View from the peak

A publication from the Mental Health Coordinating Council June 2018

# Celebrating 25 years of the Commonwealth Disability Discrimination Act and Mental Health Reform


**This year marks the 25th anniversary of the Commonwealth *Disability Discrimination Act 1992*. In acknowledging the milestone, the Australian Human Rights Commission invited people to reflect where Australia should ideally be in relation to disability discrimination in another 25 years.[1]**

The Act makes the unfair treatment of people with a disability illegal and this includes people living with a psychiatric (ie, psychosocial) disability related to a mental health condition. Disability discrimination occurs when others treat people living with a disability less favourably than they treat people without a disability. Disability discrimination also occurs when others treat people less fairly because they are relatives, friends, carers, co-workers or associates of a person with a disability.

The Act has contributed significantly to social change for people with disability and thousands of people have used it as an instrument to fight against discriminatory practices in many contexts, including employment, education, access to transport, goods, services, facilities and more. Notwithstanding successes under the Act and progress in the human rights arena, people living with psychosocial disability still face challenges and barriers in almost every aspect of life.

Most complaints under the Act arise in the area of employment. Australia ranks 21st out of 29 OECD countries in terms of employment rates of people with disability. In 2015, 57% of people with disability had jobs compared with 79% for people without disability.[2] Only 25% of people with psychosocial disability had jobs.

Since the Act was proclaimed, Australia has continued its commitment to ending disability discrimination including agreeing to the United Nations Convention on the Rights of Persons with Disabilities (CRPD) in 2008. Australia is to report progress under the CRPD to the UN Committee on the Rights of Persons with Disabilities in September this year.

The National Disability Strategy 2010–2020 is the Government's official plan to make the rights contained in the CRPD a reality. Australia has made some progress under this strategy, such as the implementation of the National Disability Insurance Scheme, which has potential to empower some people living with psychosocial disability to have valued lives in inclusive communities and workplaces. However, a truly inclusive community is still beyond the reach of many people living with a mental health condition.

The Fifth National Mental Health and Suicide Prevention Plan 2017 – 2022 recommends action to improve consistency across state and Commonwealth mental health legislation in ways that are consistent with both the CRPD and the 2016 UN Human Rights Council Resolution on Mental Health and Human Rights.[3] The latter asks Australia to support people with mental health conditions and/or psychosocial disabilities to empower themselves, and know and demand their rights. Australia has also agreed to the more recent HRC 2017 Special Report into the Highest Attainable Standard of Physical and Mental Health.[4] This recognises the need for a human rights-based paradigm shift in mental health policy and practice.

MHCC's vision for the future is a reduction in the number of people living with, or at risk of developing, psychosocial disability and experiencing disability discrimination including:

- Implementation of a model of community based mental health treatment and care that is rights-based, trauma-informed and recovery-oriented
- Reduction and, where possible, elimination of restrictive practices including seclusion and restraint in mental health treatment and care services
- Less opportunity for violence or abuse including the use forced treatment and confinement practices
- Greater paid employment opportunities for people living with mental health conditions (including but not limited to peer work roles)
- More disability inclusive communities that value diversity (including people's cognitive/thinking and behavioural differences).

1. http://www.lawsociety.com.au/cs/groups/public/documents/internetcontent/1443976.pdf
2. http://www.abs.gov.au/ausstats/abs@.nsf/mf/4430.0
3. http://www.un.org/ga/search/view_doc.asp?symbol=A/HRC/32/L.26
4. https://documents-dds-ny.un.org/doc/UNDOC/GEN/G17/076/04/PDF/G1707604.pdf?OpenElement

MHCC CEO:
Carmel Tebbutt

**It has been an exciting and challenging few months here at MHCC. I have very much enjoyed meeting with members and hearing from you first hand your issues and concerns.**

Our cover story celebrates the 25th anniversary of the Commonwealth Disability Discrimination Act and this edition also includes an update on the National Disability Insurance Scheme (NDIS) including the Hunter trial site five years on. There is no doubt the NDIS provides opportunities for greater choice and control for people and access to the community services they need. However, it also poses challenges for potential participants and service providers alike – this is raised in virtually every encounter I have with member organisations.

The issues are wide and varied including pricing, continuity of support arrangements, staff training and capacity and developing an improved understanding of the needs of people with a psychosocial disability. Many have also shared positive stories of people's lives being changed through the NDIS.

The scheme is, of course, still in transition and MHCC are committed to working with members, stakeholders and governments to ensure these issues are addressed. Gerry Naughtin, the National Disability Insurance Agency (NDIA) Mental Health Advisor spoke at our recent CEO Forum giving members the chance to directly raise some of their concerns and questions.

Our successful applications for both a national and jurisdictional grant under the NDIS Information, Linkages and Capacity Building Program will enable MHCC to take our successful reimagine.today website to the next stage and continue engaging the CMO sector about their NDIS experiences.

MHCC have also been actively engaging with the NSW Government, the Ministry and the Commission over the last few months, particularly about building sector capacity, HASI and the CLS programs, the seclusion and restraint review and the upcoming Community Mental Health and Drug and Alcohol Research Network Symposium.

