Community Mental Health Australia submission to National Disability Insurance Scheme Amendments (Quality and Safeguards Commission and Other Measure) Bill 2017

Introduction

Community Mental Health Australia (CMHA) would like to thank the Senate Standing Committees on Community Affairs Legislation Committee for the opportunity to make a submission to the *National Disability Insurance Scheme Amendment (Quality and Safeguards Commission and Other Measures) Bill 2017* (the Bill) inquiry.

CMHA is a coalition of the eight state and territory peak community mental health organisations. CMHA, through its state and territory bodies, has a direct link and contact to mental health organisations delivering services at the community level. CMHA provides a unified voice for approximately 800 community-based, non-government organisations who work with mental health consumers and carers across the nation and who are members of, or affiliated with, the various coalition members.

CMHA promotes the recovery of people living with a mental health condition so that they are contributing citizens and included in all of the economic and social aspects of their community. The organisation presents a united and representative voice for the community managed mental health sector who work every day on mental health issues and have the expertise through a specialised workforce, including a peer workforce and lived experience.

The primary part of the amendments to the Bill are to establish the new Quality and Safeguards Commission and the NDIS Code of Conduct, which CMHA does not have any major concerns with. CMHA has also separately made a submission to the inquiry on the NDIS Code of Conduct, and would note that at the time of the amendments, the Code of Conduct was still open for consultation. CMHA's submission to the NDIS Code of Conduct is at Attachment A. The main changes that have raised concerns for CMHA are those related to the intersection between disability and chronic illness. This submission will address the key amendments the Bill with which CMHA has concerns.

Support for chronic illness

The main changes with which CMHA has concerns is the inserting of words around 'support that a person is likely to require must be appropriately funded or provided through the NDIS & not more appropriately funded or provided through the NDIS and not more appropriately funded or provided through other mainstream general systems of service delivery or supports such as health or education'. This relates to, as noted in the Bill explanatory statement, primarily to chronic illness.

CMHA raised the issues if the cross-over between disability and chronic disease – noting this needed further examination - at the NDIA CEO Forum on 26 May and questions were raised on the matter 2017-18 Senate Budget Estimates on 30 May 2017 to the Department of Social Services and the National

Room 1.06, Level 1, Griffin Centre
20 Genge Street, Canberra City ACT 2601
t: (02) 6249 7756 f: (02) 6249 7801
e: abresnan@cmha.org.au w: www.cmha.org.au

Disability Insurance Agency (NDIA). At no stage in the CEO Forum meeting or in Senate Budget Estimates were the amendments noted by NDIA representatives.

The following exchange is from the Budget Estimates Hearing of 30 May regarding questioning on co-morbidity and the inter-relationship between mental health and chronic illness:

> **Mr Bowen**: We would separate the two issues. One is: does the person have a functional impairment as a result of the disability at a level to get into the scheme? If so, their access is determined. Then, in determining the roost of all necessary supports, one of the criteria that the agency must have regard to is whether those supports are best provided by another service system. In the case of many chronic health conditions, those supports will be better provided by a health system.
>
> **Senator SIEWERT:** Do you assist the participant to then negotiate with the health system?
>
> **Mr Bowen:** We would try to set up those linkages, yes.
>
> **Senator SIEWERT:** Okay. The position that has been put to me is that the chronic illness is then preventing people taking up some of the supports that they actually could access through their plan.
>
> **Mr Bowen:** That then becomes an issue around the early discussions about ensuring that state and territory mainstream services honour their obligations to provide that support, because we cannot step and fill that gap.
>
> **Senator SIEWERT:** I understand the point. I have two questions that come out of it, and then I will put the rest of these chronic illness ones on notice. There are two issues that come out of that. Is the comorbidity of the issue considered as part of the disability?
>
> **Mr Bowen:** We have many examples of people who have comorbidities. Both conditions would qualify for the scheme, so we do not need to unwind those.
>
> **Senator SIEWERT:** Yes.
>
> **Mr Bowen:** But there will be some where the person has a health condition independent of their disability, and they will need assistance to manage their health condition. Diabetes is probably a pretty good example. For example, someone with a brain injury or a significant intellectual disability may not be able to manage their diabetes because of that, so we would provide assistance to them in managing their diabetes, but we will not provide the diabetic treatment regime. That is the health system.
>
> **Senator SIEWERT:** Yes, okay. In the instance that I am talking about, with mental illness and a chronic illness, if the mental illness prevented them from being able to address their chronic illness, that would get support? Is that a correct understanding?
>
> **Ms Gunn:** A concrete example might be where we might be able to provide that person with support or equipment to remember to do things, to keep their appointments and to keep them engaged in things that will keep them well. Yes, we can provide that type of support.

