



Submission: Productivity Commission Position Paper: NDIS Costs

Mental Health Coalition SA (MHCSA)

Introduction

The Mental Health Coalition of SA (MHCSA) values the opportunity to make a submission in relation to NDIS costs for people living with a psychosocial disability related to a mental illness. We would welcome the opportunity to contribute to further discussion if the opportunity arises.

The MHCSA has over 20 organisational members and provides a unified voice for the Community Managed Mental Health (CMMH) Sector in South Australia. The CMMH Sector comprises of non-government organisations that deliver mental health services and work with people with mental illness and their families and carers across the state. The work of MHCSA includes a strong focus on supporting and growing the Lived Experience Workforce and promoting positive messages that support people to improve their well-being and reduce stigma and discrimination.

The MHCSA Vision is that all people living with mental illness in South Australia and their families will receive the mental health support they need when and where they need it. The MHCSA promotes a recovery approach meaning the goal of support is to assist people living with a mental illness to build a contributing life in the community including social and economic participation.

Context

The MHCSA is specifically interested in mental health. For psychosocial disability, the NDIS Act refers to “a functional impairment that affects daily living, likely to be lifelong caused by a mental illness”. Based upon original Productivity Commission modeling and later updates from the NDIA, 64,000 people in Australia fit that definition, with a further 210,000 with severe and persistent mental illness “with chronic and major limitations on functioning”¹. Given the number and types of programs that have funding transferred in to the NDIS (PHaMS, PIR, D2DL, MHR: Carer Support + state funded services), cost considerations must take into account both the cost of NDIS support for people living with psychosocial disability and the unintended consequence of removal of supports for people who are not eligible but need support both now and into the future.

Over the past 20 years community psychosocial rehabilitation support services delivered by NGOs have matured with a growing evidence base highlighting their effectiveness^{2 3 4}. Mental Health NGOs have

¹ P46, NMHC: National Review of Mental Health Programs and Services, V1

² <http://www.sahealth.sa.gov.au/wps/wcm/connect/d03c5c004c3ed23d9066b4e408a887aa/IPRSS+Final+Report+-+for+distribution.pdf?MOD=AJPERES;>

developed a skilled and experienced workforce to deliver (non-clinical) psychosocial rehabilitation support that has helped many people living with severe mental illness to recover to the point that they are managing to live contributing lives in the community without continued supports. Service providers are assessed for quality against the National Standards for Mental Health Services.

The MHCSA believes that a balanced mental health system has three key elements –

1. Treatment services
2. Disability services for the people whose lives are disabled in some way by their mental illness
3. Psychosocial rehabilitation services

NDIS is a welcome addition and meets a previously unmet disability support need. However, psychosocial rehabilitation services (generally non-clinical) are still critical and must be retained.

In South Australia, the transition Bi Lateral was silent on mental health, and although we officially enter the full scheme on 1 July 2018, State funded mental health programs are not expected to transition until after this date. The commitment to “Continuity of Support” is officially only until 30th June 2018 – understandably mental health consumers, carers and service providers are concerned about the future of services both within and outside the NDIS. The cost of NDIS for our state is not just about the cost of the NDIS but also loss of services for the thousands of SA consumers not eligible, whose services will end as funding is rolled into the NDIS.

The MHCSA is a member of Community Mental Health Australia, and therefore fully supports their submission. This document is intended to supplement that and add any specific South Australian reference.

Cost Pressures

Several cost pressures are evident, and can be managed without changing the rules of the Scheme. These comments are provided in the context of psychosocial disability –

1. NDIS, for psychosocial disability, should be available for the people who need it, while appropriate services for those who don't, remain. Continuity of Support must be clearly defined and shared with the community as a matter of priority. This will do two things –
 - Eligibility can be tested by people who are likely to need NDIS.
 - Those who need services outside NDIS can feel confident that these services exist, will continue to exist and are accessible.
 - Cost saving is in ensuring those who need NDIS (expensive) are supported while others have access to cost effective supports.

