10/19/2020

NDIS Supported Independent Living MHCC ACT submission

Mental Health Community Coalition ACT

Peak Body in the ACT for the Community Mental Health Sector

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About MHCC ACT

The Mental Health Community Coalition of the ACT (MHCC ACT) is a membership-based organisation which was established in 2004 as a peak agency. It provides vital advocacy, representational and capacity building roles for the Not for Profit (NFP) community-managed mental health sector in the ACT. This sector covers the range of non-government organisations (NGO) that offer recovery, early intervention, prevention, health promotion and community support services for people with a mental illness.

The MHCC ACT vision is to be the voice for quality mental health services shaped by lived experience. Our purpose is to foster the capacity of the ACT community managed mental health services to support people to live a meaningful and dignified life.

Our strategic goals are:

- To support providers to deliver quality, sustainable, recovery-oriented services
- To represent our members and provide advice that is valued and respected
- To showcase the role of community-managed services in supporting peoples' recovery
- To ensure MHCC ACT is well-governed, ethical and has good employment practices.

Preamble

MHCC ACT welcomes the consultation paper on Supported Independent Living (SIL) and hopes it will lead to a better framework that will benefit participants. MHCC ACT looks forward to contributing to the second phase of consultation around SIL in 2021.

MHCC ACT wants to take the opportunity to thank our stakeholders for their input into this submission.

Responses to the questions of the consultation paper

A. Initial steps taken to address these issues

1. *From a provider and sector perspective, what drives the 1.3% month-on-month cost increases to SIL participant plan budgets, with particular note to FY2019/20?*

   From a sector perspective, one might consider that the initial pricing was not a reflection of the actual cost of support services required to meet the needs of participants in SIL. From a workforce point of view, there is plenty of evidence[1] that the NDIS pricing guide is not sufficient to attract and develop high-quality staff. In addition participant expectations of SIL supports are continually developing as participants become more confident in expecting more choice and control from SIL arrangements than provided in congregate living arrangements pre-NDIS.

   There is also still a need for an appraisal to adequately assess and remunerate support workers for the services they deliver to participants. As an example, in our submission[2] on support coordination, we raise the additional unpaid hours support coordinators often work to support clients, beyond the allocated funding.

   It is also the case that SIL has allowed some participants to exit residential aged care and reduced reliance on hospital admissions. Increases to SIL participant plan budgets should not be considered in isolation from reduced costs in more intensive and expensive forms of care.

   MHCC ACT wants to encourage the NDIA to instigate an honest assessment of the cost of service delivery and the needs of participants. Not as a cost-saving exercise but to fully understand what is needed to make sure participants can lead an independent life, and have choice and control, especially for people with a psychosocial disability who often don't fit into the NDIS framework.

2. *What could the NDIA do to help providers and the sector address plan budget inflation?*

[1] Joint Standing Committee MHCC ACT submission to the inquiry into the NDIS workforce
[2] MHCC ACT Submission on NDIS Support Coordination

See question one concerning an honest cost evaluation of care and service delivery costs.

3. *What are the most significant challenges that participants face when receiving person-to-person support in shared living arrangements?*

   The most significant challenges are the following:

   - There is a need for increased support for decision making and capacity building to allow better choice and control for participants.
   - One of the most significant issues is not having enough skilled workers, able to to meet the needs of participants. Once again, MHCC ACT would like to emphasise the need to provide resources for providers to attract and develop a skilled workforce. A competent workforce will reduce restrictive practice, and prevent misuse of funding due to inexperience.
   - Active support training and individual allied health skill strategy implementation. Workforce training needs to be funded properly, and providers should, to a degree, be made responsible for ensuring a basic level of training for all workers, including training tailored to the individual participant and the house in which they reside.
   - Confidentiality and conflict of interest are challenges that participants often face while receiving person to person support. Barriers and risks need to be made clear by the NDIA to SIL providers creating better transparency between multiple supports to ensure a safety and quality net for participants. This will increase inclusivity and alleviate conflict of interest.
   - Better training in SIL providers' responsibilities and duty of care as well as an emphasis on incident and mandatory reporting duties will create better market innovation and NDIS successful outcomes and minimise misuse of funds.

4. *What has been the impact of recent SIL changes to provider operations and participant experience?*

   Clinical inclusions to the price guide outside of SIL funding has allowed for greater transparency. However, independent support coordinators have reported some instances of SIL providers being reluctant to allow external providers inside the SIL home. Internally provided clinical supports can lead to reduced choice and control and a risk of misuse of funding.

   The recent SIL changes have decreased young people in aged care. They have allowed for fewer hospital admissions during a time where participants are more vulnerable in high-risk areas such as hospitals.

B. Proposed short term changes

5. *What advice do you have for the NDIA working more closely with participants regarding their SIL supports?*

The NDIA could consider setting minimum requirements for being able to become a SIL provider. Being a SIL provider is more than just providing accommodation and workers. Participants need to be better supported and educated about SIL and their choices and options for care.