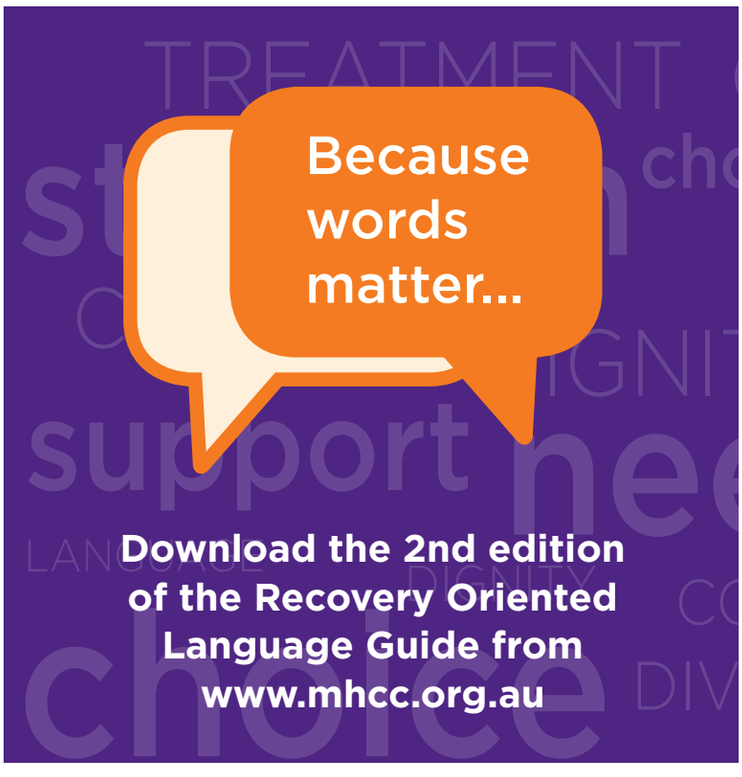
I am also pleased to report that MHCC met all the applicable standards at our recent Australian Council of Healthcare Standards (ACHS) organisation wide audit. MHCC staff work extremely hard to deliver on our key priority areas of advocacy, policy leadership and supporting the sector and it was very pleasing for this to be recognised with ACHS accreditation for another four years.

The next few months will continue to be busy as we roll out the ILC projects, review our strategic plan and continue to push for a community managed mental health sector development strategy. I look forward to working with you on these and other important priorities.

I hope you enjoy the June View from the Peak,

## In this issue





# The AIM: Assessing our mental health laws under the Convention of the Rights of Persons with Disabilities

The Convention of the Rights of Persons with Disabilities (CRPD, 2006) recognises the fundamental right of a person with disability (including psychosocial disability), to exercise legal capacity, and make and act upon their own decisions. In recognising this right, the CRPD requires a shift away from substitute decision-making towards supported decision-making. In Australia mental health laws generally provide legal mechanisms for another person (characteristically a doctor) to authorise involuntary treatment for mental illness where certain criteria are met, such as where the person does not have mental 'capacity to consent' to their own mental health treatment and care (Rosenman, 1994). This right to exercise legal capacity is rendered meaningless if mental health laws neither recognise, nor make provision for upholding the exercise of legal capacity at law. The failure of mental health laws to comply with the CRPD has long been identified as a problem, particularly in relation to the lack of clarity regarding what CRPD-compliant mental health laws should look like. This uncertainty has also impeded measuring and gathering evidence of compliance, or non-compliance, in order to advocate for legislative change.

In their article Byrne, White and McDonald (2018)*set out to address this gap by proposing a tool: the Analysis Instrument for Mental Health (AIM), and outline its scope and how it should be applied. The tool's particular purpose is to enable states and civil society to assess the compliance of non-forensic domestic mental health laws with Article 12 of the CRPD. It responds to the call for a mechanism designed to provide clear and measurable standards to undertake this task. AIM draws directly from the authoritative interpretation of Article 12 provided by the UN Committee on the Rights of Persons with Disabilities in its 'General Comment', as well as the substantial body of academic and other literature about Article 12.

In becoming a signatory to the CRPD, states have a duty to embed the human rights contained within it and be accountable for their action or inaction. The main objective of using an audit tool is to identify, analyse and measure the commitment of governments to enact the provisions of Article 12 into domestic law. AIM facilitates a robust, criteria-based assessment of the degree of commitment by governments to Article 12 in their mental health legislation. Without such mechanisms for assessment and accountability the promise of human rights is illusory and without substance in reality (Kaiser, 2009).

Difficulties surrounding legislative reform presents when legislators are unsure of how to legislate and apply human rights, particularly those seen as 'aspirational'. The challenge is to provide tangible 'standards' or 'benchmarks' for aspirational rights against which to measure compliance. An audit tool can be a powerful means to drive law reform and provide tangible evidence to governments to see how, and to what extent, their laws comply with human rights norms and provide impetus for change (United Nations Development Programme, 2000; Watchirs, 2002, 2005).

AIM is a tool specifically designed to measure compliance of domestic laws with Article 12 CRPD. For mental health laws to fully recognise the right to exercise legal capacity, either with or without support as articulated in Article 12(1–4) of the CRPD (McSherry & Wilson, 2011) requires a radical paradigm shift in philosophy, practice and service culture away from traditional approaches to 'capacity' and 'competency' of a person deemed to either 'have' or 'lack' capacity (Quinn, 2010). What Byrne, White and McDonald (2018) advocate is a shift towards laws that recognise and identify that a person living with mental disability may have specific decision-making needs. Individualised decision-making supports should be provided to help meet those needs, without loss, or restriction of the person's decision-making rights (Australian Law Reform Commission, 2014; Bach & Kerzner, 2010).

