Submission on

Proposal for a National Disability Insurance Scheme Quality and Safeguarding Framework

WAAMH

Western Australian Association for Mental Health

Peak body representing the community-managed mental health sector in Western Australia

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Proposed NDIS Quality and Safeguarding Framework

The Western Australian Association for Mental Health (WAAMH) welcomes the opportunity to provide a submission on the National Disability Insurance Scheme (NDIS) Quality and Safeguarding Framework.

The Western Australian Association for Mental Health (WAAMH) was incorporated in 1966 and is the peak body representing the community-managed mental health sector in WA. With around 150 organisational and individual members, our vision is to lead the way in supporting and promoting the human rights of people with mental illness and their families and carers, through the provision of inclusive, well-governed community-based services focused on recovery. WAAMH advocates for effective public policy on mental health issues, delivers workforce training and development and promotes positive attitudes to mental health and recovery. Further information on WAAMH can be found at http://www.waamh.org.au

WAAMH's submission focusses on the challenges for people with psychosocial disability in accessing effective support through the NDIS. These challenges have been documented at a national level, most recently by Mental Health Australia[1]. WAAMH acknowledges the state-by-state differences due to variations in the bilateral agreements, the Western Australian agreement being unique due to the decision to trial two models.

The NDIS and its roll out are of momentous interest and opportunity for the Community Managed Mental Health (CMMH) sector, which is reflected in a high level of engagement of sector organisations, consumers, carers and families. WAAMH is taking a lead role, in consultation with consumer, carer and family representative bodies, in advocacy and sector development for the CMMH sector.

As the consultation paper is divided into two parts, an outline of the Framework and the elements of the Framework, the WAAMH submission to the Framework follows this same outline.

Capacity Building

International evidence clearly identifies that capacity building for services, consumers, families and carers is a key determinant of success for person directed service reform[2].

Often in reform, capacity building supports sector organisations without recognition of the need to also empower consumers and families. Consumers of Mental Health WA (CoMHWA) identifies the "ability to empower people with psychosocial disabilities … to identify their

[1] *Providing Disability Support Through the NDIS: A Proposal Prepared by Mental Health Australia*, March 2014, http://mhaustralia.org

[2] Report by Theresa Williams *To Investigate the Policy & Practice of Mental Health Self Directed Support for People with Mental Illness*, 2011, Winston Churchill Memorial Trust, http://waamh.org.au/assets/documents/reports/self-directed-support_t-williams-2012.pdf

needs and develop capabilities for self-direction and recover" as a key issue affecting consumer access to, and benefit from, the NDIS. [3] Consistent with best practice in mental health and psychosocial disability support, NDIS and NDIS My Way should consider the value of peer- led support in achieving access, choice and control for scheme participants.

To ensure CMMH sector viability and resultant choice, control and recovery orientation for consumers, investment in developing the capability of CMMH organisations is required. Investment should achieve a balance between investment targeted specifically at people with a psycho social disability and the needs of CMMH sector organisations, and approaches that integrate psychosocial disability across services, programs and projects.

There are many aspects of the Consultation paper which are central to ensuring that participants of the NDIS are supported in the planning process and intentional safeguards are in place. Understanding risk in light of the planning process and person centred practice when the system is transitioning from a service provision orientation where the professional has been the expert and the person receiving the services has been a passive recipient will be the challenge. The schema developed by the NDIS Safeguards and Quality Assurance Expert Group and outlined in the Consultation paper provides a good starting point to understand the needs of the individual and the context of the service system in this transition.

To have formal safeguards such as quality monitoring measures and licencing regulation, credentialed and trained staff, advocates, compulsory reporting etc. in place does not automatically translate to a system whereby risk is mitigated and safeguards are in place all of the time. As Michael Kendrik 2005 points out, "the very presence of such safeguards may actually serve to relax people's vigilance".[4]

An intentional safeguarding attitude should be adopted which countenances the questions about vulnerabilities in the context of the person's life. This practice does not presume that people can do this unassisted or without difficulty, it simply argues for them to be agents in their own lives, including defining what supports they may need[5]. And in some cases this requires the worker/planner to think about the investments which are required to fill the gaps when the safeguards for the individual do not exist in their context.