The points made by the NDIA through this exchange note that with comorbidity, both conditions – i.e. the disability and the chronic illness or condition – will be considered as part of the disability and considered in eligibility for the NDIS; and that support would be provided to a person with mental illness and a chronic illness where the mental illness impacted their ability to manage the chronic illness. There is however a significant lack of clarity around how co-morbidity fits within the NDIS, given the changes proposed through the Bill.

This is an issue CMHA believes requires considerable examination before any changes to the NDIS Act around where supports are accessed is considered. This includes an examination of what funding states and territories have transferred to the NDIS that provided chronic disease support for people with disability.

Attached separately to this submission is a case study from Queensland that concerns a person with complex mental illness and chronic diabetes who received support to manage their diabetes and administer insulin. The funding for this support was transferred to the NDIS. The person was found eligible for the NDIS but was informed they would need to access support for the diabetes through state health services, despite the fact that the support they were receiving previously was now the responsibility of the NDIS. As the letter points out, the crucial fact is that the person's mental illness means they cannot look after their diabetes, therefore the disability and the chronic illness cannot be separated.

The following case study for a person with cognitive disability also provides an indication that similar difficulties will exist for other areas of disability, as they do for psychosocial disability, and chronic disease. The issues experienced with psychosocial disability and cognitive disability will also be similar.

Diabetes and cognitive disability

A man in his 40s has suffered Type 1 diabetes for over 30 years and, as a result, has developed a cognitive disability. The cognitive disability causes functional issues in terms of concentration, an ability to undertake and complete tasks and decision-making capacity. For example, while the man is able to perform physical everyday tasks, such as showering or vacuuming a room, he often needs reminding and can't focus on the task for more than a few minutes. The cognitive disability also means that, while the man remembers, from long habit, to take his insulin regularly, he ignores other aspects of managing his diabetes, such as checking his blood sugar or attending regular specialist appointments.

The man has been found ineligible for the NDIS, due to a lack of understanding regarding some disabilities do not having clear, visible physical impacts. The NDIA have determined that his needs are best addressed outside of the NDIS, despite the impact of the cognitive disability on caring for his diabetes.

The man has however been assessed as no longer able to work and is receiving the Disability Support Pension (DSP).

Room 1.06, Level 1, Griffin Centre
20 Genge Street, Canberra City ACT 2601
t: (02) 6249 7756 f: (02) 6249 7801
e: abresnan@cmha.org.au w: www.cmha.org.au

> The man is cared for by his 71 year old mother, who is finding the demands of caring increasingly difficult. She has not been found eligible to receive any carer support and has also been denied carers allowance.

There must be ways of providing coordinated support to people with psychosocial disability and co-morbidity, such as chronic illness, who are NDIS participants without them having to go to more than one service system. Coordinated, wrap-around support – regardless of what the support needs are – is the crucial part of a psychosocial approach to addressing mental illness and this will be lost if people are required to seek help in more than one service system, many of whom are not able to do this. The Federal Government and the State and Territory Governments must be able to determine with confidence where there is service crossover, and come to payment arrangements where that is required, so that NDIS participants receive the support they need through one package.