***This article is based on Byrne M, White B & McDonald F 2018, 'A new tool to assess compliance of mental health laws with the Convention on the Rights of Persons with Disabilities,' International Journal of Law and Psychiatry 58 (2018) 122–142. For references access the paper cited.**

**For more information about supported decision-making training please visit our website:**

Supported Decision-Making

Supporting Choice and Control: skills for mental health workers

# Vale Allison Kokany

MHCC is very sad to hear news of the passing of Allison Kokany (Ally) who has long been an influential voice of lived experience and a force for change in the mental health system in NSW and Australia. In her many roles as an independent consumer consultant with extensive experience in systemic advocacy at a state and national level, she also provided support and advocacy to individuals as a consumer consultant in psychiatric hospitals. Allison was chairperson of the NSW Consumer Advisory Group (NSW CAG, Being) for 6 years and held many prestigious consumer representative roles over her long career.

Allison sat on many project advisory and reference groups at MHCC and was for some time a trainer of Mental Health Connect for MHCC Learning and Development. We shall all miss her incisive and pragmatic input, her passion and thoughtfulness for the subject and people involved. MHCC staff and the Board wish to convey our deepest condolences to her family and many colleagues and friends who are deeply saddened by her passing. Thank you Ally and Rest in Peace.

# Early Intervention and Trauma-informed Practice in the UK

In 2014, five of the most deprived local communities in England, including Blackpool, were awarded a total of £215m from the National Lottery, as part of a ten-year strategic investment, to develop and test new approaches to improve Early Childhood Development outcomes. 'Blackpool Better Start' was established as a partnership with the local community and agencies from across public, private and voluntary sectors delivering a shared vision of ensuring that our youngest children in Blackpool have the best possible start in life.

### The Blackpool Better Start approach is based on four cornerstones:

1. Grounded in a Public Health Approach – promoting behaviour change through innovative approaches with our communities
2. Using Evidence-based Interventions – including innovation and co-designing programmes with community members
3. Enabling Systems Change - through commissioning differently, reframing early child development and developing a common language to describe it
4. The Centre of Early Child Development - driving the change on behalf of the partnership and working with national and international experts

During the first three years of implementation, the Blackpool Better Start partnership has developed a range of innovative services, systems and approaches to promote and improve perinatal mental health in the community as a mechanism for change.

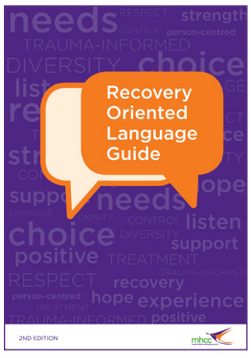
At the Centre for Early Child Development, I lead on the development and implementation of a range of targeted interventions, aimed at improving outcomes for our youngest children. Some programmes have a robust evidence base whilst others are new innovation projects. **Developing services that are trauma-informed has become key.**

During pregnancy there is an opportunity to influence change and interrupt intergenerational cycles of abuse. When mothers are living with mental health conditions, including PTSD, it increases the likelihood that children will fail to fulfil their potential and experience a range of social, emotional and behavioural difficulties. This can result in babies being exposed to toxic stress at the very earliest stages of their development. We recognise that in order to develop a healthy society, we need to change the culture of our whole system in relation to trauma and early adversity and ensure our communities' voices are affirmed and heard.

Clare Law - Development Manager at the Centre for Early Child Development, National Society for the Prevention of Cruelty to Children, Blackpool, UK

**Clare Law is a Winston Churchill Fellowship recipient. She met with MHCC and other champions of trauma-informed care and practice when she visited Australia in February.**

# Recovery Oriented Language Guide (2nd ed.) Released




Download the Recovery Oriented Language Guide: www.mhcc.org.au

MHCC's second edition of the *Recovery Oriented Language Guide* was launched at the CEO and Senior Managers' Forum held in May. The first edition published in 2013 was widely disseminated, used and praised. Acknowledging that language is dynamic, MHCC has produced a second edition which presents new information, together with information which remains relevant from the earlier version. The second edition seeks to align with trauma-informed care and practice principles, it introduces age-related language use and promotes the use of supported decision-making language.

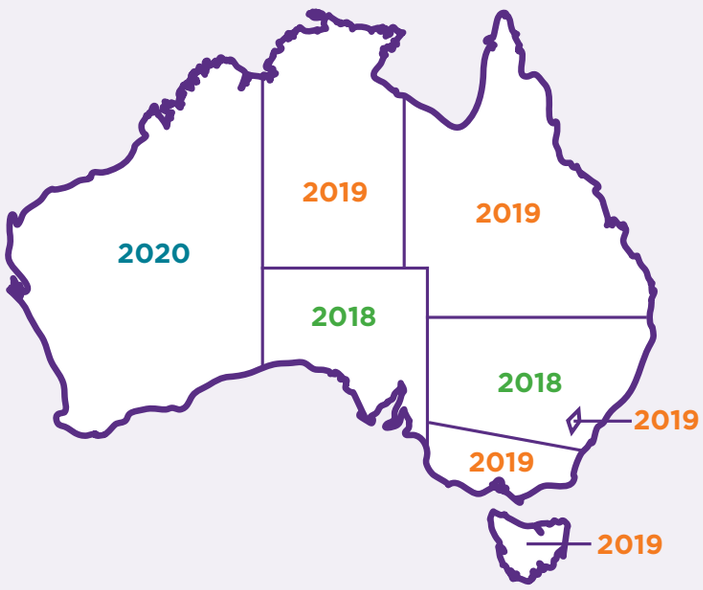
Development of the Guide has been informed by International and Australian literature on trauma-informed and recovery oriented practice, conversations with mental health practitioners across service sectors and, most importantly, through listening to the voices of lived experience concerning perceptions of recovery.

