Mind Australia Limited

Submission to the NDIS Review of Supported Independent Living Price Controls

October 2020

About Mind

Mind Australia Limited (Mind) is one of the country's leading community-managed specialised mental health service providers. We have been supporting people dealing with the day-to-day impacts of mental ill-health, as well as their families, friends and carers for over 40 years. Mind employs more than 900 staff in Victoria, Queensland, South Australia and Western Australia. We deliver services through an integrated stream approach incorporating the following:

1. **Sub-Acute Stream**: provides step up step down (Prevention and Recovery Care Services in Victoria) in partnership with health providers across Australia, continuing care units in partnership with health providers and an intensive outreach service in partnership with Victorian health providers across the state.
2. **Supported Independent Living (SIL) Stream**: SIL provides bed based residential services to customers with psychosocial disabilities with SIL packages in state government owned housing stock in Victoria, SDA properties, youth residential services, complex care, private rental and community housing.
3. **Innovation Stream**: provides care coordination service, family and carer services, outreach services, allied health services and centre based group programs and virtual group programs.

In the 2019/2020 financial year Mind delivered services to 11,480 individuals which accounted for 254,183 support hours.

Mind is a registered NDIS provider and is committed to the provision of psychosocial disability support. In the past financial year we provided a service to 2,008 NDIS participants. We are registered to provide:

- Supported Independent Living (SIL) to 170 NDIS participants.
- Supports to approximately 1838 NDIS participants including support coordination, Allied Health specialised assessment and behaviour support, and community engagement and capacity building support. These services are delivered by a Community Mental Health Practitioner (CMHP) and mobile Allied Health workforce of over 100 FTE.

Mind utilises an evidence-informed recovery-oriented approach to mental health and wellbeing that looks at the whole person in the context of their daily life, and focuses on the social determinants of mental health, as they play out in people's lives. We value lived experience knowledge of what works to support recovery, and support the ongoing development of a lived experience workforce. We value the role that carers, families and friends play in providing significant emotional, practical and financial support to those experiencing mental ill-health and psychosocial disability. Over the past six years Mind has made a substantial investment in a research program that has contributed to public knowledge on mental health recovery and psychosocial disability. Part of our research program focuses specifically on the NDIS and the inclusion of people with psychosocial disability in the Scheme. We are also dedicated to monitoring and evaluation to support practice and quality improvement.

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Introduction

Mind appreciates the opportunity to respond to the *Review of Supported Independent Living Price Controls Issues Paper.* In Mind's view, this review provides a significant opportunity to ensure that SIL pricing is set at a level which enables participants to receive a high level of service to enable them to reach and attain their goals.

Our submission provides response to all the questions posed in the Discussion Paper to assist the NDIA with its inquiry. In addition to responses to these questions, Mind also wishes to emphasise that there are key differences in providing support to participants with a psychosocial disability, which must be taken into account in the pricing model. Furthermore, there are some key assumptions made in the discussion paper which we believe requires further consideration.

In providing this submission, we wish to reiterate the following key points:

- SIL staff need to be more highly skilled and qualified as they are required to work in a holistic manner with participants on many aspects of that impact their day to day lives. This is evidenced through Mind's comprehensive assessment and planning tool called My Better Life (provided at Appendix 1) which requires Community Mental Health Practitioners to work collaboratively with participants in the 12 key domains of their life as part of their recovery. These practitioners must hold as a minimum a Certificate IV in Community Services and/or Mental Health. The current pricing model restricts providers to employing a SCHADS 2 workforce which aligns to a minimum qualification of Certificate III in Individual Support and/or Certificate III in Community Services work. These qualifications do not adequately train people in the complex nature of psychosocial disability.
- SIL staff incur higher costs due to penalty rates across a 24/7 roster and are paid more overtime than non-SIL staff to manage the requirements of providing a service to someone that cannot be re-scheduled at a later time.
- Casual workers and agency workers are utilised more in SIL services, therefore increasing costs to providers.
- Skill building and capacity building delivered by a staff member experienced and skilled in psychosocial disability can lessen the need for formal supports in the future. Mind's recovery-oriented practice and utilisation of My Better Life assessment and planning tool, together with skilled practitioners, means that some SIL participants will reach a stage where they can live independently, without SIL support.
- High-intensity SIL should not be restricted to a 24/7 support model as there is evidence that a non 24/7 model can work effectively in some instances.

