination of supports must be increased for psychosocial disability, to include:

- assertive contact where participants disengage
- one-on-one ongoing capacity building work, including building capacity to manage plan
- providing information, referral and coordinating access to other mental health supports, including liaising with clinical team
- supporting access to mainstream supports, in particular housing, other health supports, income and employment, mental health advocacy
- supporting ongoing self-discovery, goal-setting and planning activities; and re-visiting goals and helping participants prepare for plan reviews

Coordination of Supports should be built into every plan; considered a fundamental part of someone's plan; and be ongoing (even if at a lower level) for the life of a plan. The implication that participants should ultimately be able to move to self-management with little or no support coordination represents a misunderstanding of what psychosocial support is. Ongoing

[3] Davidson, L., Bellamy, C., Guy, K., & Miller, R. (2012). Peer support among persons with severe mental illnesses: A review of evidence and experience. World Psychiatry, 11(2), 123-128

[4] There is a huge range of mainstream supports that psychosocial case managers currently provide support to access, including: housing, safety, income/employment, other healthcare / chronic condition management, transport, justice system, criminal, cultural and religious needs, relationship/ family inclusion, social participation and recreation.

coordination of supports enables active management and support for individuals experiencing fluctuations in mental state, disability or need; who have difficulty in engaging with services; and/or have multiple provider involvement. For psychosocial disability, coordination of supports must include liaison with all agencies and people engaged in supporting the recovery of the individual, including health, as well as building capacity in the individual to manage their NDIA plan. Increasing the scope of coordination of support in this manner brings the item in line with evidence-based care coordination principles, and will ensure a coordinated and efficient approach across sectors. This approach will also enable early support to be activated, including clinical assistance, if a client becomes unwell.

An alternative to expanding the scope of Coordination of Supports in this manner would be to introduce a new line item for psychosocial disability care coordination, priced in line with specialist support coordination.

Increased flexibility

Flexibility is a core tenet of recovery-oriented service provision. Flexibility is required due to the fluctuating needs of people as their mental health state and function varies. Plans that are inflexible and made at a point in time are almost always under or over resourced. Flexibility could be increased via the following:

- Packages should contain adequate hours of support to allow for flexible service delivery, such that support can be front-ended at the beginning of support and taper off, and allow for a rapid increase in support during a crisis.
- Plans must be able to be reviewed rapidly where circumstances change. The plan review process needs to be more flexible and responsive with a reduction/removal of existing lengthy plan review lag times.
- Participants must have the ability to frequently cancel or change appointments at last minute on “bad days” without service providers incurring significant losses. Flexibility could be provided through alternative funding arrangements for certain activities, such as group programs, such as subscriptions, memberships, full course fees, bulk buying of support incidences in advance and/or much more lenient cancellation policies. Without this flexibility, service providers may choose to cease providing these services altogether.
- Some participants strongly benefit from centre-based drop-in style supports. Individualized funding in hourly supports does not provide adequate corporate overheads for maintaining accessible and welcoming locations, or adequate flexibility for people dropping in at short notice and for short amounts of time. Flexibility in funding would allow for use the facilities, brief interactions with support workers or general admin staff and informal interactions with other participants. Without increased flexibility, many centre-based services are facing closure.
- Continuity of care when clients are in hospital/acute setting is essential in ensuring workers can maintain contact and be involved in the discharge process. This service must be allowed to be provided under all support line items, including core and capacity building supports.

- Plans must include adequate transport for people to work on their goals and access appointments over the course of the year and/or to pay support workers to assist with transport.

The pricing

In order to create an NDIS that can respond appropriately to people's psychosocial needs, we need a better understanding of the relationship between the approved support package and the cost drivers, resulting in an appropriate hourly pricing rate. Issues related to qualifications and experience of staff; supervision of staff; training and retention of staff; and staff travel must also be included. There are many hidden costs not accounted for in the Reasonable Cost Model, and some cost pressures unique to the psychosocial disability sector.

Based on the cost drivers, the unit cost for psychosocial support estimated by some community managed mental health providers is closer to $55 to $60 for viable and appropriate core psychosocial supports. In the interest of transparency, the sector is and would be prepared to test our assumptions through targeted research, to explore options and work with the NDIA to reach a mutually agreed and appropriate outcome, that maximises the objectives of the NDIS and achieves cost-efficiencies. The objective of providing a defined cost to this Independent Review, is to provide information in a positive way to reach a constructive understanding of the cost drivers and what would be appropriate fees informed by the expertise and experience of the community managed mental health sector.