³https://www.sprc.unsw.edu.au/media/SPRCFile/1_SPRC_Report__Evaluation_of_Intensive_Home_Based_Support_Services_v2.pdf

⁴ <http://www.mhcc.org.au/media/3056/cmha-taking-our-place.pdf>

2. Access pathways to NDIS are properly supported and funded, especially for those who lack natural supports. For people with psychosocial disability this can take some time, so “NDIS cafes” or similar are an effective way to provide peer support to manage that process.
3. Assessment conversations must be properly planned and arranged. For most people with a psychosocial disability, face to face meetings with trusted supports in attendance are most likely to result in an effective assessment. If an assessor is not skilled in mental health, they should have access to expert help either internally, through LACs or service providers.
 - By doing this, access is more likely to be achieved by people who will truly benefit from NDIS supports.
4. Participants must be offered face to face meetings for their first planning meeting.
 - Planners must either be skilled in psychosocial disability or have access to expert advice.
 - Participants and their Carers are often the best experts in the room about their needs – the skill is in being able to draw out that expertise and knowledge through rapport building and skilled and open-minded questions.
 - While this may appear time-consuming and hard to manage given current KPIs, by the first planning meeting being effective, the need for immediate plan reviews is significantly reduced and first plans will contribute to the lives of participants. Savings are made in time and dollars for unnecessary plan reviews.
5. Think differently about unit costing. For psychosocial disability this is about the quality of the work delivered for the cost – what benefit is achieved for a dollar of support?
 - The cohort for psychosocial disability are at the most complex end of need, yet the Reasonable Cost Model is based on level 2.3 of the SACS award. Skilled mental health peer and support workers attract at least level 3 and often 4.
 - If a participant’s budget remained the same, would they receive more benefit from three hours of skilled support than for hours of un-skilled support? Anecdotal feedback from carers in SA suggests that they would like to be able to make the choice.⁵
 - Providing quality support does not necessarily cost the Scheme more.

Information Requests

The following feedback is intended to supplement feedback from CMHA and offer any additional South Australian context

4.1 – Reasonable and Necessary

Skill level of assessors in psychosocial disability is a current gap and for this reason, the outcome for participants is extremely varied. In addition to this, it appears that while the rhetoric of the NDIS about choice and control, participants and carers are not trusted to know what is reasonable and necessary for them. The MHCSA believes that rather than adding constraints to the assessment and planning process through further regulation, do two things –

1. Ensure that either planners and assessors of people living with psychosocial disability are skilled in mental health and building rapport and trust quickly, or enlist the help of expertise, either through NGO services currently supporting the potential/participant or NDIS/LAC staff with relevant expertise.

⁵ MHCSA carer conversations, June 2017

2. Trust that participants and carers, with the right exploratory questions, can identify what is reasonable and necessary for them.

4.2 – Delegating Plan Approval to LACs

At first glance, it would seem sensible for LACs to be able to approve plans to a certain level, however the requirement that LAC providers can't also be service providers has resulted in organisations skilled in disability and mental health not being able to tender. This is different to the trial period.

In SA, the first LAC contract has been let for the north of Adelaide, to an aged care provider from Queensland. While this organisation provides LAC services in other states in addition to their aged care work, the MHCSA is deeply concerned that they won't have either the local reach or skills to develop plans for people living with psychosocial disability.

MHCSA believes that disability and mental health service providers should be able to tender to provide LAC services, however they must be able to demonstrate governance arrangements such that conflict of interest is managed. This could be like arrangements for Tier One Housing Providers in the National Regulatory Systems for Community Housing Providers⁶

Should such provisions be put in place, MHCSA would then fully support LACs approving plans.

6.1 – Thin Markets

There is already evidence that people living with psychosocial disability are struggling to find services that can meet their needs. Despite this, NDIS reports are often silent on mental health other than to note that it is an issue. The Quality and Safeguards Framework is silent regarding National Mental Health Standards and Mental Health Acts as is the Code of Conduct; and the NDIS Act is largely silent on mental health.

Where are the drivers to ensure that psychosocial disability does not become a thin market even in metropolitan areas? The MHCSA believes that the NDIA should focus some attention to ensure that people living with psychosocial disability are respected through services that meet their needs.

Pricing and funding models in thin markets must be flexible – working with relevant communities (Aboriginal, CALD, Remote, rural) as well as Government departments, design service models that meet local need. Consumer and Carer partnership is critical to success.

6.2 – Encouraging Greater Supply over the Transition Period

MHCSA notes that the mental health sector was not mentioned in this section – rather discussion focused on the aged care sector. The aging workforce was also mentioned.

In 2015 the MHCSA undertook a training needs analysis that profiled the mental health (psychosocial support) workforce in SA. 20% of the workforce was over 45 and 52% between 25 and 45 years of age. 67% said they intended to stay in the mental health workforce for more than 5 years. 88% had a

⁶ http://www.nrsch.gov.au/_data/assets/file/0005/288230/D_Tier_Guidelines.pdf

certificate or higher mental health qualification (39% holding a degree qualification). Like the disability workforce, mental health workers are driven more by values than remuneration. However, the skills and experience they bring must be respected with reasonable remuneration and training opportunities to retain and build upon their skills.