Mind is a strong supporter of the NDIS and the inclusion of people with psychosocial disability in the Scheme. It is clear that since the scheme came into operation seven years ago it has already improved the lives of many people with a psychosocial disability, particularly those in SIL. Mind believes that ensuring pricing is set a sustainable model, which allows for appropriately skilled and experienced staff to be employed, will allow participants the best chance to attain their goals.

Key issues to be addressed in this review

In addition to the response outlined below, Mind provides the following information to assist the NDIA with its inquiry.

Mind are committed to ensuring NDIS participants with a psychosocial disability are able to have their support needs met based on their individual needs and goals are. Mind believes for some participants with a psychosocial disability, SIL is a type of support that may only be required for a period, if appropriate support is required.

Of the 170 SIL packages Mind delivered across 14 rosters of care last financial year, a resident moved out once a fortnight. Most often this was due to participants building their independence, skills in daily living, achieving goal's associated with their housing and mental-ill health recovery and then moving in to more mainstream housing with less support.

The following de-identified case studies demonstrates how recovery-oriented practices support people to gain independence and less reliance on SIL supports.

CASE STUDY ONE

Gina[*] is a 34 year old woman who was a participant in the Brunswick SIL for 18 months. Gina had significant trauma in her life as a result of family violence for over a decade. Gina's two children were removed from her care and placed in to child protection. Gina has diagnoses of Borderline Personality Disorder, Post Traumatic Stress Disorder and Anxiety disorder

When Gina commenced receiving SIL supports she could not leave her home without a staff member accompanying her .Gina's recovery focused on building the skills around activities of daily living to live independently in the community, being able to regain citizenship without fear and anxiety, and regaining guardianship of her children.

The team supporting Gina at Brunswick SIL delivered a service using recovery oriented practices. Each small step toward her achieving her goals was celebrated. A plan for Gina to progressively leave the property was put in place once trust and rapport had been established.

Over a number of months, Gina developed strategies that made her feel safe at home and built capacity to interact with her housemates. Gina gained more confidence until she was ready to regain her autonomy and engage in community life on her own. This required intense support from staff who understood Gina's trauma, her triggers and early warning signs around deteriorating mental health. Building routine was fundamental to assisting Gina to build skills in becoming more independent.

After 15 months of receiving SIL support and building skills, confidence and capacity Gina received a letter from DHHS Public Housing and was offered a home in her community of choice. Gina accepted the offer, equipped with tried and tested strategies to help her feel safe and confident to engage in community life and living on her own.

CASE STUDY TWO

Leon is a 28 year old man who spent three years at Williamstown SIL. Before Leon received support at the SIL, Leon experienced a drug-induced-psychosis which led to spending extensive time in a psychiatric inpatient facility. Soon after discharge from hospital, Leon began to hear voices and experience extreme paranoia. Leon was diagnosed with Paranoid Schizoaffective Disorder.

[*] Names have been changed in both case studies

Leon's relationships deteriorated and he became estranged from his partner and family and soon after became unemployed. Leon then became a rough sleeper and heavy user of substances, His clinical case manager at referred Leon into emergency accommodation. While in emergency accommodation Leon got his access requirements for NDIS approved and met the reasonable and necessary requirements for SIL. Upon assessment, SIL staff guided Leon through a strengths-based-assessment process and identified goals related to Leon gaining greater control over his mental illness, developing skills in activities of daily living, gaining employment again in construction and living in safe and affordable private rental accommodation.

Williamstown staff worked with Leon to better understand the voices he was hearing in his head and form and maintain positive habits around his domestic life. When Leon began to understand his illness he was able to focus on developing the skills required to maintain his home and develop routine in his life. Leon engaged in a co-designed dual diagnosis peer support group with other peers from other SIL Mind SIL residences. Leon's experience of peer support in the group proved to be the catalyst for him to cease substance use. This helped Leon focus more achieving his goal of gaining employment. Leon with staff support were able to identify the early warning signs when he was becoming unwell. Leon collaborated with staff to develop strategies to stop a decline in his mental health. This gave Leon the confidence to consider employment.

Initially, Leon began working one or two days a week. Staff continued to encourage Leon using a strengths approach until he secured a full time job in construction. Leon saved the money for a bond for a private rental unit which he ultimately secured. During his time at Williamstown SIL, staff worked with Leon to rebuild his relationship with his family. Leon's family became important partners in Leon's recovery journey.

