Mental Health Australia

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# Submission to the National Disability Insurance Scheme Independent Pricing Review

**OCTOBER 2017**

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## Introduction

In commissioning McKinsey and Company to undertake an Independent Pricing Review, the National Disability Insurance Agency (NDIA) Board has recognised that a deeper understanding is required of key dimensions of pricing.

To date, there has been no transparency over the NDIA's efforts to properly price NDIS services. Mental health stakeholders have repeatedly called attention to the inefficiency and ineffectiveness of pricing arrangements for psychosocial support services, with no apparent impact on the NDIA's decisions in setting prices or determining support items. Consequently, the sector has little confidence at present that the NDIA has the necessary expertise to establish a pricing regime that will serve the NDIS and its participants into the future, let alone have responsibility for market stewardship.

The Independent Pricing Review is a rare and welcome opportunity to properly understand the psychosocial services market. At this stage of Transition the mental health sector considers such a review is urgent: smaller organisations with less working capital are already folding, merging and otherwise needing to make difficult business decisions. These outcomes are not necessarily in the interests of people with psychosocial disability. Corrective action must be taken by the NDIA on a range of fronts, including on pricing arrangements, to provide a more stable future for the psychosocial services market. The right solutions can only be found through deep engagement with mental health stakeholders, a task Mental Health Australia stands ready to assist with.

## Key messages

It is critical to emphasise at the outset that many participants with psychosocial disability are either receiving services they do not want, or not receiving services they want or would benefit from. In the context of a review into pricing, this raises serious questions of both inefficiency and ineffectiveness. It also raises a question about whether people with psychosocial disability are able to exercise genuine choice and control, a fundamental principle underpinning the Scheme.

The reasons this is occurring are multifaceted, and are not simply related to well-known challenges associated with the planning process. For the purposes of the McKinsey Review, the structure of the Price Guide and the rigid manner in which it has been applied has contributed to the current set of challenges. There is substantial scope for the NDIS Price Guide to be updated so that providers can respond more flexibly to the needs of people with psychosocial disability. The review should consider additional pricing and payment structures that would enable providers to deliver services which build the capacity of NDIS participants and consequently reduce their long-term reliance on the NDIS.

Examples of such approaches are provided in this submission. This is not an exhaustive list, and Mental Health Australia looks forward to working collaboratively with the NDIA and mental health stakeholders to test and refine these and other concepts. This would in

fact be the first time consultation regarding how to capture the needs of people with psychosocial disability in the NDIA's pricing arrangements would have taken place; until it occurs, the Price Guide remains an artefact of a Scheme designed for a different population.

The NDIS is based on insurance principles, but it is especially difficult to see the investment approach realised in plans developed for participants with psychosocial disability. Current arrangements are most likely to keep participants dependent on welfare and disability support, rather than building their capability wherever possible.

However, with a combination of a newly designed Price Guide, more flexibly applied, better planning and other strategies, the investment conditions will be in place to support participants with psychosocial disability to maximise their social and economic participation over the medium and long term, despite the impact of living with a mental illness. Such an approach is not only consistent with Scheme principles, it is fiscally responsible and is likely to lead to a downward trajectory in lifetime liabilities.

In order for these issues to be adequately addressed, we ask that the McKinsey Review examine:

- the distinctive characteristics of people with psychosocial disability, which give rise to the need for intensive support delivered by a workforce with specialist skillsets
- options for alternative product structures with appropriate pricing mechanisms that can lead to both more effective and efficient service delivery and greater choice and control for participants with psychosocial disability
- the operational costs of providers of psychosocial services through empirical data analysis.

## This submission

Against the relevant terms of reference for the Review, this submission will explain how psychosocial support services differ from attendant care services and therefore require specific items in the NDIS Price Guide. It will also demonstrate how the NDIS Price Guide is creating an inefficient and ineffective NDIS for people with psychosocial disability, and offer some alternative approaches.