The mental health support workforce is a skilled group that can be built upon to provide effective psychosocial disability support across the whole mental health system including NDIS – meeting increasing resource levels across the implementation to full Scheme. In particular - we can build the Lived Experience (Peer) workforce. The challenge is in an uncertain environment about continuity of support, providers are reluctant to commit to additional workforce. By addressing Continuity of Support the mental health market will stabilize and feel confident to attract new workers. The MHCSA is in discussion with the SA Department of State Development around strategies to add mental health to their current strategies for the disability workforce.

7.1 – Holistic Workforce Strategy

The development of an Holistic Workforce strategy should be a partnership that includes consumers/people living with disabilities, carers and services providers, as well as Governments and the NDIA. Consumers and carers know what they need, and service providers are for the most part, the employers of workers supporting NDIS participants.

Any workforce strategy developed must include specialist psychosocial disability support – identifying the skill-set, qualifications and experience required to work with people living with a psychosocial disability. It is not enough to understand disability – mental health must also be integrated in to the strategy.

Lived Experience Workforce should be included – focused on paid peer workforce as well as volunteer opportunities. Research undertaken by the MHCSA in partnership with Don Dunstan Foundation and Flinders University in 2016 resulted in a recommendation to build the peer workforce (MacKay and Goodwin Smith, 2016, p78)⁷. The SA Mental Health Commission recently undertook an extensive community consultation that also strongly supported growing the peer workforce⁸.

Training and professional development is an important element of a Workforce Strategy and should also be reflected in the calculations of the Reasonable Cost Model.

7.2 – Respite Services

Until services for carers are clearly defined and implemented through the National Carer Support Strategy, services such as Mental Health Respite: Carer Support (DSS) must be retained.

⁷ “Mental Health: Exploring Collaborative Community reform in South Australia” MacKay, T & Goodwin-Smith, I. 2016 <http://www.mhcsa.org.au/wp-content/uploads/2016/08/Community-Mental-Health-Report.pdf>

⁸ SA Mental Health Commission: Key Findings <http://samentalhealthcommission.com.au/what-we-do/sa-mental-health-plan/>

8.1 – Support Coordination

Where a person lacks natural supports, support coordination can be the difference between receiving supports and a plan that goes un-used.

The MHCSA does not understand the rationale behind time-limiting support coordination in participant plans. Many people living with psychosocial disability are likely to need some level of support coordination for many years if not for the life-time of their support.

8.2 Intermediaries

For many people living with psychosocial disabilities, having someone they trust to intervene and manage challenges with them is very useful, especially where advocacy is required. Plan management through an intermediary as an alternative to the NDIA may also be attractive and should be by the choice of the Participant. An intermediary with whom the Participant has a trusted and on-going relationship could have positive effect on plan reviews – ultimately saving time and ensuring the plan meets the needs of the Participant.

9.1 – Slowing Down the Roll-out of NDIS

The roll-out to full Scheme for the NDIS is very ambitious and the MHCSA applauds the intent to roll out the Scheme in a timely fashion. However, we need to take the time to fix systemic issues and review processes so that potential and existing Participants have a positive experience in a sustainable NDIS.

One systemic change that could be undertaken is to re-consider the rules for transition of some mental health programs. For example, the MHCSA has been informed that for PHaMS participants to receive Continuity of Support (CoS), they must test their eligibility for NDIS. Evidence across all jurisdictions is that over 50% of PHaMS participants are not likely to be eligible for NDIS supports –

The MHCSA recommends grouping PHaMS participants in to three groups.

1. Likely to be successful in accessing NDIS – test eligibility
2. May be successful in accessing NDIS – test eligibility but have CoS in place should they not be eligible.
3. Unlikely to be successful in accessing NDIS – CoS in place so the PHaMS participant does not lose supports.

By simply grouping current PHaMS participants in to three groups we reduce time and effort for potential participants and NDIA assessors or LACs who would be better placed supporting people who need the Scheme. Of course, all participants have the right to test their eligibility – by their own choice rather than imposed rules. And CoS would have to be defined and available.

If the Scheme roll-out is slowed down, current block-funded supports must remain in place. A comprehensive communication strategy would be needed to explain the slow-down, the impact for the community and plans for the move to full Scheme roll-out.