These two case studies demonstrate that SIL residents rely on staff to have significant expertise the impact of severe and persistent mental illness can have on managing daily life. Both individuals were experiencing acute symptoms of their illness when they became SIL recipients in their new home. Each individual also required intense and diverse support delivered to them in their shared living environment.

The positive outcomes achieved by both individuals is partly due to their ability in overcoming adversity as well as working on their own personal recovery. This would unlikely have been achieved if the staff team were not highly skilled and trained in understanding and supporting people with a severe and persistent mental illness delivered with a recovery oriented approach.

Mind SIL staff are mostly classified at a SCHADS Level 3. 70% of Mind's SIL workforce have an undergraduate degree in social work, psychology or the social sciences. The minimum qualification required is a Certificate IV in Community Services and/or Mental Health. The SIL workforce is supervised by SCHADS Level 6 Team Leader. This role is vital in providing leadership in complex environments to ensure the preconditions required for recovery oriented practice are in place. Mind contends that the qualifications and skills of existing SIL staff directly contribute to the outcomes many SIL participants experience. This means that SIL participants develop skills for independent living sooner than if they were supported by a lesser skilled and/or qualified workforce. Again, the two case studies provided illustrate this important point.

Mind are concerned that in this discussion paper SIL is defined as *personal care in a shared living environment*. For people with a psychosocial disability, personal care may be just one type of support they receive from their worker. SIL participants with severe and persistent mental illness receive a diverse range of supports from skilled practitioners in a shared living environment. It is important to note that when supporting people with severe and enduring psychosocial disabilities skilled

interventions are required to ensure environments are calm and are conducive to minimising behaviours of concern. Such interventions may include:

- Trauma informed care
- Motivational interviewing
- Techniques and skills to manage mental distress
- Strategies to manage self-harm and suicidality
- Dual diagnosis interventions
- Harm minimisation
- Therapeutic group work programs

It is Mind's view that best practice occurs when these interventions are provided by a suitability skilled and qualified workforce such as the one that currently exists.

People with severe and persistent mental illness deserve to have staff skilled providing psychosocial support to them in their home so they can feel safe and so their needs are able to be readily met.

As mentioned in one of the case studies, prior to the individual receiving SIL they were receiving clinical support in a psychiatric inpatient setting. NDIS participants with a psychosocial disability are frequently referred to Mind for SIL support from clinical mental health services from across Victoria, Queensland and South Australia. Often, SIL participants have been living in a sub-acute residential rehabilitation program for up to two years when referred by psychiatric nurses and allied health staff. Maintaining a level of continuity of support by a qualified and skilled worker is integral to achieving positive outcomes for the individual. Mind identifies that NDIA providing funding that would only enable Mind to employ lesser qualified and skilled staff will directly impact its ability to achieve the same positive outcomes.

Mind believes that SIL participants are entitled to the funds being invested in them to build capacity in activities of daily living to ensure targeted outcomes articulated in My Better Life plans are achieved. Mind has invested heavily in the development and implementation of an outcomes measurement tool that provides clear evidence of the progress individuals are making. The data Mind obtains from these tools also enables continuous quality improvement of service delivery in SIL services.

In the discussion paper, the mention of SIL only being provided to participants who require 24/7 support appears to be a change in policy by the NDIA. Mind are committed to ensure SIL has a strong focus on gaining independence through building capacity. Reducing reliance on formal supports is a common goal amongst participants that Mind supports. In the past the NDIA have built a framework of SIL being delivered in 24/7 or non-24/7 environments. Mind believes people who share supports in a shared living environment should not be restricted to requiring 24/7 care, but have access to flexible and individually tailored support based on what they are assessed as requiring.

Responses to the Discussion Paper questions

1. **What do you consider are the potential advantages or disadvantages for participants with regards to this new approach to Supported Independent Livin**g?

Advantages:

The intention for SIL pricing to be better understood by participants is a clear advantage. The new website has more accessible information for SIL participants which enables a greater level of choice and control.

Mind supports the aim of the new process to expedite funding approval for SIL participants and recognises this as a significant advantage to enable participants to receive this support in a timely manner.

