

MHCSA Submission: NDIS Quality & Safeguarding Framework

## MHCSA

The Mental Health Coalition of South Australia (MHCSA) is the peak body for the non-government mental health sector in South Australia (SA). Our vision is that ‘all South Australians affected by mental illness are receiving the support they need to live well in the community’. Our mission is to influence the development, range and responsiveness of services to support people affected by mental illness by:

* Working to reduce stigma and increase an understanding of mental illness and its prevention;
* Representing and working with the community mental health service sector (non government) to support people affected by mental illness; and
* Promoting and building the role of the community mental health service sector (non government).

The MHCSA consulted with member organisations that are service providers to develop this submission.

The focus of comments and recommendations in this submission relate to community members living with a psychosocial disability.

## General Comments

The MHCSA welcomes the opportunity to provide feedback on the NDIS Quality & Safeguarding Framework. We notice that the document refers to compliance with National Disability Standards. For NDIS participants supported due to their psychosocial disability the MHCSA believes that reference to the National Mental Health Standards[[1]](#footnote-1) is the appropriate reference.

Recommendation 1:

That Quality and Safeguarding references the National Mental Health Standards for participants living with a psychosocial disability.

## Communication and Information

MHCSA believes that a range of communication mechanisms and information types is essential to reach the community that will benefit from NDIS. Consumer and carer participation from a range of disabilities including psychosocial disability will ensure that language is appropriate and meaningful for a range of stakeholders.

Not all people use or want to use the internet – it is critical that all stages of connection to NDIS be available through multiple means. Phone contact with the NDIA should be timely and have a human voice straight away rather than requiring callers to navigate a menu system.

MHCSA advocates for the promotion of peer support to assist potential participants to navigate the information and assessment process, through multiple gateways including NDIA and other organisations that people with disabilities and their families typically approach for information. One example may be a call centre staffed by peer workers from a range of disabilities including psychosocial disability so callers can connect with someone who has empathy with their particular story. This has the added benefit of contributing to participation in the workforce for people living with disabilities.

The needs of Aboriginal and CALD communities and those from rural and remote areas should be considered using a “community development approach”, seeking expert advice from the communities and organisations that are currently providing a service that is well received. MHCSA applauds the approach taken with the NPY Women’s Council project (Case example, P18) and believes the time and effort taken in this and other communities will lead to a culturally and regionally sustainable NDIS.

On-line forums and feedback mechanisms are very useful but should be moderated in a timely way and utilising a set of pre-defined guidelines. Surveys and feedback received should be retained and used for benchmarking and measurement of customer satisfaction and outcome measurement.

Staff of NDIS provider organisations should be informed and able to have NDIS conversations with their clients over and above the specific support service they are performing.

Recommendation 2:

Offer a range of communication mechanisms for all stages of information, connection and participation in NDIS.

Recommendation 3:

Utilise peer support in a paid capacity to support people into and through the NDIS experience.

Recommendation 4:

Utilise feedback from on-line forums for bench-marking and outcome measurement.

Recommendation 5:

Work directly with Aboriginal, CALD and rural and remote communities to define and measure the effectiveness of communication in those communities. Build upon initiatives such as the NPY Women’s Council in South Australia (P18).

Recommendation 6:

Support providers with communication and development tools for front line staff so they become part of the communication mechanism for NDIS.

## Building Individual Capacity

For psychosocial support providers, the Mental Health Recovery Framework (<http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-recovgde>) offers a fully person-centred approach to case management and support. The national framework defines recovery as ‘being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues’ (*National Framework for Recovery-Oriented Mental Health Services*, 2013 p2). MHCSA recommends that Planners and Local Area Coordinators fully understand the Recovery Framework if they are to work effectively with people living with a psychosocial disability.

Mental illness is often episodic and consumers/participants may have periods of wellness where they are managing their lives, however when the need for support exists it must be responsive and timely. MHCSA recommends that NDIS considers this in the development of plans with participants.

For many individuals in the target group for psychosocial disability support under NDIS, a significant level of effort will be required to engage and assist them to access NDIS support. How the NDIA links with other relevant services and supports will also be important to the effectiveness of support for people living with psychosocial disability.

For mental health consumers with complex needs and few natural supports, complex case management models such as Partners in Recovery (PIR) offer a current and effective process to support this cohort. PIR Support Facilitators and other case managers skilled in complex case management are a useful resource in supporting some mental health consumers and can assist those with high and complex, multi-disciplinary needs to build capacity.

Local Area Coordinators can’t be expected to be experts in everything. The role should work with organisations, with contributing expertise, and consumers and carers for example through local area advisory groups that bring a range and depth of knowledge. Bringing together expertise and commitment at a local level is a powerful tool to assist individual capacity building.

The value of consumer and carer peer support is well recognised in the mental health sector and a formal qualification (Cert 4 in Mental Health Peer Work) has recently been revised. The MHCSA strongly supports the notion of disability peer support and the development of a specialist vocational qualification. Peer workers can “walk along side” NDIS participants to role model and build capacity.