Since 'recovery' was originally defined from the perspectives of adult mental health consumers, we sought to identify whether these standpoints also apply to people at different developmental stages of life. The literature suggests that whilst the recovery oriented approach applies to everyone, the language and ways of communicating needs to be relevant to particular age groups. The Guide now provides an opportunity for reflection on that diversity, which includes young people coming to terms with the new experience of mental health and older people possibly coming to terms with this identity and other associated trauma, grief and loss experiences.

The Guide asks us to reflect on how we communicate, whatever a person's stage of life. It also invites us to familiarise ourselves with language that reflects a trauma-informed recovery oriented approach to practice and to have an awareness of the prevalence and impact of trauma.

We hope that you enjoy reading and using the *Recovery Oriented Language Guide* (2nd ed.) now available to freely download from MHCC's website.

# Establishment of the NDIS Quality and Safeguards Commission




## National roll-out of Quality & Safeguarding Framework

**2018** - NSW & SA
**2019** - ACT, NT, QLD, VIC & TAS
**2020** - WA

**The national NDIS Quality and Safeguarding Framework will be phased in over the next few years. This process includes establishment of the NDIS Quality and Safeguards Commission, with operations set to start in NSW on July 1.**

The Commission is a new independent body that will regulate the NDIS market and support the resolution of complaints about the quality and safety of NDIS supports and services. Over time, it will replace the quality and safeguards arrangements that now operate in each state and territory.

The Commission will be responsible for:

- registration and regulation of NDIS providers, including through the new NDIS Practice Standards and an NDIS Code of Conduct
- compliance monitoring, investigation and enforcement
- responding to concerns, complaints and reportable incidents, including abuse and neglect of a person with disability
- national oversight of behaviour support, including monitoring the use of restrictive practices within the NDIS with the aim of reducing and eliminating such practices
- leading collaboration with states and territories to design and implement nationally consistent NDIS worker screening
- facilitating information sharing arrangements with the NDIA, state and territory, and other Commonwealth regulatory bodies.

### What does this mean for participants?

The Commission will work to improve the quality of services and help to ensure that they are safe for NDIS participants.

### What does this mean for providers?

**If you are a registered NDIS provider in NSW, you will automatically transfer to the national system.** The Commission will expect you to complete a new Practice Standard audit at some time in the future. MHCC recommends that NSW providers update their NDIA registration groups and contact details now to make the transfer as smooth as possible.

If you are a multi-state NDIS provider who acquires national registration when the Commission implements the Framework in NSW, you will still need to comply with other state-based NDIS registration requirements until they have transitioned.

**For providers not yet registered with the NDIS there will be two pathways for registration:**

1. VERIFICATION (for providers of lower risk, less complex support): A simplified process for individual or small providers of low risk supports or allied health professionals already certified with governing bodies, as well as larger providers who want to register individual employees.

2. CERTIFICATION (for providers of high risk, more complex supports): A third party audit against the NDIS Practice Standards every three years, with a desktop audit annually. Additionally, you may be required to complete modules about specific registration groups.

### Release of NDIS Quality and Safeguarding Rules (NDIS Provider Registration and Practice Standard) 2018

In May, MHCC attended an Information Session convened by the Commonwealth Department of Social Services to discuss establishment of the National NDIS Quality and Safeguards Commission commencing operations in NSW 1 July; this included discussion and about the rules and standards.

More information about the practice standards and rules, and from the Information Session, is available here.

The newly released rules and practice standards are available on the NDIS Quality and Safeguards Commission Website.

# Signs of Positive Change

**NDIS particpants with a plan living with a pyschosocial disability**
National Disability Insurance Agency (NDIA) quarterly report (March 2018)


NSW is nearing five years of NDIS implementation, during which the mental health sector has been supporting people to make access requests with rigour. However, the NDIS is still in a transition phase and governments and others are identifying quality improvements to ensure the NDIS operates optimally.

At the end of March 2018, there were 5,196 people in NSW with a primary psychosocial disability and NDIS plan. This is 7% of all people with a disability and NDIS plan in NSW with a psychosocial disability target of 13.9% (about 20,000 people). Across Australia, there are 10,984 people with a primary psychosocial disability and NDIS plan. The NDIA report that the NSW/Hunter and Victorian/Barwon trial sites and the ACT have people with a primary pyschosocial disability and plans at 13%, 14% and 13% respectively.

A large number of NDIS related reports became available in early 2018. The National Disability Insurance Agency (NDIA) released reports related to participants, providers and pricing. The Joint Standing Committee released reports on NDIS implementation inquiries (transition, market readiness, psychosocial disability). These all contain numerous findings and recommendations for quality improving the NDIS.