Disadvantages:

- Mind is concerned about the removal of the complex price rate for SIL. This ultimately restricts choice and control for the participant. This is driven by the fact that participants with complex needs may lose a placement due to providers not being funded sufficiently to support them.
- Public holidays are capped at 12 days per year, so for states and territories where there are more than 12 public holidays in a calendar year (Victoria has 15) participants will not receive adequate supports for these days as their provider will not be funded to do so.
- In Mind's recent experience, not all NDIA staff in service delivery have been orientated to the new SIL process. This is resulting in delays in SIL packages being approved which is impacting when a participant can receive support. Mind is aware of one participant who had a plan review in August 2020 who is still waiting for SIL approval at the time of writing this paper. The new approach will limit access to Mind's residential SIL services for a large number of people we traditionally work with due to the eligibility for high intensity support excluding these people. The people we typically support have complex needs in relation to mental health but do not necessarily require personal care assistance or demonstrate a behaviour of concern at least once in each shift. Mind is concerned that people with complex needs will be excluded from SIL despite the strong outcomes this cohort of people with a psychosocial disability have been achieving through Mind's model of care in relation to the development of independent living skills.
- SIL participants will not receive the same quality support if Mind are not able to continue to recruit and train a suitability qualified and skilled workforce to deliver recovery oriented practice and the range of interventions outlined earlier in this paper, including the establishment of a comprehensive My Better Life plan.

2. **Are there particular factors you think the Agency should be aware of regarding how Supported Independent Living and related supports are defined, costed and charged to participants? Maintaining the quality of staff, training, compensate for staff turnover and bed vacancies. Provide clear definition of overhead**s.

- The agency has cost assumptions that are not commensurate with raw data available.
- Workers compensation of 1.7% is not reflective of actual costs. Mind has a cost approximation of 4.5% for workers compensation and leave as a proportion of salary.

- Irregular support is now funded separately and capped at 15.2 days per year for complex and standard needs clients, and 10.2 days per year for lower needs clients. This severely impacts people with a psychosocial disability whose support needs fluctuate due to the cyclical and often unpredictable nature of mental illness.
- Non-billable time (team meetings, supervision, handover) are not considered in cost modelling.
- The Roster of Care is limited in its functional capacity as it is only a weekly outlook to project support over a period of 12 months. There is also a limit to the number of placeholders available for ratio combination. This is particularly important when SIL is provided to 10 or more participants.
- The process of filling a vacancy can take up to 25 hours of non-billable staff support in profile preparation, tenancy matching and all necessary transitional support.
- In September 2019 NDS submitted recommendations on planning and SIL to the Joint Standing Committee on the NDIS after it conducted a consultation of SIL providers. NDS reported a 9% vacancy rate across SIL residences nationally. The loss of income when a vacancy arises, whilst still trying to maintain a permanent workforce, presents significant business challenges to the SIL provider.

Base Wages

3. **Is there a material difference in the base hourly wages paid to workers delivering SIL services compared to workers delivering non-SIL services?**

   Does this reflect different levels of required training, the nature of the work, or some other reason? How large is this difference?

   No. Across Mind direct support non-SIL and SIL staff are paid at a SCHADS 3 level in line with Mind's EBA.

   SIL staff work in participant's homes. This increases the time at which they are in contact with the participant and as well the likelihood of having to support participants exhibiting behaviours of concern. The requirement to have comprehensive training as these can occur outside business hours is a must. Other types of training, i.e. medication management, fire safety, evacuation training is also unique to SIL staff.

On-costs

4. **Are salary on-costs different for workers delivering SIL services compared to workers delivering non-SIL services?**

   Yes, because these are percentage of base salary. 24-hour services need penalties and allowances such as sleepover, recall allowance on sleepovers. Afternoon/ evening and overnight shift costs 15% more than the base rate.

   First Aid costs are also incurred by the SIL provider. This is $145 per staff every 3 years and $90 every year for CPR refresher.

   In comparison, Mind's non-SIL staff rarely work weekends as appointments can be scheduled in business hours.

   What aspects of each service type necessitate this difference? How large is this difference?

As above 15% above base salary in addition to other penalties such as double time Sunday, time and a half on a Saturday, overtime and public holidays rates as per award.

Overtime

5. **Do you observe significant differences in the rate of overtime costs between staff delivering SIL services compared to non-SIL services**?