In relation to the assumptions applied to estimating the efficient cost of the provision for attendant care, the following comments in relation to psychosocial disability apply:

Base hourly rate

A key determinate in relation to clients receiving services relevant to their needs is the knowledge, skills and experience of people working with people experiencing mental health issues and psychosocial disability. The Reasonable Cost model assumes workers with no or low (certificate-level) tertiary education[5], whereas workers are currently hired at much higher levels. The delivery of recovery oriented and capacity building support to a person with psychosocial disability requires a skill set that enables the worker to target the underlying barriers to functional engagement. The workforce that delivers psychosocial supports is highly skilled and these skills must be reflected in the pricing. The NDIA has stated that it sees capacity building-style work as integral to all kinds of support, including those described as "core". However, the pricing model, based on SCHADS SACS Level 2.3[6] for core supports, does not enable service providers to employ staff with the skills to manage complexity, respond to challenging behaviours, maintain engagement and build recovery.

[5] p28-29, Cortis, N., Macdonald, F., Davidson, B. and Bentham, E. (2017). *Reasonable, necessary and valued: Pricing disability services for quality support and decent jobs*. Available at: http://apo.org.au/system/files/98111/apo-nid98111-354151.pdf

[6] P12, NDIA and NDS (2014), *Final Report of Pricing Joint Working Group*. Available at: https://www.ndis.gov.au/html/sites/default/files/documents/final_report_of_pricing_joint_working_group.pdf

Non-client facing time

The requirement for 85% - 95% client-facing time under the Reasonable Cost Model[7] requires an increasingly mobile staff, with very little in-office time, therefore reducing opportunities for incidental supervision. The current Non-client-facing time assumptions fail to account for the following:

- Assertive outreach activities, which may be classified as time not directly with a client. Many clients with psychosocial disability require an assertive approach to ensure engagement.
- Liaison between support co-ordinators and other supports working with the person. To ensure all supports are delivered in a coordinated way, and all providers can respond effectively to the changing needs of participants and their families, it is imperative that a deliverer of core supports is able to meet, for example, 1 hour per month, with the Support Coordinator so that they are aware of the current issues that are impacting on the client's life and are confident in recognising emerging risks and warning signs for the individual.
- Training and development. This is a significant part of furthering the skills of the workforce but is not accounted for. The cost model must factor in an additional 2% non-client facing time for training and development, as well as an additional 1% training costs into overheads.
- Staff travel time and transport costs, particularly for outreach and services in regional, rural and remote areas is not adequately considered in the hourly cost model.

Supervision and debriefing

The Reasonable Cost Model assumes supervision at a ratio of 1:15 by a SACs Level 3.2. This is contrary to the Award conditions, which stipulates that staff at a Level 3 can supervise only limited employees.[8] It is also lower than current standards of supervision in the sector, which are maintained as an Occupational Health and Safety requirement to reduce burnout and compassion fatigue for both supervisors and staff providing high-intensity emotional support to people with often significant levels of trauma. Furthermore, a significant priority of the psychosocial disability support workforce are peer support workers, who often require additional supervisory support but also bring invaluable expertise to the workforce.

Organisational overheads

The cost of transition processes to the NDIS is causing significant administrative costs, so the assumption should not be these costs have reduced through a higher-level efficiency. Inclusions in Corporate overheads must account for the significant costs of development and maintenance of administrative and IT systems, finance, human resources, governance, accommodation and utilities.

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[7] p12, NDIA and NDS (2014), *Final Report of Pricing Joint Working Group*. Available at: https://www.ndis.gov.au/html/sites/default/files/documents/final_report_of_pricing_joint_working_group.pdf

[8] p44, Cortis, N., Macdonald, F., Davidson, B. and Bentham, E. (2017). *Reasonable, necessary and valued: Pricing disability services for quality support and decent jobs*. Available at: http://apo.org.au/system/files/98111/apo-nid98111-354151.pdf

Rural and remote areas, and supporting Aboriginal and Torres Strait Islander people

The pricing does not adequately reflect the true cost of services for rural and remote areas, and in supporting Aboriginal and Torres Strait Islander communities, particularly in remote areas. The additional cost pressures faced in rural and remote areas can include significantly increased transport costs; additional overheads associated with remote premises; additional staff benefits to attract staff and the need for more specialised and trained staff where language and cultural differences exist; and staff housing requirements.