The submission does not address broader issues relating to provider efficiency or the adequacy of provider returns. Given the state of heightened uncertainty that psychosocial service providers are experiencing with Transition, we expect it will not be possible for the Independent Pricing Review to arrive at any definitive findings. Accordingly, our submission is focussed on how the structure of NDIS pricing arrangements can best meet the needs of participants with psychosocial disability, taking into account the Review's terms of reference.

## Context

There are several important contextual factors that the Independent Pricing Review needs to take into account.

First, prior to the NDIS psychosocial support services were funded by governments under programs and financial arrangements that gave providers much greater flexibility to engage people with their service and to accommodate their individual needs. With some exceptions, this means that the community mental health sector has been delivering 'choice and control' to consumers for many years, via a different funding model. This is direct evidence that choice and control is still possible through funding arrangements that differ from the hourly rate of service model adopted since NDIS rollout commenced.

Second, psychosocial disability was added to the NDIS in response to vocal consumer and carer advocacy for its inclusion in the Scheme. While the Productivity Commission gave some consideration to the distinctive needs of this group, the nature of the existing service system was not given the same consideration as for other types of disability. As a result, implementation of the Scheme has focused on physical disability systems, with ad hoc responses to the needs of people with mental illness associated with psychosocial disability. For the purposes of this Review, it is worth noting that the Price Guide was developed without reference to the needs of people with psychosocial disability.

Third, to date providers of psychosocial services have had no involvement in the process to set NDIS prices for their services. Instead, the NDIA has imposed a complex and activity-driven pricing regime, developed for the broader disability sector, on the community mental health sector, which has different service models, skillsets and cost drivers. Providers have had to accommodate prices set through the Reasonable Cost Model (developed jointly by the NDIA and National Disability Services, with the involvement of no other party), which is itself a cause of contention across the broader disability sector.

There has been some activity sponsored by the NDIA that held the promise of proper consideration of mental health prices. The NDIA and Mental Health Australia jointly undertook the Psychosocial Supports Design Project with the intention that the project's findings would support future work on pricing matters. In addition, a Community Mental Health Australia paper funded by the NDIS Sector Development Fund identified that the pricing constraints and rigidity in the (then) Catalogue of Supports was impeding providers' efforts to remain faithful to a recovery model and to deploy and manage the specialised workforce effectively. To date, neither activity has influenced the maximum prices offered for NDIS-funded services or the categories of support people with psychosocial disability typically access through the Scheme.

Responses to specific terms of reference are set out below.

## Services with different levels of complexity

The impairment and participation restrictions associated with psychosocial disability include loss of or reduced abilities to function, think clearly, experience full physical health and manage the social and emotional aspects of life. The best outcome for people experiencing such disability is achieved through supports that mitigate the effects of impairment or participation restriction and enhance the social and environmental

opportunities to expand their capabilities.[1] Supports need to be flexible to respond to the fluctuating needs of people with psychosocial disability.

Psychosocial services align with the principles in the *National Framework for Recovery-Oriented Mental Health Services.*[2] The concept of recovery has grown out of the mental health consumer movement and describes the personal process by which mental health consumers and their carers work through the challenges of mental health conditions and their experiences with services to re-establish self-esteem, identity and a meaningful role in society.[3]

A recovery-oriented approach aligns with the objective of the NDIS to maximise independence and social and economic participation at the individual level, and is consistent with the Scheme's emphasis on choice and control.

The community mental health sector has developed a specialised workforce that is appropriately qualified and skilled to provide unique support that builds the capacity of people with psychosocial disability to recover, manage their activities of daily living and lead contributing lives.

The dynamics of engaging people with psychosocial disability with the NDIS and providing them with the services they need are somewhat different to physical disability where consumers will seek out services and have a greater need for attendant care (or core supports) to assist them with activities of daily living.

Consumers with significant psychosocial disability impairments are frequently reluctant to engage with support systems. Psychosocial service providers use assertive outreach to engage the consumer, followed by a period of relationship building to establish trust. Only then can a psychosocial support worker work with the consumer to assess their needs, set goals, formulate a plan and coordinate supports.