Recommendation 7:

Planners and Local Area Coordinators understand and utilise the National Recovery Framework when working with NDIS participants living with a psychosocial disability. Plans should take into account and plan for episodic needs where they exist.

Recommendation 8:

Develop effective linkages with PIR and other complex case management models to support NDIS participants with high and complex, multi-disciplinary needs who may have few or no natural supports.

Recommendation 9:

Recognising that Local Area Coordinators can’t be experts in everything, use local expertise to bring NGO and peer support to add depth/breadth of knowledge to local area coordination.

Recommendation 10:

Utilise peer workers to assist with engagement by “walking alongside” NDIS participants with a psychosocial disability to help build individual capacity.

Recommendation 11:

Support the development of the peer workforce through Certificate 4 in Mental Health Peer Work.

## Quality & Oversight

Mental health and disability are different in many ways – it is impossible to assume that disability standards will encompass mental health. The Quality and Safeguarding document does not refer to the National Mental Health Standards at all – rather the focus is on Disability Standards. While there is significant common ground, the NDIA and providers offering support to NDIS participants with a psychosocial disability must conform to the National Mental Health Standards (<http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-servst10>).

To deliver high quality supports, providers must understand the NDIS, how it works and how to work together. Internally staff must have appropriate training, professional supervision and support to do their job well. The mental health sector has focused on developing a professional and well trained sector for non-clinical services. As a result staff currently employed by mental health psychosocial support services are highly trained and often come with degree-level qualifications (social work, psychology, social sciences). Within the current pricing structure maintaining such a well trained workforce will be difficult to achieve given that psychosocial support staff are generally paid at a higher rate that their disability counter-parts, and NDIS pricing is predicated on disability pay rates. MHCSA recommends that support elements and pricing be reviewed for psychosocial disability support to ensure that staff are able to receive the same level of training and professional supervision their disability counter-parts will receive, with a purpose of delivering high quality and professional services to participants.

Given that NDIS is a national system, the MHCSA believes that quality systems and over-sighting should also be national, leading to consistency across jurisdictions. To mitigate conflicting quality system requirements across states for organisations delivering services additional to NDIS, negotiation between the Commonwealth and State departments may be required to reduce the need for multiple accreditations.

For sole or micro providers (typically supporting only the cohort who self-manage their NDIS budgets) the MHCSA believes there should be a minimum standard enshrined in a Code of Practice that all providers sign up to. There should be an auditing mechanism for sole and micro providers so that spot checks can be undertaken.

Some mental health consumers are vulnerable and lack trustworthy natural supports. In these cases “pre-planning” using experts skilled in connecting and building rapport with complex community should be funded to ensure this cohort does not “slip through the cracks” and end up in acute/emergency settings through lack of engagement. Quality and effectiveness of these services should be audited alongside “post plan” service providers. This links with previous comments about PIR, complex case management and the involvement of peer workers.

Recommendation 12:

Incorporate National Mental Health Standards into quality and safeguarding for organisations providing psychosocial disability support.

Recommendation 13:

To ensure quality of service provision, that support elements and pricing be reviewed for psychosocial disability support to ensure that staff are able to receive a reasonable level of training and professional supervision.

Recommendation 14:

Adopt a national accreditation standard and negotiate across jurisdictions to mitigate the likelihood that States will require different accreditation for State-funded programs incorporating Disability and Mental Health standards.

Recommendation 15:

Sole or micro providers must sign up to a Code of Practice and that mechanisms are in place to do spot audits.

Recommendation 16:

Fund “pre-planning” using experts skilled in connecting and building rapport with complex community to ensure this cohort does not “slip through the cracks” and end up in acute/emergency settings through lack of engagement. Quality and effectiveness of these services should be audited alongside “post plan” service providers.

## Provider Registration

The MHCSA supports national quality and safeguarding arrangements, however these should reference Mental Health Standards in addition to Disability Standards where services are provided to a person living with a psychosocial disability. All providers must meet these standards regardless of whether they are a large, small or sole provider.

MHCSA supports option 3 as a minimum and option 4 preferred (eg for larger providers) from the summary of options for registration (p32). It is imperative that NDIS service providers offer a consistent and high level service. This may require support for small and sole providers such as accreditation preparation workshops, assistance with compliance, incident reporting and management etc.

There have been significant gains in developing the mental health workforce and this should not be lost so we ensure that NDIS participant receive a professional and caring service. All staff providing psychosocial support services should have a minimum qualification such as Certificate 4 in Mental Health or Mental Health Peer Work. There would be value in supporting professional development on a fee for service basis for sole providers to ensure that they maintain their skills.

The NDIS Code of Conduct should be consistent with both disability and mental health standards and all providers regardless of size should sign the Code of Conduct. A “Plain English” version may be helpful.

MHCSA recognises the right of the individual to choose their service provider. Where that choice is a sole provider who is not formally registered as an NDIS provider, a bare minimum should be signing of the Code of Conduct and Vulnerable Person clearance. If working with children they must have a “working with Children” clearance.

Recommendation 17:

Options for Registration: Option 3 as a minimum for small providers and Option 4 for large providers.