   SIL staff regularly need to work overtime due to a crisis occurring in the SIL environment or workers cancelling shifts with limited time to cover the Roster of care. In these instances staff are offered time in lieu of payment, which means hours of the roster of care need to be backfilled which is an additional cost. On other occasions, Mind staff are paid overtime in instances where a shift cannot be filled and the staff member is required to work additional hours.

Leave costs

6. **Are leave costs different for workers delivering SIL services compared to workers delivering non-SIL services?**

   Leave costs do not differ substantially between SIL and non-SIL services. A key difference however with SIL services is that all shifts need to be back-filled when staff are on leave, often by agency staff or casual staff, incurring greater costs.

Enterprise Bargaining Agreements (EBAs)

7. **Does your organisation currently operate an EBA for some or all of its employees**:

   Mind uses the Richmond Fellowship of Victoria Incorporated Union Collective Agreement 2006

   Do the EBA conditions differ for workers delivering SIL services compared to non-SIL services? Which conditions are different, and why? How large is this difference?

   As above SIL Staff attract penalty rates due to the nature of the 24-hour model as described previously.

Casual staff

8. **Is there a material difference in the proportion of employees employed on a casual basis between employees providing SIL and non-SIL services?**

   Yes, SIL services employ more staff on a casual basis. This is due to often needing staff at short notice due to being a 24 hour service and staff calling in sick at short notice. SIL's are striving to implement a workforce model of 70 to 80% permanent/part time workers and 20-30% casual workers. Non SIL services at Mind would typically rely on permanent staff.

9. **What is the average number of hours per week that a casual staff member is employed in your organisation**?

   Approximately 15.2 hours per week

10. **Is there a material difference in the average number of hours per week that a casual staff member is employed in your organisation between employees providing SIL and non-SIL services?**

    If there is a difference, how large is this difference?

Mind does not experience a material difference in the average number of hours per week.

Part-time staff

11. Is there a material difference in the proportion of employees employed on a part-time basis between employees providing SIL and non-SIL services?

If there is a difference, which aspects of SIL service delivery are suited to more (or fewer) part-time permanent employees relative to full-time permanent employees? How large is this difference?

Across all of Mind's business, both SIL and non-SIL, most direct support staff are employed on a permanent part-time basis.

Team Leaders are employed on a full time basis.

95% of permanent employees providing direct support are employed on a part time basis.

12. What is the average number of hours per week that a part-time staff member is employed in your organisation?

30 hours per week

13. **Is there a material difference in the average number of hours per week that a part-time staff member is employed in your organisation between employees providing SIL and non-SIL services**?

If there is a difference, how large is this difference?

Mind does not experience a material difference in the average number of hours per week between SIL and non-SIL services.

Agency staff / temporary replacement staff

14. Are temporary replacement staff engaged more or less often for SIL services? If there is a difference, what are the key drivers of this difference? How large is this difference?

Agency staff are engaged much more often for SIL services.

The key driver for this difference is a minimum number of staff need to be rostered on in a shift to ensure the safety and support of participants. This is unlike one-to-one personal appointments, which can be re-scheduled at another time if a staff member needs to take leave at short notice. Mind are obligated to fill every shift on the roster of care.

Agency staff cost up to 50% more than Mind employed staff

15. Is the cost of the temporary replacement staff different between SIL services and non-SIL services?

No.

Level of staff

16. **What level of worker do you use for standard vs higher requirements, and when do you decide if a participant requires higher-intensity support?**

Support levels are determined through intake and assessment, completion of risk assessments and My Better Life planning.

Mind employs a SCHADS Level 3 workforce across all its SIL residences. Where higher-intensity support is required, additional training is provided to direct support staff such as positive behaviour support, medication training, occupational violence and restrictive interventions.

Training requirements

17. Do training requirements – and associated costs – for workers differ between SIL services and non-SIL services?

Yes. Because SIL workers support clients 24/7 and with varying complexities, training requirements are more significant given the higher needs and the environments in which SIL is delivered. In SIL environments, this includes managing incidents and incident reporting. Incident reporting is a crucial component of the SIL model regarding risk management and providing appropriate support to participants. In Mind's SIL's in the last quarter, we completed 320 incident reports which demonstrates the high number of incidents we manage. Many of these are complex situations that require skilled interventions and responses. The complexity of the client to client dynamics in the home environment also adds to the challenging nature of the work and as such to the great training needs of staff. The additional types of training required includes:

- Safety in residential settings
- Positive behaviour support
- Medication training
- Sharps management
- Dual Disability training
- Introduction to NDIS SIL
- Infection Control
- Restrictive Intervention Data System (RIDS) training

If there is a difference, what are the key drivers of this difference? What aspects of delivering SIL services require more (or less) staff training? How large is this difference?

