NDIS Psychosocial Supports Optimisation Project – Outcomes of Expert Group Meeting One, 26 March 2018

Melbourne Airport, Parkroyal Hotel Mornington Boardroom

In attendance: Sarah Pollock (Chair), Debbie Hamilton, Laura Collister, Jenny Hall, Mark Wheeler, Kate Snars, Alan Murnane, Suzy Berry, Dr Erin Wilson, Kerry Hawkins, Belinda Highmore, Josh Fear

Apologies: A/Prof Richard Newton, Aidan Conway

Agenda item 1: The Chair welcomed the group and provided a brief explanation for the role participants were expected to provide.

Agenda item 2: The group considered the 'methodological proposal' and the Chair provided contextual history to the project. There was a brief discussion about the projects aims and the relationship between the Expert Group and the Project Management Group.

Agenda item 3: The group considered and accepted the Terms of Reference as drafted. It was noted that a confidentiality agreement would be provided prior to the next meeting when agency data would be available for consideration.

Agenda item 4a) i): The group considered the summary document describing relevant legislation and rules associated with decisions about participant planning. It was noted that the rules on participant planning required the NDIA CEO to take expert opinion into account on the benefits and effectiveness of activities available in plans. In general terms the group agreed that we would not be seeking to recommend amendments to the legislation or rules of the scheme, but rather seek to amend policy documents that interpret and apply them, as this would require the burden of parliamentary or ministerial agreement.

Agenda item 4a) ii): The group considered the outcomes of the NDIA outcomes framework and discussed alternative frameworks that could apply. It was noted that the NDIA had invested considerable time and effort in developing the framework and that attempting to change this framework may be met with resistance. Further discussion on this item occurred at agenda item 4b.

Agenda item 4a) iii): The group considered the summary document of the price guide and list and noted its structure, approach and limitations. The group noted that amendments to this document are central to the group's work. Some early discussion noted that there may be significant opportunities to better utilise the capital support items for psychosocial disability.

Agenda item 4a) iv): The group noted the existing support categories and had some preliminary conversations about the role of core versus capacity building items for psychosocial disability. Further discussion on this item occurred at agenda item 4b.

Agenda item 4a) v): The group noted the literature review and commended its coverage of the issues. There was discussion about additional papers that individual members felt they could contribute. Members undertook to provide additional evidence to the project team.

Agenda item 4b): The table below summarises the discussion on the questions and propositions put forward at the meeting. Not all questions were completed in the allotted time and members committed to review the remaining questions and provide relevant advice.

Question(s) considered by Group	Important Discussion points (incl potential data sources)	Outcome of Discussion
Entry and access criteria (Slide 18) Should the functional impairment requirement from s 24 of the NDIS Act that was used to accept a participant into the NDIS scheme be advised to the service provider when engaged to provide services under the NDIS? Is this knowledge relevant to the services provided to a participant?	• Achieving a successful application to NDIS (system access) may require different evidence from the evidence that may be most important to the client (lived experience and priorities) in planning appropriate care Questions asked: • How will a focus on eligibility criteria (functional impairment assessment) assist services to work constructively with a client? • What happens if an individual receives low score across all domains, but together, they add up to profound psychosocial disability? Key challenges with the NDIS assessment process: • NDIS impairment assessment tool is based on physical impairment model; questions don't align with mental health model • Functional impairment assessment is completed/considered independently of a client's context	• Two main views: 1. Service providers should have access to all assessments/ information to deliver the care plan appropriately (NDIS application is another information source to inform the plan) 2. NDIS application focus may limit care plan focus/ reduce important services • Agreed that knowledge about functional impairment requirement is relevant to understanding and