The uniqueness of psychosocial disability is that, rather than physical barriers, consumers have cognitive, social and motivational barriers to activities of daily living. These barriers are addressed with a coaching approach that is personalised to the individual, builds on their strengths and maximises their potential to manage everyday life and participate in the community. A psychosocial support worker requires a higher level of independent judgement and carries a significant responsibility and duty of care to the consumer far higher than that expected of an attendant care worker. This may not however be immediately obvious to an untrained observer witnessing the care being delivered on any particular day, which might seem identical to (say) a cooking or cleaning task but which is designed to assist a participant build his or her capacity for independent living.

Psychosocial services build the capacity of the person, which improves their mental health status and their social and economic participation. Psychosocial disability requires supports that emphasise capacity building – yet unlike the pre-NDIS programs being

[1] National Mental Health Consumer and Carer Forum. *Unravelling Psychosocial Disability*. 2011 p.16
[2] Endorsed by the Australian Health Ministers' Advisory Council in 2013
[3] National Mental Health Consumer and Carer Forum. *Unravelling Psychosocial Disability*. 2011, p.30

replaced, participants' NDIS plans are favouring core supports (in the order of 70% of package costs to date).

From the outset, the NDIS (including the current Price Guide and its predecessors) was designed for physical and sensory disability, with an emphasis on core supports in the general context of people whose needs remain largely or stable over a lifetime, and who do not generally require specialist skills to engage effectively. Psychosocial support providers consistently report having to adopt 'workarounds' in response to the current NDIS Price Guide, particularly when they are delivering core support items, with common misunderstandings about what item descriptions are intended to mean for this cohort or frustration about how quality support can be delivered for the price on offer.

An alternative approach taking into account the distinctive needs of participants with psychosocial disability would require:

- specific funding arrangements for providers to work with people before they become an NDIS participant,
- specific items in the Price Guide for specialised psychosocial support services that are intended to build participant capacity, priced accordingly, and are not solely focussed on connecting or coordinating access to other services, and
- a range of new, pricing arrangements which move beyond hourly pricing and provide greater incentive for providers to focus on participant outcomes, with some examples discussed below.

## Effectiveness of the hourly return approach to set prices

### Efficiency

While this submission does not address the NDIS planning process, it is important that the Review recognise that NDIS expenditure is subject to allocation of supports that are inefficient and/or ineffective. Supports are inefficient if they fail to aid the recovery of and support for people with psychosocial disability. High-quality psychosocial support should always emphasise capacity building and recovery. However, from our participation in the NDIA Mental Health Sector Reference Group, Mental Health Australia understands that at present the majority of investment for people with psychosocial disability is directed towards core support, which is precisely the wrong emphasis. This review should therefore investigate the ratio of core vs capacity building support types in NDIS plans for people with psychosocial disability. This analysis should consider in detail the allocation of each of the three levels of 'Support Coordination'. The levels range from Support Connection, which is time limited, less intensive and offered at a lowest hourly rate, through 'Coordination of Supports' which requires a higher level of skill and is funded accordingly to Specialist support coordination, requiring an allied health professional for delivery and the response to "high risks in the participant's situation'.

In practice Mental Health Australia understands that the time limited 'support connection' level of support coordination (which can be delivered by Local Area Coordinators) involves only the establishment of connection with other services. Therefore this item could be considered as akin to the delivery of core supports (rather than capacity building supports) due in part to its time limited nature. Accordingly, it will be important

for this review to distinguish between the various levels of support coordination when analysing the appropriateness of the ratio between core and capacity building supports in NDIS plans for people with psychosocial disability.

Although core supports can address some of the immediate barriers that prevent a person from undertaking activities of daily living and social and economic participation, they are generally not focussed on building the capacity of the person to independently overcome these barriers into the future. Without a complementary approach that addresses underlying barriers and functional impairments, people may not build the independence that they may otherwise would be able to with the right support and would therefore be reliant on core support in the longer term.

In time Scheme data will show these have been the wrong investments, but feedback from participants and providers today suggests that some participants are receiving services they do not want or need, and not receiving services they want or would benefit from. Further, the Price Guide, in addition to the planning process, appears to be a key contributing factor. This cannot be allowed to continue.