The key drivers are the risks associated with working in people's homes on a 24/7 basis. The importance of safety for participants and staff when a workplace is situated in a person's home. The regularity of needing to manage emergencies and crisis. The frequency of supporting participants exhibiting behaviours of concern.
Estimated difference at least 3% of paid time

18. **Do initial training requirements – and associated costs – for new workers differ between SIL services and non-SIL services**?

Yes. New workers are required to undertake mandatory orientation to comply with organisation policies, mandatory reporting, fire safety induction, and work health and safety that is specific to the SIL dwelling along with occupational violence, first aid, CPR, My Better Life and incident report writing training.

Other non-billable activities

19. Is there a material difference in the non-direct care activities that staff in SIL services, compared to staff in non-SIL services, are required to undertake (for example: handover between shifts and/or note-taking specific to the individual)?

There is a material difference in the non-direct care activities that SIL staff are required to undertake which include:

- More regular team meetings in SIL environments
- Care coordination meetings in partnership with clinical services
- Family and carer meetings
- Handover is mandatory at the commencement of each shift. In most SILs, this means there are there comprehensive handovers each 24-hours. Handovers ensure continuity of support, risk management and mitigation and safety for participants.
- Case noting and other planning requirements per participant.
- Incident report writing

Supervisor wages and on-costs

20. **Is there a material difference in the wages and on-costs of supervisor in SIL services compared to non-SIL services? NDIA has used the cost model that assumes a supervision rate of SCHADS 4.2 for very high intensity support. Mind uses SCHADS 6.1 for all the team leaders in SIL services. If there is a difference, what are the key drivers of these differences? How large is the difference?**

The key drivers are complex work environments and the nature of SIL means that the workplace is the person's home. Staff are exposed to all parts of a participant's life which requires very regular debriefing of staff by the Team Leader. Emergencies and crises are not uncommon, which require highly skilled Team Leaders to manage risk and support staff to manage risk.

Supervision ratio

21. Is there a difference in the number of workers per supervisor for SIL services compared to non-SIL services?

Yes.

If there is a difference, what aspects of service delivery mean that more or fewer supervisors are required? How large is the difference?

Mind believes it is reasonable that SIL supervisors have less direct reports that non-SIL supervisors. As outlined above, this is due to the nature of the SIL environment. SIL staff experience all parts of a participants life, including crisis, emergencies and periods of mental distress. The supervisor therefore plays an important role in providing regular supervision support to SIL staff to avoid burn out. Supervision support is not something that can be postponed or missed due to the adverse impacts on SIL staff if this were to occur. Supervisors also play a vital role in providing debriefing support when SIL staff experience a crisis or an emergency. This may include severe self-harm and/or suicide attempts,

Corporate overheads

22. Is there a difference in the level of corporate overheads that are incurred in delivering SIL services compared to non-SIL services?

Yes

23. **If so, what aspects of the SIL operating environment drive this difference? How large is the difference?**

    Facilities management, depreciation of equipment and staff room fit-outs, learning and development and practice quality maintenance. The difference has been calculated to ~4% of income.

Turnover rates

24. **Do staff turnover rates differ between staff who deliver SIL services compared to non-SIL services?**

    No

25. **What costs are incurred when staff turnover? Do these costs differ between staff who deliver SIL services compared to non-SIL services?**

    Additional costs are incurred in SIL due the need to fill vacant shifts with casual or agency staff while recruitment takes place. In addition the extra training that new SIL staff require as mentioned above incur a minimum cost of 3% in comparison to non SIL staff.

Vacancy management

26. **What is the average vacancy rate across your properties?**

    Our average vacancy rate is 12.4% for unfunded beds. A contributing factor is due to the rehabilitation model of SIL which Mind deliver as outlined in the beginning of this document.

27. **Is the vacancy rate of a property influenced by factors such as the complexity of participants in each property, the rurality of the property, and the number of rooms in the property?**

    Yes. Some properties are designed for a cohort of people who have experienced homelessness or require admissions to hospital.
    Mind also delivers SIL in to state-government properties which could be defined as congregate living due to between 10-17 people living in cluster style or shared living. This type of living arrangement does suit all participants needs thus increasing the vacancy rate.