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	• There is no explanation when an NDIS application is declined • Assessments to access funding (NDIS) and assessments to plan for meeting client needs are separate processes. • There are 2 stages in accessing NDIS: 1. client is categorised as having physical/sensory/cognitive disability; 2. severity of functional impairment is assessed. Challenge is that psychosocial disability not understood and therefore clients are diverted in step 2 to packages for clients with much less complex needs.	informing the architecture of NDIS access. • **The group did not resolve whether a policy change should be sought on this matter.**
Outcome domains (Slide 19) Should the outcome domains for the NDIS be subject to modification when assessing the goals of people with psychosocial disabilities? If so, what data would support these changes? Should they capture a recovery framework? Do they do this already? What can we bring back to the next meeting to assist this decision?	• The immediate focus will be on recommending additions and alignments to the existing framework. The group may wish to lobby for a different framework over longer term. • Mind mapped a customer value proposition model (grounded in service data and qualitative research data with clients) against NDIS domains. Key gaps in NDIS outcomes that mattered most to clients related to identity i.e. support to develop positive and coherent sense of self that is the basis for breadth of engaging in other life domains. • Relevant factors that could sit under the NDIS outcomes include: empowerment, identity, financial health, physical health, dental health, sleep health, focus on family/ sustainable relationships (broader than 'carer') • Key gap in NDIS framework: NDIS focussed on individual; we know supporting the family[1]/ positive sustainable relationships is equally important in individual's recovery. Can this be included in framework? i.e. active network building/ informal supports. • Recommended papers to review: CHIME Framework and National Consumer Carer Forum paper on unravelling psychosocial disability evidence review • Prices guide focusses on technologies/ concrete activities. Are there opportunities to add items related to relationships and support networks?	• Agreed to focus on recommending psychosocial-focussed additions/ alignments to existing NDIS framework (recommend reframing of language and intent of framework) • Recommending activities aligned to the NDIS outcome domains may have a more successful outcome than recommending changes to the outcome domains themselves • **Action**: Sarah Pollock to share map of model against NDIS outcome domains • **Action**: for debate at next meeting, DM to present 2–3 propositions for changes to existing framework. • **Action**: consider opportunities to leverage NDIS outcomes measures for carers, to strengthen focus on relationships

[1] The importance of a broad definition of 'family' (beyond biological family) is acknowledged.

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'Support purpose' categories (Slide 20) Are the 'Support Purpose' categories (Core, Capital and Capacity Building) applicable in a meaningful way to psychosocial disability when it comes to delineating activities and determining their prices? Is there merit in 'Support Purpose' categorisations that reflect a participant's current circumstances such as 'Activities to establish support'/'Activities to promote recovery'/'Activities to address crisis-destabilisation'? What alternatives would you propose? What evidence do you have to support that proposition? What evidence could we seek on your behalf?	Applicability of the Support Purpose categories • Challenge: there is disincentive to use the Capacity Building category because it's less likely to be funded (across all disabilities, not just psychosocial). • Categories are not particularly meaningful but likely to be here to stay. Acknowledge here to stay but shouldn't use them as guiding principle in alternate package to be developed by this group. Agreed a request to change the categories is likely to be unsuccessful but could advocate for a change in how the categories are used. • If the funds (from all categories and separate line items) could be considered together, could reach a better client outcome (client-driven/ self-managed approach). NDIA appears to be receptive to service providers that have flagged desire to be able to shift some items/funding from Core to Capacity Building for individuals. • Qualitative research shows that the Core supports are very important for establishing the foundations for Capacity Building over the top of that. • Conceptual challenge: if Core funds are allocated to manage reputational risk to the program, it will be difficult to challenge the categorisation. • Discussion around use of 'Recovery' rather than 'Capacity Building'. Challenges around categorising some supports as 'recovery' and other supports as 'not recovery'. All supports needed to be considered in context of recovery.	• Agreed the project will continue with the three categorisations for now. • Agreed the project will challenge the concept of Core being more important (funding balance) than Capacity Building. • Agreed will not recommend use of 'recovery' terminology in the support • Agreed project will revisit pricing alignments at a later stage. • **Suggested action**: recommend to NDIS that service providers are supported to move the funding between Support Purpose categories to best meet client needs. • **Action**: DM to review statements regarding capacity building within the Productivity Commission Cost Report, for potential application to this project. • **Next steps**: identify activities that should be available, then work out how to categorise them and what those category labels should be.
Activity Item – support coordination (slide 22) Is there an existing support category or support item that delivers the same activity? Is there a scheme outcome from the outcomes	Advocacy support and planning: additions to the potential line items: • Add to the under-represented groups included in the 'specific engagement items' including: the homeless; people who identify as LGBTIQ. • Advocate for support for family literacy and how to construct plans that meet the needs of the family (rather than individual only).	• Key issue for the project to address: address gaps in 'Coordination of Supports' definitions (compared with quality integrated care coordination). • Agreed general support for:

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framework that this activity would assist to achieve? Is there a 'support purpose' that the activity fits within? Is there evidence to say that the activity is value for money? Is there evidence that demonstrates that individuals in the scheme wish to access such an activity?	• People coming out of institutions and their families also have unique, unmet needs (e.g. WA experience). • Advocate for specialist support, skills and tools/aids (e.g. communications, visualisation, decision-making) to support people with complex needs in making informed decisions. Can't leave people on their own to make these decisions. • There is a current gap in the market for explaining to clients the availability of appropriate local services suited to their individual needs (in addition to the support needed for making decisions). Suggestions that the Telstra Health 'My Chooser' and UK 'league table approach' might be relevant models for the NDIS context. • Discussion about the NDIS definition 'Coordination of Supports' and definitions of best practice, integrated coordinated care. NDIS definition doesn't appear to align with definitions of integrated coordinated care planning. e.g. participation in hospital discharge planning.	- new price item around introducing people to the NDIS (pre-access) - specific engagement for under-represented populations - providing culturally specific services for those populations - advocacy for participants during planning phase with NDIA officers - assistance with navigating services, comparing/choosing providers
Activity Item – advance directives (slide 23) Is there an existing support category or support item that delivers the same activity? Is there a scheme outcome from the outcomes framework that this activity would assist to achieve? Is there a 'support purpose' that the activity fits within? Is there evidence to say that the activity is value for money? Is there evidence that demonstrates that individuals	Additions to the potential line items (assistance with completion of advance directives): • If restricted to health professional, assistance with completion of advance directives is likely to be considered health activity rather than NDIS. • Language – suggest consider more broadly as 'wellness planning' or 'relapse prevention planning' (e.g. practical life supports, pet care, childcare, voluntary guardianship administration requirements), then may be more relevant in NDIS. • Key question – is this likely to be considered within the NDIS responsibilities? Appears to be a strong argument that advance directives are covered by some Mental Health Acts (varies between states) and therefore within remit of 'health' rather than NDIS. • Should NDIS line item be focussed to cover support for implementing the advance directive (breadth of practical supports) when it becomes active? • Discussion around avoiding word 'recovery' in context of NDIS. Concern that NDIS currently excludes 'recovery' vs not avoiding a term that is embraced by the whole mental health sector.	• Agreed no support to focus on advance directive focus (as traditionally conceptualised). • Agreed to focus on 'wellness plan' or 'relapse prevention plan' or 'wellness action plan' • **Action**: revisit concept as get discuss the WRAP

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in the scheme wish to access such an activity?	• Key challenge across all line items: getting the right balance between generality vs specificity (which may lead to more exclusions)	
Activity Item – assertive outreach (slide 24) Multifaceted item that incorporates assertive outreach approaches and case management. Is there a place for provider determined packages of care under the banner of assertive case management?	• Question rationale for including assertive outreach – is it to try to fill gaps in mental health services? In Victoria for example, assertive outreach/ community mobile teams is traditionally within clinical mental health world. • Noted that assertive outreach is a methodology rather than a program/service. • An assertive outreach approach would work well for clients who contact NDIS initially but find it difficult to maintain engagement in the services; the approach won't work for people who haven't engaged with NDIS to start with. • Challenge is that if line item is included, clients may not want to purchase it, as the benefits are unlikely to be well understood. (It's similar with peer support because the benefits aren't understood by the individual). One suggestion is that the agency can apply for additional item to support the individual in this way and attract a weighting to the price of the item rather than create a separate item for "outreach'. • Question to the group – what is the balance between meeting aims through packaging items together (e.g. under 'case management') vs losing some choice and control?	• **Action**: All to supply DM with references that would support case for assertive outreach/ case management • **Action**: DM to work on a 'weighting' definition linked to individual items.
Activity Item – personalised support (slide 25) Is this activity sufficiently covered by the existing items? Is there an argument for funding to work to a specific 'recovery plan'?	• Specific skill bases need to be considered in the support – psychosocial disability and dual disabilities. • Queried how practical it is to have a personalised, dedicated support person. Some interpreted this to mean rostered support.	• The group would like more time to consider this item and will revisit at a later stage.
Activity Item – peer support (slide 26) Is the role of peer support sufficiently robust in the scheme? Is a single item,	• There is already an item for peer support and mentoring. Is this sufficient? • Agreement over the value of peer support work, particularly as a discipline. Focus on hope, meaning, purpose, that doesn't exist in other forms of support. More than a	• Need to test how appealing the items are to clients