Rates of chronic disease among people with mental illness

Data on chronic illness shows that there is a strong correlation between mental health and chronic disease. Self-reported data from the Australian Bureau of Statistics (ABS) 2014–15 National Health Survey (NHS) reported by the Australian Institute for Health and Welfare (AIHW) showed that the most common comorbidities for the 0-44 years age group was mental conditions with back pain and problems (3.3%), asthma (2.7%) and cardiovascular disease (1.7%). Mental health conditions were reported as a comorbidity among 38% of people with chronic obstructive pulmonary disease (COPD), 30% of people with back pain and problems, and 29% of people with asthma.[1]

A report from the Royal Australian and New Zealand College Psychiatrists (RANZCP) examining the economic cost of serious mental illness and comorbidities concluded that:

> Overall, this report shows that, for people with mental disorders, physical illness comorbidities and their risk factors are the rule rather than the exception. The evidence indicates these are associated with significantly higher rates of premature mortality in people with serious mental illness. This adds significantly to the health and economic burden of serious mental illness in both Australia and New Zealand.[2]

The World Health Organisation (WHO) have also noted the following key facts regarding premature death among people with severe mental disorders:

[1] Chronic disease comorbidity, AIHW, http://www.aihw.gov.au/chronic-diseases/comorbidity/,Accessed 17 July 2017

[2] Royal Australian and New Zealand College of Psychiatrists (2016) The economic cost of serious mental illness and comorbidities in Australia and New Zealand, A report prepared for The Royal Australian and New Zealand College of Psychiatrists and the Australian Health Policy Collaboration by the Victoria Institute of Strategic Economic Studies. RANZCP.

Room 1.06, Level 1, Griffin Centre
20 Genge Street, Canberra City ACT 2601
t: (02) 6249 7756 f: (02) 6249 7801
e: abresnan@cmha.org.au w: www.cmha.org.au

- People with severe mental disorders on average tend to die earlier than the general population. There is a 10-25 year life expectancy reduction in patients with severe mental disorders.
- The vast majority of deaths are due to chronic physical medical conditions such as cardiovascular, respiratory and infectious diseases, diabetes and hypertension.
- Mortality rates among people with schizophrenia is 2 to 2.5 times higher than the general population.
- People with bipolar mood disorders have high mortality rates ranging from 35% higher to twice as high as the general population.
- There is a 1.8 times higher risk of dying associated with depression.
- People with severe mental illness do not receive the same quality of physical health care as the general population.
- The majority of deaths of patients with severe mental illness due to physical medical conditions are preventable.
- There is a need for increasing access to quality care for patients with severe mental disorders, and the integration of mental and physical health care could facilitate this.[3]

This data points to the need for further examination of the relationship between psychosocial disability - and other areas of disability – and chronic disease as it relates to the NDIS. There are and will be considerable numbers of people with comorbidity who will be applying for or currently participants of the NDIS, and any changes which will impact on these people must be examined and implemented in a way which ensures complete confidence.

Other proposed amendments to the NDIS Act

The other proposed changes to the NDIS Act in the Bill which CMHA has concerns with are:

- All references of 'review' being changed to 'reassessment', and the explanatory statement not being clear on the inference or impact of this. The explanation states it reflects a change in terminology only and does not change the rights of participants, however, there would be the same concerns as above regarding interpretation by the NDIA.
- Inserting the word 'sustainable' around people accessing innovation etc. to have a 'normal 'life'. The changes amend the principle in subsection 4(15) of the NDIS Act to directly refer to a diverse and sustainable market and sector in which innovation, quality, continuous improvement, contemporary best practice and effectiveness in the provision of those supports is promoted. While these amendments would seem appropriate on face value, the significant issues that are occurring around what is 'reasonable and necessary' would mean that the

[3] Information sheet, Premature death among people with severe mental disorders, http://www.who.int/mental_health/management/info_sheet.pdf

Room 1.06, Level 1, Griffin Centre
20 Genge Street, Canberra City ACT 2601
t: (02) 6249 7756 f: (02) 6249 7801
e: abresnan@cmha.org.au w: www.cmha.org.au

addition of further words that focus on sustainability may cause further complications if the main driver is a cost factor. Hearing the stories from the Joint Standing Committee on the NDIS town hall meeting on 12 May, this could become an interpretation issue about what is considered sustainable by the NDIA.