28. **What factors are considered in optimising the number of participants per SIL property? What impact does this have on costs?**

    Matching tenants is an important factor to ensure SIL residences are harmonious. The house dynamics for the dwelling are carefully considered in accepting new referrals for SIL support Mind is also required to meet the needs of the housing provider based on the number of beds they have available to be occupied within their property.. This process adds onto the timeline for filling vacancy at SIL and this means the SIL provider is out of pocket when the room is not filled. The SIL provider also has a vacancy management team that contributes to the corporate overheads.

29. **What approach is used to optimise vacancy levels across your properties?**

    Mind use various platforms such as Housing Hub listings, stakeholder engagement strategies, social media campaigns and a vacancy mail out list to potential referrers, including clinical providers.

Mind have a team dedicated to referral processing and assessments that have been co-designed with participants and other stakeholders. Due to the immaturity of the SDA market and other housing providers, there is often an ability for the housing provider to take a proactive role in identifying and securing suitable tenants.

Vacancy costs

30. **How do vacancies impact the costs of delivering SIL services?**

    Vacancies have a significant impact on the cost of delivering a SIL service and accounts for a high proportion of income lost. Staffing rosters need to be maintained where possible to ensure other residents within the residence do not have their levels of support impacted due to a vacancy occurring. One vacancy in a dwelling cannot also warrant a reduction of staff in SIL. This means there will be less income but with the same staffing costs of a fully occupied dwelling. Maintenance schedules, testing tagging and support services all remain the same regardless of occupancy. Staffing rosters are fixed and need to be maintained.

    Please quantify these costs for your organisation?
    $1.4 million in lost income due to vacancies.

31. **Some costs associated with vacancies can be considered to be "fixed" – for example, an inactive sleepover for a three bedroom house has the same cost whether there are two or three participants in the house. Other costs can be considered to be more "variable" – for example, the vacancy costs of a three bedroom house with three residents each receiving 1:1 supports can, in general, be managed through change in rostering.**

    What proportion of vacancy costs are fixed or variable in your organisation?
    80% of the cost is fixed.

Participant complexity

32. **What impact does participant complexity have on the costs of delivering supports in the SIL environment?**

- As previously indicated additional training is required and minimum Certificate IV qualified workforce.
- Greater supervision is required for complex participants as the team can 'burn out' without adequate supervision.
- Participants with more complex needs can trigger distress in other participants. This often results in the SIL service needing to include additional shifts in a Roster of care that are not accounted for in funding or incidental supports. This includes the provision of active overnight sleepover workers to ensure adequate support is available through the night.
- Participants with more complex needs can at times lead to increased absenteeism due to the complex behaviours that staff find challenging to manage in an ongoing manner therefore require higher level of time away from the workplace to ensure their own wellbeing. This requires SIL services to engage more casual relief and agency staff to fill shifts. This is far more costly as pointed out earlier in this paper.
- At times, participants who exhibit some types of behaviours of concern can lead to other participants feeling unsafe or dissatisfied and leaving the SIL prematurely. The costs incurred through a vacancy can be significant as illustrated in this paper.

33. **What approach is used to optimise the allocation of participants with different support needs across your properties?**

    A SIL referral to a dwelling is carefully considered based on various factors such as:

    - Current occupants living in the SIL
    - Support needs of the participant
    - Support network in the area for the participant (formal & informal)
    - Assessment panel recommendation
    - House configuration (Active night shift vs inactive night shift)
    - House design for appropriateness

Shift costs

34. How many shifts are provided in a 24-hour period? To what extent is the number of shifts driven by factors such as the number of participants in the property, the mix of support needs within the property, or other factors?

    Usually three. Day, afternoon and night. The number of staff in any particular shift varies according to client numbers/needs/complexities as some clients may attend a day program or receiving support from an external provider.

35. How sleepover and crossover do shifts impact on supply costs?

    Handover is a crucial part to ensuring continuity of support is provided to the participants within their home. Sleepover shifts require staff to sleep onsite. This can be a challenge as staff may have family commitments or unwilling to sleep away from home. This typically means there is little choice for sleepover staffing or an adequate pool to recruit from.

    1.5 hours per SIL per day of crossover time to accommodate the need for handover which is an additional cost.