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sufficient to capture what peer workers can achieve? Is there a role for peer support in the development of plans, advocacy and the identification of recovery outcomes? If so, how would you define this?	modality – specialisation of the discipline of peer work should be elevated in the classification structure. • Option to rename the item, to describe what peer support delivers and to align with what clients are more likely to relate to e.g. like 'building hope and identity'. Discussed option of creating two items: one that describes what is delivered (ie hope and identity) and one that specifies delivery by a person with lived experience. • There is some literature evidence around the value of the discipline of peer work. e.g. Mike Slade	• Agreed to describe what peer support delivers, rather than how/the modality of delivery. • Could use the 'weighting' method to apply the use of peer workers to existing activity items. • Agreed at least one item needs to specify that it is being led by trained peer workforce. • DM to map these activities against CHIME.
Activity Item – illness management (slide 27) An illness management item that assists in supporting medication compliance, co-ordinating clinical contacts and assists with behavioural strategies that can assist with illness or symptom management.	• Agreed interface between recovery/support and clinical care systems is important and might be worth pursuing, however, labels of 'illness management and recovery' is unlikely to be successful with NDIS. Title 'wellness management' will be more appealing than 'illness management'. • Alternate options to consider – shared care, transitional care, references to autonomy. It is important to retain a reference to symptom management (because it is not supported by clinical system). Consider including reference to autonomy. • This item could include a person to support client to have conversations with GP to negotiate alternate treatments, for example. • Recommended evidence for this item: Brophy et al 2014. 'the Barwon Project'	• Agreed there would be value in pursing an activity item that covers these concepts, but using different language. • **Action**: Participants to provide DM with language that will be helpful for supporting this interface between recovery/support and clinical care systems
Activity Item – peer coaching (slide 28) A specific item for peer coaches. If so how would it differ in its definition from peer support? What qualifications may be necessary?	• What are the differences between peer coaching, life coaching, peer work? Coaching is an interesting concept and helps describe why peer work is a skilful intervention. Could be incorporated under peer work.	• Agreed to incorporate peer coaching into consideration of peer work

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Activity Item – wellness recovery plan (slide 29) An item to provide support in the development of a recovery plan. This could be peer driven or provider driven, or both.	• Covered under earlier discussion items	• Agreed there is support for a wellness recovery plan item concept
Activity Item – alcohol and drugs (slide 30) An item to assist with attendance at self-help groups, and to assist with the management of triggers to use. It should be noted that the NDIS legislation specifically excludes funding activity that is the remit of Health agencies.	• It is impossible and undesirable to separate out significant mental health issues from drug and alcohol issues for individual clients. • Is the activity item a support to access a service, or an assessment item around how existing activity items are implemented (similar to the assertive outreach item)? e.g. supports around triggers for drug and alcohol use. • Discussion about the skill base and capability of the workforce needed to deliver this item, and extent to which this description may be useful when advocating to NDIS e.g. motivational interviewing under coaching can be clearly described, defined and packaged. In addition, the item descriptions should be linked to a functional outcome. • Possible functional outcome for this item: social and economic participation. • Agreed it is important to incorporate the **concept of trauma** in the response – navigational support to and weighting piece support. Cautious approach needed in the language used around this item, distinguishing between an individual's trauma/trauma response versus the individual's life circumstances that are creating the trauma.	• There was support for an activity item that incorporates alcohol and drugs, incorporates concept of trauma and is linked to a functional outcome
Remaining Activity Items		• **Action:** DM to circulate slides for all participants to comment on the remaining items

Agenda item 5: The group noted that our second task is to determine appropriate groupings (or categories) of NDIS participants that logical sit together for the purpose of having similar participant plans.

Agenda item 6: The group noted our third task is to allocate activities to participant categories to create 'typical support packages' or 'reference packages'.

Next meeting	Tuesday 8 May,	Melbourne