One recommendation is for the establishment of a psychosocial disability pathway into the NDIS. The term pathway relates to improving the planning experience of people living with mental health conditions and the experiences of applying for access and reviewing the effectiveness of services. The NDIA is now trialling general pathway improvements in Victoria (for participants) and the ACT (for providers).

The psychosocial pathway is likely to, for example:

- Ensure that planners with specialist knowledge of psychosocial disability are available
- Better describe flexibility in support use, in anticipation of episodic need
- Increase the focus on outcomes appropriate for people with psychosocial disability, supported by common tools and measurement approach.

The NDIA has also released the Independent Pricing Review (IPR) Report. The NDIA's Board and Senior Management have accepted all of the Report's 25 recommendations, in principle. Some will start on 1 July. They have also acknowledged a payment delay issue identified in December and have since established a new provider payment team.

Former MIND Chief Executive, Gerry Naughtin, has commenced in the role of Mental Health Advisor to the NDIA. MHCC welcomes this appointment and looks forward to working with Gerry given his substantial experience of both the mental health sector and NDIS, including being an inaugural member of the NDIS Independent Advisory Council. We extend our thanks to the outgoing advisor, Eddie Bartnik, for the many contributions he made to us all better understanding the NDIS, mental health and psychosocial disability.

Mental Health Australia

# NSW NDIA Workshop Developing NDIS Psychosocial Pathways

The National Disability Insurance Agency (NDIA) is exploring the establishment of a specialised psychosocial participant pathway. The NDIA will design this new pathway to best support people living with mental health conditions navigate the system. The psychosocial disability pathway is intended to compliment recent improvements to the general disability pathway for both the NDIS participant and provider experience.

The NDIA engaged Mental Health Australia (MHA) to conduct workshops nationally and gather feedback to inform the design and development of the psychosocial pathway. MHA ran workshops for NDIS participants, their families/carers and NDIS providers in Sydney, Brisbane, Melbourne and Townsville. MHCC attended the Sydney workshop in February. These workshops enabled participants to provide feedback on what was working, possible improvements, where gaps have presented and to share innovative ideas. MHA will collate the feedback from the workshops and the NDIA will use this to inform and progress the psychosocial pathway development.

# The NSW Hunter Trial Site Five Years On

This July it will be five years since the NDIS began rolling out. In March, the Hunter New England Local Health District invited MHCC to attend its Hunter Mental Health Interagency meeting. This was a discussion on the challenges of providing services for people with high levels of psychosocial disability, associated with severe and persistent mental illness, under the NDIS.

Hunter New England Mental Health (HNEMH) invited both MHCC and National Disability Services (NDS), the disability peak body, to participate in this discussion facilitated by HNEMH at the request of their Community Advisory Group. About 40 people attended the meeting.

MHCC and NDS spoke of their work in NDIS implementation. For MHCC, this included convening an NDIS and Mental Health Community of Practice during the NSW NDIS trial 2013/16. No similar learning network has since emerged and HNEMH noted this gap to be a huge problem. HNEMH asked participants to discuss their experiences and challenges.

Even with five years of experience, many service providers continue to find the access and planning process to be complex and confusing. There can be long and frustrating delays. Planners and Local Area Coordinators (LACs) do not seem to have the right experience or training for their important role. **Some people are falling through the cracks. Others feel they are worse off than before the NDIS.** Frustrations are evident for use of IT and payment systems. There are large concerns about reductions in quality and safety arising from inadequate NDIS pricing, associated workforce impacts (i.e., skills reductions) and the disadvantage being experienced by people living with mental health conditions whether NDIS eligible or not.

**Hunter NDIS service providers demonstrated a sophisticated breadth and depth of knowledge and experience in their conversation about challenges. This included acknowledgement that when the NDIS works well it can make a profound difference in peoples' lives.**

Other challenges raised by participants included:

- NDIA Engagement Team were attending the HMHI but handed this over to LACs
- LAC contracts ending at the end of June and arrangements after this remain unknown
- Concerns that the independent pricing review recommendations will not be adequate to ensure an appropriately skilled workforce, and ensure quality and safety, for people with complex needs
- A trend for NDIS registered providers to not want to work with complex clients at current pricing levels and that many of these people are presenting to HNEMH psychiatric facilities
- Concern that the NDIS service delivery model is not a good fit for people with psychosocial disability (although the philosophies of choice/control and social/economic participation are excellent)
- Participants are choosing core supports rather than capacity building due to greater ability for flexible funding, even though capacity building items may be more aligned with recovery oriented practice (eg, employment support)
- Identification of Day to Day Living program clients who are now being disadvantaged through NDIS implementation and not benefiting from the 'continuity of service' arrangements
- The need to identify other Commonwealth mental health program clients who are now disadvantaged
- Lengthy delays in the NDIA responding to requests for internal reviews
- Service providers expressed a view that they can be penalised by the NDIS for acting as client advocates
- Concern about the NDIA sometimes providing information/services in ways that contradict Administrative Appeals Tribunal decisions.

MHCC will continue to work with NDIS service providers and people with mental health conditions and experience of the NDIS, and to take issues forward for the benefit of others in NSW and nationally. Both MHCC and HNEMHS will share feedback from the Hunter Five Years On with the NSW Ministry of Health and the NDIA.