Establishment costs

36. **On an annual basis, how often is a new participant established in a property?**

    Last financial year Mind had 26 new participants out of 145 participants move into existing properties and newly established properties. Mind experiences a high throughput rate of clients as Mind's psychosocial SIL model has a strong emphasis on recovery, rehabilitation and stepping down in to an environment where less support may be provided.

37. **Is there a material difference in the costs of establishing a participant between SIL and non-SIL services?**

    Yes

    Fit-out costs are incurred when establishing a new house (cost can range from $30,000 to $50,000).

Staffing costs as the participant transition into the house occurs are not fully funded as all 4 participants do not move in at the same time.

SIL submission and supporting evidence gathering takes around 25 hours to complete a for a SIL participant.
We also have establishment costs relating to staff recruitment and training in preparation for staffing a new house. These costs are estimated at $6,000-8,000 per staff member.

If so, what aspects of the SIL operating environment drive this difference? How large is the difference?

Compatibility with other participants is important. If a stay is going to be long-term, more work is required to establish suitability. This is because SIL services stagger transition to ensure the success of the dwelling. It would not be suitable for multiple participants with complex needs to move into one dwelling at the same time. This transition can span out to be around 6 weeks for the house to be fully occupied. This means a total of income lost for 6 weeks for all participants.

Location differences

38. **Do costs for delivering SIL services differ significantly between metropolitan centres versus regional, rural and remote areas? If so, what is the average cost differential, and what elements of the cost drive this difference?**

Recruiting staff in regional areas is more challenging than recruiting in metro areas as there is a smaller pool of qualified and experienced staff to choose from, especially those with experience supporting people with behaviours of concern. There is also a smaller pool of qualified casual workforce available at short notice as staff work for other providers in the area.

Other supply costs

39. **In delivering SIL services, what proportion of Disability Support Worker time is spent on providing support to participants? Note that this includes time directly interacting with participants, as well as tasks which do not involve direct interaction with participants such as preparing meals or sleepover shifts.**

SIL services aim for 80% direct support work and 20% indirect work

The 80% accounts for:

- One on one direct support
- Group work- shared supports
- Support with community participation in some instances
- Support attending appointments

The 20% accounts for:

- Handovers
- Case noting
- Incident reporting
- Care coordination related tasks
- Working with families and carers

Other costs

40. Are there any additional costs incurred in non-SIL or SIL services, which are not currently captured in the Cost Model?

Yes.

18 % of income is used for support service charges and management costs.

Investment in management costs is critical to ensuring:

- Safety and risk oversight
- Governance
- Accountability
- Support and Supervision for operational managers
- Compliance with legislation, policy and regulations

Mind's Support Services that exists to ensure operations can deliver best practice care and Support include:

- Learning and development,
- Facilities management
- ICT Services
- Vacancy Management
- Quality and Practice
- Human Resources
- Corporate Services
- Finance Services
- Research and Advocacy
- Diversity and Participation team that drive inclusion and the promotion of the profound nature of lived experience across the organisation

Mind Support services support operations through a range of best practice activities and processes that make valuable contributions to service delivery. These contributions to service delivery are important factors that provide the preconditions required for frontline staff to perform at their very best and in doing so, assist participants to achieve their goals. Examples of these activities include:

- Communities of Practice
- Critical Incident Reviews
- Complex Case Reviews

- Clinical governance
- Targeted training programs
- Leadership development program
- Program Evaluation
- Data collection and dissemination
- Evidence Informed Practice Developments
- Front Line Worker Tool Kits and Resources
- A Comprehensive Intranet
- Continuous quality improvement

Appendix 1

My Better Life®

Mind's **My Better Life®** model to help our clients to find a path to a better life and improved wellbeing is a structured evidence-based and co-designed recovery tool which supports clients to talk about their needs, hopes and dreams.

"We can help you, but the control is with you"

A core part of the support offered is to assist people to identify goals aligned to improved wellbeing, including routines, re-establishing 'activities of daily living.' This is reinforced by the use of goal-setting. This is a practical application of a Behavioural Activation approach. Behavioural Activation involves the positive reinforcement of healthy behaviours recommended as an evidence-based treatment for depression (NICE, 2016). Systematic reviews indicate that it is at least as effective as CBT (Cuipers et al, 2008).

A trusted provider of community mental health support services to people and their families, friends and carers for over 40 years.

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Help, hope and purpose

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