- This item amends the Act by inserting a new general principle into section 4, being that people with disability are central to the NDIS and should therefore be included in a co-design capacity. The centrality of people with disability and their inclusion in the NDIS decision-making framework is integral to the NDIS. Whilst we understand and support the intent of the insertion of the word 'co-design', there is no agreed process with people with lived experience on how this should be applied, and the amendments being proposed actually contradict principles of co-design. Further, in some cases, the use of the term varies across jurisdictions and in some cases the term 'co-production' is used.

  Co-production goes beyond traditional methods of consultation by forming authentic partnerships with consumers, carers and service providers at all levels within services, and in interactions with government. It utilises their knowledge and experience in the planning, design, resourcing, delivery and evaluation of mental health policies and services. The methodology is underpinned by principles of early engagement. This is how co-deign must be a part of the NDIS.

With regards the overall amendments, the concern is that the NDIA have made these changes on issues that have been raised with them as concerns, but have not consulted about the implications of making the changes prior to proposing amendments to the NDIS Act. It goes to issues which have been raised previously about the way in which the NDIA is communicating and working with the sector.

CMHA wrote to the office of Christian Porter, Minister for Social Services raising these concerns. The office of the Minister for Social Services provided a response based on advice from the Department of Social Services, which primarily noted that the amendments were in response to the Ernst and Young 2015 review of the NDIS Act, and had been agreed by COAG and were supported by the NDIA and all state and territory Disability Ministers through the Disability Reform Council. However, the top-line point in the Ernst and Young report, was that the recommendations were being made at a time when the NDIS Act was not at implementation and that any recommendations needed to be tested when the NDIS Act was actually being implemented. The response from the Minister did also not address the case study from Queensland – which was provided - and that other such cases were likely.

The Productivity Commission NDIS Costs Position Paper has recommended that until interface issues and associated boundaries are settled, it is important that governments do no withdraw from services too quickly. The Productivity Commission Position Paper has also made the point that with the agreement between the Commonwealth and State and Territory Governments to provide continuity of support, there is considerable confusion and uncertainty about what this actually means in practice. As

Room 1.06, Level 1, Griffin Centre
20 Genge Street, Canberra City ACT 2601
t: (02) 6249 7756 f: (02) 6249 7801
e: abresnan@cmha.org.au w: www.cmha.org.au

noted above, there would presumably be other similar cases of funding for chronic health and disability support being transferred to the NDIS, which reinforces the point of the Commission that governments do not withdraw from services until interface issues are resolved.

Recommendation

It is CMHA's recommendation that in order to allow a proper and through examination of the concerns and issues identified above – references to chronic disease; all references of 'review' being changed to 'reassessment'; inserting the word 'sustainable' around people accessing innovation etc. to have a 'normal 'life'; and inserting words on co-design when there is no agreed process on how this should be applied – that these amendments be separated from the Bill and considered separately, and that the NDIA or DSS undertake a separate consultation process on these amendments. In particular, as noted above, the issues around the crossover between disability and chronic disease require examination before any changes to the NDIS Act, and relates the Productivity Commission NDIS Costs Position Paper, which has recommended that until interface issues and associated boundaries are settled, it is important that governments do no withdraw from services too quickly.

Attachment A

Community Mental Health Australia Submission to National Disability Insurance Scheme (NDIS) – Code of Conduct

CMHA would like to thank the Department of Social Services (DSS) for the opportunity to provide a submission on the National Disability Insurance Scheme (NDIS) – Code of Conduct.

CMHA is a coalition of the eight state and territory peak community mental health organisations. CMHA, through its state and territory bodies, has a direct link and contact to mental health organisations delivering services at the community level. CMHA provides a unified voice for approximately 800 community-based, non-government organisations who work with mental health consumers and carers across the nation and who are members of, or affiliated with, the various coalition members.

CMHA promotes the recovery of people living with a mental health condition so that they are contributing citizens and included in all of the economic and social aspects of their community. The organisation presents a united and representative voice for the community managed mental health sector who work every day on mental health issues and have the expertise through a specialised workforce, including a peer workforce and lived experience.