# Mind the Gap: The NDIS and psychosocial disability


The Sydney Policy Lab at the University of Sydney and Community Mental Health Australia have released a report describing the NDIS related experiences of people with lived experience of a mental health condition and those that provide supports and services to them. The report highlights concerns about the NDIS for people with psychosocial disability such as eligibility criteria, slow uptake and engagement. With an estimated 690,000 Australians living with mental health conditions, the most significant concern highlighted is the number of people who may not be eligible under the NDIS and who risk losing support when funding for existing state and federal services end.

Read the report here:
http://sydney.edu.au/health-sciences/documents/mind-the-gap.pdf

# CMHDARN Research Ethics Committee to Provide Guidance

The Community Mental Health Drug and Alcohol Research Network (CMHDARN) is a partnership between MHCC, the Network of Alcohol and other Drugs Agencies (NADA) and the Mental Health Commission of NSW. CMHDARN was established in 2010 to broaden the involvement of community mental health and alcohol and other drugs (AOD) sectors in practice-based research and to promote the value and use of research evidence in practice. Its overall aim is to improve the quality of service and correspondingly, outcomes for people with lived experience. It also promotes increased understanding of co-existing mental health and AOD issues. CMHDARN shares information and engages with members via its website, workshops, forums, reflective practice webinars/ webcasts and other activities.

Early in 2018 the CMHDARN Research Ethics Consultation Committee (RECC) was established to provide ethical guidance to researchers and research participants. The RECC provides a forum for guidance in ethics regarding human research within the mental health and AOD communities. Apply to consult with the RECC via the website, cmhdaresearchnetwork.com.au.

CMHDARN is hosting a one-day Symposium on 20 June, we'd love to see you there (register here). Keynote presentations will include discussions around the management of critical transition points, language, and co-occurring conditions. A key outcome of the day is to hear participants' views on strategic directions for CMHDARN and identify priorities for building research capacity. A snapshot presentation from the latest recipients of CMHDARN Research Seeding Grants will be an opportunity to hear from emerging researchers in the field. A report will be made available on CMHDARN's website

For more information email the Research Network Coordinator: info@cmhdaresearchnetwork.com.au.

CMHDARN
Community Mental Health, Drug & Alcohol
RESEARCH NETWORK


## newparadigm

The Summer edition of new***paradigm***, the Australian Journal On Psychosocial Rehabilitation, focuses on the impact of contemporary research on mental health practice. Debra Parnell reports on the high expectations expressed by government, funders and all stakeholders that research is collaborative, interdisciplinary and co-designed with consumer and carer researchers at its centre. In her article *Supporting choice and control*, Corinne Henderson from MHCC argues that this fundamental principle is more important than ever in an NDIS environment, particularly given the vital role psychosocial support workers play in maximising people's autonomy. Lisa Brophy, Assoc Prof University of Melbourne, discusses a new consumer self-rated measure of personal recovery, and Occupation Therapy Australia writes about the under-recognised role of Occupational Therapists within an NDIS framework.

To read more or to contribute or subscribe to the next edition of new***paradigm*** visit vicserv.org.au/publications/newparadigm

# Mental Health Safety and Quality in NSW:

## A plan to implement recommendations of the Review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities

The NSW Government recently released the independent *Review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities* by the state's Chief Psychiatrist, Dr Murray Wright, and a panel of five mental health experts. The review panel conducted community consultations for consumers, their families and friends and other community stakeholders. It was an opportunity for people to share their experiences and ideas, and was a whole of system review. The expert panel visited 25 NSW Health facilities to meet with leaders and frontline staff from acute mental health units and declared emergency departments (EDs). The facilities were representative of rural and metro settings, differing unit designs, servicing diverse groups of people.

The NSW Government has demonstrated its commitment to reform by accepting all 19 recommendations and by providing $20 million to help hospital managers improve the therapeutic environment inside acute mental health units. These recommendations are based on findings that were evident across the mental health system. MHCC understand that implementation of seclusion and restraint prevention initiatives are already underway.

The Plan states that improvement is required in all mental health units and declared EDs in NSW, but that the scope of recommendations will require system-level change in a range of areas beyond the operations of mental health units and EDs including workforce, culture and leadership, and governance. It also identifies working with health professionals including professional bodies, consumers, carers, peak mental health organisations, Official Visitors and the Mental Health Commission of NSW as crucial to successful implementation.

The reduction and, where possible, elimination, of restrictive practices in mental health services has been identified as an important issue for NSW Health, and it has reported that it has taken significant action to address restrictive practices and the rate of seclusion in NSW, and has reduced such practices by over 30 per cent since 2010-2011. However the 2017 Review raised the primary question of whether the system has "the right vision and goals, properly supported by effective strategies, policies and resources, to enable the sustained prevention of seclusion and restraint."

NSW Health has identified that the outcomes of implementation will broadly provide safe, respectful, trauma-informed and recovery-oriented care to consumers. They propose that seclusion will be less frequent, shorter, and likely reduced and that this will lead to improved patient and carer experience with clinical staff more engaged in consumer-focused mental health care. Action is being taken across seven domains: culture and leadership; patient safety; accountability and governance; workforce; consumer and carer participation; data and the built and therapeutic environment.