It is not entirely clear how we have arrived at this juncture, the problem (or the solution) does not lie solely with the planning process. Instead, much of the issue is with the Price Guide itself, and the design principles which underlie it.

## NDIS Quality and Safeguarding

Mental health service providers have repeatedly highlighted that the pricing structure underpinning NDIS supports is inappropriate for the psychosocial support work currently delivered by suitably qualified people outside the NDIS in line with the National Standards for Mental Health Services.

Under current NDIS pricing arrangements, community mental health organisations face restrictions on their capacity to provide appropriate professional supervision, learning and development opportunities or in enabling two workers to attend visits to clients who have a history of violence or live in unsafe living conditions. An inadequate pricing structure can create situations where workers with limited qualifications, experience and training may be operating without adequate supervision in complex situations. This raises serious health and safety issues for both workers and mental health consumers.

Such scenarios are at odds with the National Mental Health Workforce Plan endorsed at the Australian Health Ministers' Conference in 2011, which specifically advocated increasing opportunities for supervision, lifelong learning and professional development to "promote increased quality and safety for consumers, families and carers and staff" in the mental health sector.[4]

With pricing for supports continuing as they are currently structured, providers may also struggle to meet their future obligations as outlined in the NDIS Quality and Safeguarding Bill (currently before the parliament) and subsequent rules, which will include the NDIS Practice Standards.

[4] Mental Health Workforce Advisory Committee, *National Mental Health Workforce Plan*, 2011, p3.

## NDIS Price Guide

NDIS funding via the Price Guide and its hourly prices falls short in meeting the needs of people with psychosocial disability for the following reasons:

- There is no payment mechanism for ***assertive outreach*** to engage people who are likely to be eligible for and will benefit from the NDIS, by the community mental health sector. This is core business for established providers who are trusted by the communities they serve, and should remain so under a high-functioning NDIS.
- There are no specific items for ***recovery-oriented psychosocial support*** that is most often needed after the planning process and before the utilisation of supports. The *support coordination* and *capacity building* items are quite specific in focus and do not obviously accommodate where a provider needs to work with the participant to stabilise their situation before embarking on recovery and capacity building.
- Hourly prices for ***group activities*** assume a full contingency of clients always participate. If only a few clients attend, as occurs regularly, the activity is not a profitable one for the provider, even if participants find the activity highly beneficial.

## Alternative pricing and payment structures

Mental Health Australia expects the McKinsey Review will examine not only the prices in the NDIS Price Guide, but the full suite of services needed for people with psychosocial disability. Not all of the services lend themselves to an hourly rate. The review should consider additional pricing and payment structures that would enable providers to deliver services which build the capacity of NDIS participants and consequently reduce their long-term reliance on the NDIS.

Just like in any market, organisations which operate in the psychosocial disability market must be able to structure the way they receive their income to match the type of service they provide in order to remain efficient and financially viable.

The following alternative pricing and payment structures are informed by early NDIS experiences and suggestions of service providers, and would benefit from full consideration by the Independent Pricing Review and broader consultation with consumers, carers and providers.

### *Block payment*

Assertive outreach is unlikely to be provided in the absence of some degree of block funding. Assertive outreach takes place before someone accesses the NDIS, so NDIS registered service providers are not able to charge the NDIA (regardless of whether a consumer ultimately becomes an NDIS participant). It may also occur once someone has become a participant – when the NDIA is at risk of losing contact with a participant experiencing an episode of high need. The very low prices for NDIS supports mean that providers of psychosocial services have no scope to cross-subsidise assertive outreach activities. Without direct funding for specialist assertive outreach, the organisations that regularly work with hard to reach people are unlikely to continue this activity. In the long term, the inevitable result will be this most vulnerable of population groups will

experience higher levels of illness and disability, increasing costs to both mainstream systems and to the NDIS.