CMHA remains committed to the NDIS and the benefits that it can bring to the lives of people living with a mental health condition. However, it is vital to ensure that the recovery focus of community managed mental health services — that has come to inform the overall approach that is taken to addressing mental illness — is not lost. We also do not want to create a situation where some people receive a high level of support and others do not. People living with a mental health condition must have their psychosocial needs met regardless of whether they are eligible for the NDIS or not.

General comments

In relation to the NDIS Code of Conduct, CMHA's submission will address the main sections of the Discussion Paper. A significant issue for CMHA is how providers will be able to meet the necessary requirements of the Code of Conduct as training and related factors are not a part of the NDIS pricing structure. CMHA has continually raised the issue of the NDIS pricing structure and its impact on the community managed mental health sector, and the added requirements as a part of the Code of Conduct will add further pressures and costs that the sector will have to absorb.

An ongoing concern for CMHA is what level of accountability is being applied to the National Disability Insurance Agency (NDIA). The processes being implemented such as the Code of Conduct and the NDIS Quality and Safeguards Commission (the Commission) announced in the 2017-18 Federal Budget focus on the conduct and operation of providers. There is no national independent oversite of the NDIS, its conduct and operation, and complaints that are not undertaken internally by the NDIA. All risk and operation complaints are being shifted to the responsibility of providers and workers. The sector supports unequivocally the need for oversite of the quality of care provided to consumers, however given the significant concerns with the implementation and operation of the NDIS, the lack of accountability being applied to the NDIS itself remains an ongoing concern and significant gap.

Room 1.06, Level 1, Griffin Centre
20 Genge Street, Canberra City ACT 2601
t: (02) 6249 7756 f: (02) 6249 7801
e: abresnan@cmha.org.au w: www.cmha.org.au

The discussion paper states the obligations in the Code of Conduct are broad to account for diversity of participants, however, this broadness also means it is likely to be difficult to provide clear guidelines on its application to providers and workers, and to develop defined training and other related processes. CMHA recognises that further detail is likely to occur at the process for the Code of Conduct develops further, however a very broad list of 'statements' and not a defined set of requirements will mean that the detail of how it will be applied and implemented will be essential and important it is provided early on. A key factor is the rights and responsibilities that come with a Code of Conduct, for not just providers and workers but also consumers and clients, and this inclusion of rights and responsibilities should be a consideration. This is to ensure that consumers and clients are central to a Code of Conduct, as even though it states this is for delivering quality of care, the consumer or client is completely absent in how this Code of Conduct is described.

The discussion paper notes that the Code of Conduct aligns with the NDIS Quality and Safeguarding Framework. CMHA has raised through a number of submissions, including the 2017-18 Federal Pre-Budget submission, that in order to maintain and support the community managed mental health sector workforce and ensure the current quality of service continues through the transition to the NDIS, it is vital that NDIS Quality and Safeguarding Framework develops quality assurance processes specifically for psychosocial services. CMHA would continue to content that this is needed and is likely to impact on how the Code of Conduct is applied for people with psychosocial disability and providers and workers in the community managed mental health sector.

Who will be covered by the NDIS Code of Conduct?

Providing training within the NDIS pricing structure

A key issue for CMHA with the Code of Conduct is how providers will be expected to provided training given funding or time allocation for training is not a part of the NDIS pricing structure. Currently the NDIS sets the basic rate for support work at $43.58 per hour. Rob Woolley, General Manager of Just Better Care has been quoted as describing this as "a bargain basement rate for what is expected to be a platinum quality service."[4] The discrepancy in NDIS rates and what organisations have previously been paying support workers and other staff, puts significant pressure on organisations and places at risk the required number of workers available to provide services at NDIS rates and the Government's commitment that nobody would be worse off under the NDIS. The hourly rates included in the NDIS pricing structure demonstrate a lack acknowledgement and understanding about the level of skills and expertise that are required to provide disability support to individuals with serious mental illness.