NDIA Provider registration

To have the highest regulatory standards in place is where the benchmark needs to be set for all providers, not just some. To this end the Consultation paper outlines this benchmark

[3] Consumers of Mental Health WA, 2014, 'Disability Insurance Initiatives Consumer Participation: Advocacy Brief' http://www.comhwa.org.au/wp-content/uploads/2013/02/CoMHWA-NDIS-Advocacy-Brief-07072014.pdf

[4] Kendrik, Michael J., "Self Direction" In Services and the Emerging Safeguarding and Advocacy Challenges that may Arise, Discussion Paper of the Connecticut Office of Protection and Advocacy for Person with Disabilities, 2002

[5] ibid

in option 4. All providers whether they be individuals, organisations or private providers should be registered with the NDIA as a minimum. Option 4 – mandated participation in an external quality assurance system for providers already occurs in Western Australia for those providers in receipt of funding from the WA Mental Health Commission and the Disability Services Commission. A word of caution: for individuals to base their choice of providers solely on whether the provider has delivered outcomes for other individuals through an accreditation and standards process could be limiting. It is difficult to understand whether there were other factors at play that may have had a significant impact on outcomes for the individual's and not just adherence to an accreditation and standards process.

There needs to be recognition of other industry standards which organisation has been accredited against and which can be mapped to reduce the administrative burden and reporting. For example, the Accreditation Systems Recognition Tool, National Standards for Mental Health Services (NSMH) developed by JAS-ANZ enables service providers to understand how their current accreditation/certification status meet the NSW DSS and the areas that require further evidence to meet the standards which differ across different service types and sector standards. This is a useful tool and provides opportunities for organisations to understand the discrepancies between their current practices and policies against what is expected in other domains.

WAAMH recommends Option 4 outlined in the Consultation Paper.

Systems of handling complaints

As outlined in the Consultation paper WA has complaints handling mechanisms in place from consumer law protection to other legislative requirements. In the Mental Health sector The Council of Official Visitors is an independent agency established by the Parliament of Western Australia. The Council is primarily there to ensure that individuals who are being treated under the Mental Health Act and/or who are currently living in licensed private psychiatric hostels:

- are aware of their rights;
- these rights are being observed; and
- to investigate and seek to resolve complaints

The Health and Disability Services Complaints Office (HaDSCO) is an independent statutory authority providing an impartial complaints resolution for complaints relating to health or disability services provided in the State of Western Australia. This service is free and available to all users and providers of health or disability services. Both these complaints mechanism should be maintained to enable people who are receiving services from the NDIS to access impartial and independent complaint resolution processes.

A common feature of complaints mechanism before the complaint gets into the domain of the statutory authorities outlined above is that providers/organisations who have to adhere

to standards and accreditation have to provide evidence that their processes meets this standard. Professionals who are registered with the Australian Health Practitioner Regulation Agency (AHPRA) have processes in place to handle complaints. A complaints mechanism should be highly visible for people accessing the services and be used as a process to improve service quality and provision.

WAAMH would recommend that a consistent national registration framework, informed by the National Standards for Mental Health Services be put in place.

Ensuring staff are safe to work with participants

Strengths based person centred practice, starts with the person in their support plan – the aim is to fit the services that are needed into their life and not to make assumptions about the vulnerabilities of the person.

Intentional safeguards which form the underpinning of any planning document goes to the heart of ensuring that the planning coordinators for NDIA are appropriately skilled in understanding this. Person centred strengths based practice is an imperative and imbedded into the plan from the start – not as an adjunct. Safeguarding becomes intentional and in the hands of the person whose support plan it is. *When I was asked what is important in my life I was suddenly stuck as no one had asked me that before.*

At a minimum all employees should have a Certificate IV qualification in Mental Health or Peer Work this ensures that staff have a basic understanding and a frame of reference from which they are practicing. Organisations should have in place police check policies for all staff which are time limited, that is employees are required to present a police check every three years. It may be prudent to have other safeguards in place such as vulnerable people checks; however the risk needs to be weighed up against the administrative burden and the flexibility that is required in the workforce. As outlined in the Consultation paper WA has in place a Working with Children Check. There is merit in having an outside agency to make the decision about whether individuals are safe to work with vulnerable people with a psycho social disability and not leaving this decision to employers through trial and error and reliant on police checks which at times do not show any evidence of risk. There are aspects of the Working with Children Check process that could delay employment of workers, for example in small rural towns and in areas where the access to people to do the work is limited and this could have a negative effect in providing appropriate services to those who need it the most.