The implementation plan works towards the goal of elimination of seclusion and restraint and the NSW seclusion performance indicator is being revised to support further improvements.

MHCC welcomes the initiatives outlined in the Mental Health Safety and Quality in NSW Plan and looks forward to it's implementation in full.

# Data and Reporting in Mental Health Community Organisations: Scoping Study

MHCC has long advocated for a coordinated approach to data collection and reporting from community managed organisations (CMOs) that provide NSW Government-funded mental health support services. MHCC's CMO Non-Government Organisation Establishments 'Scoping Study' Project (CMO NGOE) is one component of the NSW Health CMO Expenditure, Resources and Activity (ERA) Project. This project aims to aggregate data on funding, activity, workforce (the National Mental Health NGO Establishments data), and consumer and carer experience of services (the Your Experience of Service and Carer Experience of Service questionnaires).

The primary responsibility of the MHCC project is to scope the feasibility of implementing a minimum data set in NSW CMOs that receive NSW mental health funds. The current CMO data collections in Western Australia and Queensland are being reviewed and the project report will identify any issues, recommendations and potential options for implementation.

Julie Millard has been engaged by MHCC to lead this Project, as she facilitated Phase 1 of the MHCC Data Management Strategy in 2010. She can be contacted on: 9555 8388 or info@mhcc.org.au

# Parramatta Mission


## Meet **Chantal Nagib**, General Manager of Clinical Services at Parramatta Mission

My role is focused on operational leadership, ensuring optimal performance of all programs within my portfolio and high quality care for all consumers accessing services. Within my portfolio, I have responsibility over a number of programs, these include:

- **headspace** Mt Druitt, **headspace** Parramatta, **headspace** Penrith and headspace Castle Hill - provides young people 12-25 years old, with access, support and information for a broad range of concerns, including mental health, physical/sexual health, drug and alcohol, counselling services, employment and education and support for families and carers.
- **headspace** Youth Early Psychosis Program - specialised service for young people who are experiencing a first episode of psychosis or at ultra-high risk of experiencing psychosis.
- **LikeMind Seven Hills and Penrith**
- **North Sydney Karrikin Youth and Adolescent Mental Health Program**
- **Warekila mental health service**

### What is the headspace mission?

To improve young people's mental, social and emotional wellbeing through the provision of high quality and integrated services. headspace aims to provide a one stop shop with no wrong door for young people.

### What are the main challenges facing young people across Western Sydney?

Some of the main challenges for young people presenting to headspace services across Western Sydney include:

- feeling down, stressed or can't stop worrying
- worried about relationships, friend or family pressures
- not coping with school/university/ work
- finding it difficult to concentrate
- have questions about, or want to cut down on alcohol or other drug use
- want to talk about sexuality, gender identity or relationships
- have sexual health issues or want information about contraception
- feeling bullied, hurt or harassed
- at risk of homelessness

### How does headspace respond to these challenges?

Our headspace centres respond to these challenges by providing a range of services and a flexible model of care. Utilising a consortium model, at each of our sites we provide mental health services, physical health services, vocational/educational assistance as well as AOD services. We also aim to support young people and their families to navigate the mental health system if we are not the right service to meet their needs.

Youth participation is also a key focus of our headspace sites. We work hard to ensure young people are consulted at every level of service delivery; individual, service and governance levels. This assists us to maintain a youth-friendly environment that is relevant to the needs of young people.

### What are some of the simpler messages that headspace conveys to assist young people with their mental health?

Simple messages are used to reinforce early help-seeking behaviour and encourage family and friends to notice when things are not okay.

We encourage young people to seek support early, so that everyday life is not disrupted (study, work, personal relationships) and things stay on track.

Our community development team is responsible for service promotion, increasing mental health literacy in the community and reducing stigma. They deliver consistent messages to the community to raise awareness, increase ease of access and reduce the stigma often associated with receiving support from a mental health service.

### What impacts have you seen in the young people you work with as a result of headspace support?

- staying in school and an increase in school attendance
- finding employment
- experiencing a reduction in mental health symptoms
- an increase in social connectedness
- a decrease in substance misuse
- increased family and friend education, focused on how to support their young person
- increases in quality of life and general satisfaction
- a decrease in distress

Parramatta Mission

# MHCC Response: 2017 National Report on Mental Health and Suicide Prevention


**The National Mental Health Commission has released its 2017 report card against the priorities of the Fifth National Mental Health and Suicide Prevention Plan 2017 – 2022. For 2017, the Commission is reporting on the outcomes of its engagement with stakeholders and work undertaken to help shape a mental health system that can respond to peoples' needs more effectively.**

In the report card, the Commission reports on work undertaken in the following ten areas:

- Embedding consumer and carer engagement and participation
- Promoting access through digital mental health
- Improving physical health to promote wellbeing
- Linking housing, homelessness and mental health
- Preventing suicide
- Reducing seclusion and restraint
- Supporting Primary Health Networks (PHNs)
- Putting mental health on the economic agenda
- Transitioning to the NDIS and understanding the challenges ahead
- Supporting mental health reform implementation.