With interim block funding arrangements applying during Transition via the Partners in Recovery (PiR) programme, there is emerging evidence that assertive outreach ceases to be delivered when the NDIS rolls out and the PiR programme closes – particularly for new clients. In the long term, without specific new pricing and payment structures, there is a major risk assertive outreach for people with severe mental illness and complex needs will no longer be delivered at all, either through the NDIS or elsewhere.

Assertive outreach is the critical first step in engaging a person with psychosocial disability with the NDIS. It is entirely appropriate therefore that the NDIS fund registered psychosocial service providers to provide assertive outreach, either through the Information, Linkages and Capacity Building stream, or through a specific annual payment. It could be efficient to allocate funding through regional block grants based on estimates of unmet need amongst hard-to-reach populations.

### *Blended payment*

Given the episodic nature of mental illness, it can be difficult for organisations to plan delivering even one-on-one psychosocial disability supports. It can also be difficult to bill for services under the inflexible, hourly, NDIS pricing structure. For example:

- mental health consumers may miss their appointments (sometimes frequently) with psychosocial recovery workers or actively avoid them due to the symptoms of mental illness
- mental health recovery workers can spend significant amounts of time re-establishing contact with existing clients who fall out of contact due to, for example, hospitalisation, the onset of homelessness or interaction with the justice system
- mental health consumers may use services less than planned when well and more than planned when unwell.

A blended payment might therefore be appropriate, whereby block funding is provided for the organisation's fixed operational costs and fee-for-service funding is provided for each occasion of service.

This may be particularly efficient in rural and remote areas where demand for services may not establish enough of a core funding base under current funding structures for a provider to maintain financial sustainability.

### *Annual subscription*

Psychosocial services in the form of ***group activities*** have a combination of fixed and highly variable costs. For example, the Clubhouse model of service creates a community, which people experiencing psychosocial disability can join as a member. As a member of a Clubhouse mental health consumers have both access to activities run by the Clubhouse and shared responsibility with other Clubhouse members for the success of the organisation. Each member of the Clubhouse makes a contribution to its running, including everything from washing up after lunch to participating in managing the

organisation. Rather than there being specific appointments Clubhouse members can choose to attend any time that the Clubhouse is open for business.

The fixed costs for the service include rent and/or property ownership costs, staff salaries, utilities connection, insurance, maintenance, etc. The variable costs include food, travel and costs of specific activities, e.g. admission fees or materials, and are highly dependent on the number of individuals participating in the activity.

Given the episodic nature of mental illness, members' attendance at Clubhouses can be difficult to predict. The hourly payment for a group activity means that on occasion the total payment received through participants' NDIS individual funding packages may fall short of meeting fixed and variable costs. Accordingly under the NDIS funding structure, providers are challenged in planning the daily activities for their members and their long term viability.

Under a subscription model of funding, consumers would be able to subscribe to a particular Clubhouse, paying an annual subscription fee from their NDIS plan upfront. A Clubhouse member (and NDIS participant) would then also pay an attendance fee on attending the Clubhouse.

This payment structure would enable Clubhouses to set their membership levels in a manner that ensures fixed costs are covered by the subscription fee and the hourly rate covers the variable costs. This in turn provides some certainty for Clubhouse members that the organisation will be there when they wish to use it and that it won't disappear if, for example, a number of members are admitted to hospital for a period and therefore are unable to attend.

### *Outcome-oriented funding – 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 outcome-oriented basis and invoiced once a Collaborative Recovery Support plan has been written and agreed with the participant. Providers would be required to demonstrate that the plan was person led, involved family/carers, and collaborated with other providers where appropriate. 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.

## Conclusion

NDIS pricing arrangements 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 community mental health sector stands ready 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 on 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 maximises outcomes for participants, supports a skilled and thriving psychosocial support workforce, and ensures provider organisations can operate sustainably into the future.

Mental Health Australia

Mentally healthy people,
mentally healthy communities

Mental Health Australia is the peak independent, national representative body of the mental health sector in Australia.

Mental Health Australia Ltd
9-11 Napier Close
Deakin ACT 2600
**ABN** 57 600 066 635

**P** 02 6285 3100
**F** 02 6285 2166
**E** info@mhaustralia.org
**W** mhaustralia.org