WAAMH recommends Option 3 – working with vulnerable people clearances.

Safeguards for participants who manage their own plans

In WA safeguards for participants who manage their own plans have been in place for people who have a disability for some time. The WA Disability Services Commission outlines a policy for Share Management on their website which was developed in 2011. This policy is underpinned by the principles that people with disability have the same right as other members of society to participate in, direct and implement the decisions which affect their lives (Principle 5, WA Disability Service Act 1994). WA Individualised Services is an organisation which has been set up to help individuals navigate this process and have significant understanding of the key issues which can impact on the development and implementation of support plans for individuals who wish to manage their own plans. This work does not necessarily transcend into plans for people with a psycho social disability simply because the organisation has not had to consider the different contexts for people with a psycho social disability. This work is a good starting place when considering safeguards for people with a psycho social disability.

Here it is important to go back to the first question in the Consultation paper and the work that was led by the Safeguards and Quality Assurance Expert Group, "citizen capital is the foundation of understanding people, their resources and their context and is a valuable way to develop a good plan that incorporates effective safeguards"[6] even when people choose to self-manage.

WAAMH would recommend Option 3c – Individuals to be employed have been screened and to consider the work done by WA Individualised Services in Shared Management as a resource.

Reducing and eliminating restrictive practices in the NDIS funded supports

In Western Australia the Chief Psychiatrist is committed to reducing the rate of seclusion and where possible eliminate the use of restrictive practices in mental health services across Western Australia (WA) and as such WAAMH does not support the use of restrictive practices as a way of responding to challenging behaviours. In 2013 a United Nations report (United Nations Human Rights Council, 2013) called for a ban on the seclusion, confinement and restraint of people experiencing psychological or intellectual disabilities. The report, although not legally binding in Australia, states the practice of seclusion and restraint from a human rights perspective is no longer acceptable. It is widely accepted that the use of seclusion and restraint do not meet the human rights principles.

Reducing and eliminating the use of restrictive practices is consistent with the UNCRPD and its intent to protect the rights, freedoms and inherent dignity of people with disability. This includes involuntary mental health practice including, for example, involuntary hospitalisation and Community Treatment Orders (CTOs). Requirements of involuntary

[6] Walker M, Fulton K, and Bonnyhady B " a Personalised Approach to Safeguards in the NDIS" March 2013

mental health orders have impacts not just on 'clinical' mental health services but also the non-government providers of psychosocial disability and recovery support services, which are increasingly funded through the NDIS.

The Australian Law Reform Commission (ALRC) released a Discussion Paper in May 2014 regarding 'Equality, Capacity and Disability in Commonwealth Laws'. This Discussion Paper is the second consultation document in the ALRC's Inquiry into Commonwealth laws and legal frameworks that deny or diminish the equal recognition of people with disability before the law, and their ability to exercise legal capacity and is a precursor to the current National Quality and Safety Framework consultation. Content related to consideration of state/territory based (involuntary) mental health legislation as restrictive practice is included on pp 231-233 and elsewhere. Review of this state/territory legislation is recommended, however, it appears that the NDIS is not to be a vehicle for this to occur.

The use of restrictive practices and seclusion in Australia for people affected by mental health conditions – including psychosocial disability – is of great concern as detailed in the National Mental Health Consumer and Carer Forum (NMHCCF) position statement 'Ending Seclusion and Restraint in Australian Mental Health Services' (2009) and advocacy brief 'Seclusion and Restraint in Mental Health Services' (May 2012).

Supporting this position, 'The Australian Civil Society Parallel Report Group Response to the List of Issues' as part of Australia's appearance before the UNCRPD in 2013 expressed concern that people with disability, especially cognitive impairment and psychosocial disability, are 'routinely subjected to unregulated and under-regulated behaviour modification or restrictive practices such as chemical, mechanical and physical restraint and seclusion' (8.6 of the discussion paper).

The absence of a discourse in the NDIS quality and safeguards consultation paper regarding the use of restrictive practices both under and outside of existing state/territory mental health legislation as identified above is of great concern. WAAMH supports the position that use of seclusion and restraint practices should be reduced, with the ultimate goal of elimination of such practices, as set out in the 'National Framework for Reducing and Eliminating the use of Restrictive Practices in the Disability Service Sector' (2014).

WAAMH would support option 3 in the Consultation paper which is similar to the approach used in Victoria.