Recommendation 18:

To ensure a consistent quality of service, all staff providing psychosocial support should have as a minimum Certificate 4 in Mental Health or Mental Health Peer Work.

Recommendation 19:

To ensure that all providers of mental health services maintain an appropriate level of skill, NDIS could support fee-for-service professional development training for small/sole psychosocial support providers.

Recommendation 20:

All providers regardless of size should sign a Code of Conduct. This is especially important if staff are working alone or coming into NDIS participants homes.

Recommendation 21:

Unregistered sole providers must have signed the Code of Conduct and have obtained a Vulnerable Persons clearance. If working with children they must have a “working with Children” clearance.

## Handling Complaints

MHCSA supports option 2 where providers are required to demonstrate that they have a complaints handling process in place. The complaints scheme should cover all supports provided; with a comprehensive risk matrix to assist providers to assess the severity and impact of risk.

We believe that all critical incidents should be reported to the NDIA so the agency is able to track and monitor both incident resolution and processes to reduce the risk of re-occurrence.

In the future there is value in developing a single external body that participants can go to if their complaints are not addressed, however we should maintain processes within jurisdictions while this is being properly established. Where complaints must go to multiple agencies (eg NDIS and Child Protection) there should be effective inter-agency communication systems. The complaints body should have the power to recommend actions and have the power to recommend suspension or de-registration as a provider if deemed necessary.

No provider should be exempt from having a complaints system or participating in investigations of complaints to a central body. Small providers may need support to do this.

The MHCSA fully support the Community Visitors Scheme which should be enshrined in the NDIS Act. The use of “peers” or people with lived experience of disability/psychosocial disability as community visitors is highly recommended.

Recommendation 22:

Implement option 2 (internal and external complaints handling requirement) as a minimum and should be required of all providers.

Recommendation 23:

Maintain external complaints handling bodies in jurisdictions until a single external body is properly established. It should apply to all funded supports and should respond in a timely manner and have appropriate linkages with Child Protection and the criminal justice system.

Recommendation 24:

Enshrine the role of the Community Visitors Scheme in the NDIS Act.

## Ensuring Staff are Safe to Work with Participants

The MHCSA believes that all people with a psychosocial disability have a right to receive high quality supports from people they can trust. For this reason we recommend that staff delivering supports should have Vulnerable Persons checks (Working with Children for those delivering services to children). Processing of clearances must be timely so that organisations are able to recruit staff in a reasonable timeframe.

Individuals seeking work in the sector should be able to apply for their own clearances prior to employment.

Recommendation 25:

All staff working for providers should have a Vulnerable Persons check, managed and processed in a timely manner.

Recommendation 26:

Establish processes whereby prospective staff can obtain their own Vulnerable Persons check prior to employment rather than the current system where the employer must make the request.

Recommendation 27:

Adopt option 3b (p73) where all providers are required to have a Vulnerable Persons check and be registered as such with the NDIA.

## Safeguarding Participants Managing Their Own Plans

For self managed participants the MHCSA supports option 3b – providers should be approved by the NDIA with all providers having to go through a standard registration process. Where an NDIS participant is employing their own service provider they may need to be supported to manage this process by (for example) developing Plain English fact sheets, telephone support and an on-line process if possible for support providers. Consultation with participants to identify exactly what support they need should be undertaken.

Recommendation 28:

Consult with NDIS participants who self-manage their funds to establish what additional support they need to manage the clearance/registration process.

## Reducing and Eliminating Restrictive Practice

Restrictive practices should be a rare event. In line with National Mental Health Standards, the MHCSA supports reducing the use of restrictive practices for people living with a psychosocial disability and for that reason recommends that the NDIA adopt option 4 (p82) – restrictive practices could only be authorised by an independent decision maker. Every restrictive practice event (eg PRN medication) that is authorised must be fully documented in the support plan and signed off by the appropriate person. In some cases this will be a multi-disciplinary team with a nominated lead.

Whenever restrictive practices are used they must be recorded and reviewed periodically with the participant and independent decision maker. Multiple events must be reported to the independent decision maker.

Education and training are critical to ensuring we don’t use restrictive practices unnecessarily and staff working with complex participants should receive appropriate training, eg therapeutic crisis intervention.

It must be noted that within NDIS guidelines a service provider may not be privy to the whole support plan for a participant. It is imperative that information relevant to the support provided is shared, for the safety of the participant and provider staff.

Recommendation 29:

Adopt option 4 – restrictive practices could only be authorised by an independent decision maker and should comply with the Mental Health Act for participants with psychosocial disability. In some cases this will be a multi-disciplinary team with a nominated lead.

Recommendation 30:

Restrictive practices to be documented and multiple instances reported to the independent decision maker.

Recommendation 31:

Support providers to offer relevant training to build the capacity of staff, for example therapeutic crisis intervention training.

Recommendation 32:

For the safety of participants and provider staff, all relevant NDIS support plan information must be shared with the support provider, to enable the service provider to develop appropriate support plans and manage risk.

## Summary of Recommendations

### General

Recommendation 1:

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### Communication and Information

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