Investment in recruitment, training, development and ongoing support of local Aboriginal workforce, for example, can involve additional short-term costs, but produces significant long-term savings. There should be a consideration of expanding the regions defined as rural and remote; and undertaking a review of the business model for providers operating in these areas, to develop pricing that adequately reflects the significant cost pressures.

Case Study

The following case study demonstrates the approach that was taken through an NDIS funded environment to a person with a psychosocial disability experiencing a crisis. It then outlines what a better response would be and the funding structures that support this response and approach.

Approach through the NDIS

'Sarah' had been receiving supports for:

- increased community and social participation – very limited funding for Sarah to engage a service to declutter her house
- support connection – 30 hours to assist connection to mainstream supports
- occupational therapy (OT) assessment
- core supports – by far the majority for house maintenance and assistance to access community and recreational activities

Sarah chose the same provider to deliver Support Connection and the OT assessment, and deliver the core supports. Sarah became quite unwell during this support delivery, and was experiencing disturbed sleeping, disorganised thoughts and an inability to make any stable decisions about her engagement with the provider.

The provider responded to all her requests for plan changes. They changed Sarah's worker, and refunded multiple hours of support that she now objected to – including the content of the OT assessment. She was at times satisfied with the provider's responses and at other times dissatisfied.

With Sarah's permission, the provider liaised with her private psychiatrist to gain an understanding of her treatment plan and develop a more integrated and effective response. This highlights:

- That significant work was undertaken in response to Sarah and her expressed needs. This was unfunded.
- That there was no coordinated response between Sarah's treatment team and the provider. Sarah was experiencing a mental health crisis that required treatment, and

reached out to the provider as her support provider. The response was however disconnected. The provider's liaison with the private psychiatrist was unfunded, as Sarah would not agree to it being delivered as part of her plan.

- Sarah's plan, although ideally could have had hours "banked" to respond to crisis issues, was not adequate to address her escalating mental health needs. She had a small allocation of Support Connection that focused on her using her NDIA plan.
- The support staff delivering her core supports (at $44/hour), and capacity building ($57/hour), were ill equipped to recognise and adequately respond to escalating mental health issues early.

A better response

This response could be greatly improved by the following adjustments.

At the beginning:

- Sarah could have a comprehensive collaborative Recovery Support Plan that recognised her strengths and potential barriers to achieving her goals.
- This would be developed in collaboration with Sarah and important others – such as her private psychiatrist and her family
- This would include an understanding of potential mental health issues, triggers, and an Advance Plan
- This means her support provider would be well equipped to respond to Sarah's needs and proactively manage risk. These strategies would be led by Sarah.

During delivery:

- Engagement with a skilled mental health practitioner could build skills to assist her in addressing the functional impact of her mental health issues – such as managing her hyperactivity and disturbed sleep and wake cycle that were impacting on her daily life and participation. This is about the development of self-management skills that support wellbeing.
- Focus on addressing barriers to her performing household tasks – rather than providing assistance.
- Engaging a skilled peer worker
- Engagement with a skilled practitioner would also mean early signs of mental ill health could be detected and responded to
- Liaison with treatment team.

What funding structures support this approach?

- Capacity to engage participants in an assessment and planning response over time - probably over 6-8 weeks
- Expanding the scope of Coordination of Supports, or creating a new item that addresses psychosocial barriers and builds upon strengths funded at a level that enables skilled mental health recovery practitioners to be engaged
- Funding non-face-to-face time in Core Support and in non-Support Coordination Capacity Building Supports, to ensure all supports are delivered in a coordinated way.

Conclusion

The independent price review is a vital opportunity for the mental health sector to raise issues and concerns about the pricing structure of the NDIS for psychosocial disability supports, and to demonstrate the importance and value of a recovery based model of supports. Best practice in this space goes beyond the specific hourly price allocations, to a broader understanding of how supports to people with psychosocial disability are provided to ensure the best outcomes for people, and the ongoing viability of service providers.

The sector has always been and is prepared to explore options and work with the NDIA to develop options that are appropriate for the sustainability of the NDIS and what will deliver quality supports to people with a psychosocial disability. More grounded research is required to test the assumptions of the model and better understand psychosocial disability support, which will serve to inform the co-design of service-types and cost drivers that can be applied to the NDIS. The objective of providing this submission to the Independent Price Review is to provide feedback from the sector on the key elements required to fund recovery-oriented psychosocial disability support, and understanding some key cost pressures, informed by the expertise and experience of the community managed mental health sector. We look forward to working further with the NDIA, McKinsey and Company, and other stakeholders, including participants, in developing an approach that meets the needs of people with psychosocial disability.