Other important work of the Commission at present seems to be the development of a new framework for monitoring and reporting. The lack of meaningful data for social, system and individual/population change has vexed much of the 25 years of the National Mental Health Strategy. This problem now exists at the local level as PHNs are now working with Local Health Districts towards developing Regional Mental Health and Suicide Prevention Plans in 2018.

The Commission's 2017 report card notes that it is looking forward to a new approach to reporting in 2018. The new reporting framework will enable it to consider national reform in mental health and suicide prevention through the lens of consumers and carers, and their experiences. The reporting framework will help ensure that the aspirations of the Fifth Plan can be realised.

However, it seems that the new reporting framework intends to be broader than Fifth Plan indicators and accountabilities. Consultation occurring in late 2017 proposes that it will have social, system and population domains and additionally align to the reform priorities of:

- Commission's 'Contributing Lives' Framework
- National Disability Insurance Scheme (NDIS)
- PHNs.

What the Commission is setting out to do to by reforming reporting processes is ambitious, innovative and makes good sense.

The Commission's reporting framework also intends to bring a national perspective to mental health and suicide prevention, by drawing together information that provides insight on longer-term outcomes and to deliver an independent, consistent, and comprehensive account of reform progress.

The Fifth Plan lists many of the commitments that the Government has made to mental health reform, most of which are not yet funded, and MHCC notes the $338M Commonwealth commitments announced in the May 2018 budget. The mental health sector needs funding for implementation of the Fifth Plan and transparency in budgets for funding commitments are necessary to ensure reform accountability.

> **"The mental health sector needs funding for implementation of the Fifth Plan and transparency in budgets."**

Additionally, there is a budget commitment of $92.1M for an NDIS Continuity of Support measure over four years (while not mental health specific this includes Commonwealth mental health programs clients' ineligible for the NDIS). The measure builds on May 2017 budget commitment of $80M for psychosocial disability support services over four years for people who do not qualify for the NDIS, with funding contingent on matched contributions from states and territories (National Psychosocial Support measure). Both measures will commission services through PHNs. This funding is welcomed but will not be sufficient to meet the reform aspirations of the Fifth Plan, let alone address the level of psychosocial rehabilitation and recovery supports available to all who need them.

While mental health is a national issue, improving outcomes requires collaborative action at all levels. Strengthened approaches to reporting will enable the Commission to demonstrate if reform is making a real difference, and it will ensure accountability and provide information to support change. However, this is only if the funding for much needed services and supports is available.

## MHCC ACTIVITIES – AT A GLANCE

### Key Projects

- Community Mental Health Drug & Alcohol Research Network (CMHDARN- Partnership MHCC, NADA & Mental Health Commission NSW)
- CMHDARN RECC - Research Ethics Consultation Committee
- CMO – ERA Data Scoping Project
- NSW ILC Grant: Community engagement education package
- Mental Health and NDIS Project (NSW Department of Premiers and Cabinet/DPC)
- 'Navigating the NDIS: A NSW MH Perspective' Training
- Recovery Oriented Language Guide 2nd Edition
- Recovery Oriented Service Self-assessment Toolkit (ROSSAT) Consultancy
- National ILC Grant: Reimagine Today: Stage Two
- Trauma-Informed Care and Practice (TICP) & Organisational Toolkit (TICPOT) consultancy
- TICP: Policy & Protocol Resources Project
- NDIA/LAC reimagine.today training

### Key Learning and Development Projects

- Care Coordination: Professional Development
- Supporting choice & control: Professional Development

### Key Submissions & Publications

- AHRC Violence against people with Disability in institutional settings: Issues paper
- Member Consultation Briefing Paper: Community Managed Mental Health Sector Development Strategy
- CMHA submissions see website: http://cmha.org.au/advocacy-representation/
- CMHA Senate Standing Committee on Community Affairs inquiry into mental health services in rural and remote Australia
- FACS Operational Framework for the One Offer Policy
- Key Enablers for building effective localised community based services and supports, MH Commission NSW
- Law Reform Commission- Review of the Guardianship Act 1987 (NSW): Draft Legislation Proposals
- Review of the Mental Health Commission of NSW, Report to Parliament 2018 Consultation Draft
- Ministry of Health Seclusion & Restraint Implementation Plan
- NSW Attorney General, Establishment of a Public Advocate in NSW and the role of Community Advocacy
- NSW Equal Access to Democracy Disability Action Plan
- NSW Strategic Framework for Mental Health and Workforce Plan 2018-2022 (draft)
- Recovery Oriented Language Guide 2nd Edition
- Review NSW Mental Health Commission, Ministry of Health Family Focused Recovery Framework

### MHCC facilitated and/or presented at the following events

- THEMHs Summer Forum 2018 "Trauma Matters"
- MHCC Meet Your Neighbour: Hawkesbury; South Western Sydney, Blacktown & Bondi
- Public Guardian Supported Decision-Making Community of Practice

### Notable Forums Attended

- Health Ethics Sydney Uni & The Jewish Museum, Exhibition and Forum: Human Rights, Disability
- NDIS Psychosocial Pathway Workshop
- National Disability Services Conference
- NSW Mental Health Commission Reference Group
- FACS Homeless Strategy Forum
- National Women's Health Forum
- FACS Commissioning Workshop KPMG
- Mental Health Australia Forum
- ANZCP Psycho-geriatrics in perspective Symposium
- Commonwealth PSS Quality and Safeguards Commission Information Session

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