One option could be to include support coordination in plans for a more coordinated approach, even for participants who self-manage. Participants and their carers are often not always aware of their options. Most participants have previously lived in institutions or group homes, where they were not encouraged to be more involved in their care, and have become accustomed to those service models. Others remain stuck in facilities that do not provide the most appropriate form of support for them, due to lack of knowledge and expertise by their informal supports or guardians. Some participants do not wish to change as they are unsure if the next option will be better or worse then their current arrangement.

A focus on capacity-building and supporting the ability of participants and their carers and families ot exercise informed choice and control will provide improved outcomes.

6. *What are some effective ways for providers and participants to jointly work through and agree on an appropriate roster of care?*

- Educate support workers to understand the needs of the participant, and the nature of SIL needed to address those needs.
- Coordinate NDIA reviews to ensure choice and control for the participant to have oversight over the SIL roster of care vs the community access.
- Changes need to be implemented within a reasonable time frame.
- More access to this roster and the SIL quote may also create transparency to the NDIA around informal support involvement, STA, external supports, and community access.

7. *What could the NDIA do to help assist providers in communicating the rationale behind a change in a participant's circumstance?*

- Provide capacity-building support to support workers
- Clarify how to write reports to makes sure the participants get the best outcome; For example, how to document the impact of the disability on the participant's life and how to justify trials. Another example, a change of circumstance is often self-explanatory; often, however, the NDIA response states that something is missing and needs to be amended. This can be particularly difficult for people with psychosocial disabilities. One solution may be to make a minimum amount of core or CB funding flexible to allow a support coordinator to engage with someone who would benefit greatly from their support and knowledge.

8. *How are providers currently informing participants and their families about the supports that they should be receiving? What has been more effective in your experience*?

- Involve the participant and their family continuously in all discussion and decisions
- Service agreement and schedules of supports are currently the primary forms of communication to participants and their informal supports.
- Discuss outcomes and recommendations which participants can charge for under the current price guide
- Encourage that the provider engages at key timelines through the plan to ensure that the agreed supports and goals are still relevant.

Currently support coordinators often inform participants and their informal support, but this should to a greater degree be part of a SIL provider's responsibility for long term engagement.

9. *What might explain variability in support levels across providers for participants with similar circumstances?*

   The lack of knowledge and training of support workers is a significant issue. MHCC ACT would like to refer to our submission to the Joint Standing Committee on the NDIS workforce[3]

   Before the NDIS, there was widespread employment of people with Certificate IV level qualifications working in the sector in the ACT. This was the result of a concerted campaign to raise the skill levels and quality of this workforce. Since the introduction of the NDIS, this is no longer the case, particularly for NDIS workers where pay and conditions more typically attract a person with lesser qualifications. This has created a casual, poorly skilled workforce impacting the consistency and quality of care.

   Providers also emphasise inconsistency in NDIA planning and decision making.

10. *What support from the NDIA would be most helpful to providers to reduce administrative challenges?*

    Simplify the administrative burden of service providers by streamlining reporting requirements.

11. *What are a provider's pain points in working with NDIA on SIL rosters of care, and what else could the NDIA do to simplify processes?*

    The lack of a coordinated approach with all providers at the review meeting, including the support coordinator and participant/informal supports.

C. Developing a long-term roadmap

[3] Joint Standing Committee submission to inquiry into the NDIS workforce

12. Do these guiding principles appropriately shape SIL reform?

These guiding principles will appropriately shape SIL reform, but only if they are correctly implemented and adhered to by all stakeholders.

13. What items should a Home and Living Policy address?

A home and living policy has to centre around choice and self-determination for the participant.

Some things to include:

- The choice of who lives with them
- The choice of a service provider and skilled support worker(s)
- The choice regarding how often workers work with them
- The choice of activities
- The choice of meals
- The choice of visitors

14. Are there any other comments or suggestions? What have we missed?

Many of the issues in SIL are similar to other concerns within the NDIS service model. There is a lack of a skilled workforce to provide the supports participants need and deserve. This gap of available expertise is limiting the choice of participants and impacting the quality of their care.

To resolve many of the current issues, the economic model for the NDIS has to allow service providers to establish robust business models, including fair pay and conditions for workers, as well as efficient and innovative back office arrangements. Providers would be better able to meet the needs and goals of participants. Of course, this needs to be accompanied by rigorous safeguards and quality requirements, as well as financial accountability.

There is also the need to develop relevant training to increase the number of people who will be able to provide the required standard of care for participants and to create a large enough pool of skilled workers so that the participants will have a genuine choice. Once again, however, unless providers can offer competitive pay and conditions for their workforce, there is a danger that at best, they become a training ground for new graduates who then take their skill set to better-paying positions elsewhere.

In sum MHCC ACT wants to raise that a holistic approach is needed to address the problems participants face regarding their care, choice and self-determination; these

issues are linked to the lack of a well resourced and trained workforce. You can not solve one without addressing the other.

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