The NDIS recognises complexity of support and differentiation in cost of service provision due to penalty rates in some of its pricing. However, it only provides a "maximum payment for short term accommodation in a centre or group residence set at a single rate per person per 24-hour period. This is an inclusive, all expenses price for a 24-hour period with no additional loading permitted. While this

[4] Norman Hermant, 'We have grave concerns': There could be trouble ahead for the NDIS if the ACT's problems go national, Updated 6 Jan 2017 http://www.abc.net.au/news/2017-01-03/ndis-there-could-be-trouble-ahead-after-problems-in-act/8157662

Room 1.06, Level 1, Griffin Centre
20 Genge Street, Canberra City ACT 2601
t: (02) 6249 7756 f: (02) 6249 7801
e: abresnan@cmha.org.au w: www.cmha.org.au

amount may be adequate for a range of lower needs participants, it is often not sufficient for those requiring higher support or levels of supervision to stay safe, particularly during higher wage periods."[5]

CMHA's submission to the NDIS 2017 Price Controls Review in relation to the assumptions applied to estimating the efficient cost of the provision for attendant care, made the following comments in relation to mental health:

- Base hourly rate:
  - the assumed qualification levels will be higher for some mental health workers
  - employees were more commonly employed on a permanent basis however NDIS is leading to increased casualisation of the workforce
  - the 24/7 nature of many mental health services is not accounted for in the categorisation of rates

- Non-client facing time:
  - Doesn't account for outreach which may be classified as time not directly with a client
  - Training and development is a significant part of furthering the qualifications of the community-managed mental health workforce and should be included as a consideration by the NDIA
  - Travel time, particularly for outreach and services in regional, rural and remote areas needs to be included.
  - The cost of transition processes to the NDIS is causing significant administrative costs so the assumption should not be theses costs have now reduced, given many services in mental health are still transitioning over the next years to the NDIS.

This information in relation to mental health fitting into the NDIS pricing structure is relevant to the Code of Conduct as it will add a further requirement that providers and workers will need to meet. Presumably – as it is not addressed in the discussion paper – this cost and time will not be accommodated in NDIS costings, and providers will be expected to absorb the cost and workers undertake the training in their own time. The discussion paper states that:

> Providers registered under the NDIS will be obliged to comply with the Code of Conduct as part of the NDIS registration requirements.
>
> A compulsory orientation module will be introduced for registered providers delivering supports, and all workers of registered providers engaged in the delivery of NDIS funded supports.

The discussion paper does not state who will develop this 'compulsory orientation model' and how it will be delivered, including:

- Will it be developed by the NDIA or the Commission; will either of these bodies be responsible for then undertaking or providing the training and will they provide it at no cost or a cost to workers?

[5] Ibid.

Room 1.06, Level 1, Griffin Centre
20 Genge Street, Canberra City ACT 2601
t: (02) 6249 7756 f: (02) 6249 7801
e: abresnan@cmha.org.au w: www.cmha.org.au

- Will providers and workers be allocated a training budget from the NDIA for this training to be undertaken or will it be accommodated in the NDIS pricing structure and include the time required for workers to undertake the training?
- Will providers and workers be provided with any type of support – monetary or otherwise – to undertake the training?

It also states that unregistered providers who might be engaged to deliver services by self-managed NDIS participants will also be subject to the Code of Conduct. The discussion paper further states:

> Information about the Code of Conduct, and how to comply, will be available to all participants. Self-managing participants will be strongly encouraged to provide information about the Code of Conduct and its obligations to any unregistered providers they engage.

This process places the entire onus on participants to provide information on the Code of Conduct, which in the case of episodic illness such as psychosocial disability may not always be possible. This once again shifts risk away from the NDIA and on to consumers or participants. The discussion paper does not address what might occur in an instance where a participant does not provide information on the Code of Conduct to an unregistered provider and what impact this would have on any breach of the Code of Conduct. Overall, it is difficult to see how unregistered providers will be subject to the Code of Conduct when they will not be required to undertake compulsory orientation, and the onus is on participants to make them aware of it.

Safe and ethical work environments

An omission in the discussion paper and the Code of Conduct is the responsibilities of people with disabilities, their carers and the rest of the community to work with service providers to ensure that the services and workers work in a safe and ethical environment.

The document states that work health and safety legislation has been taken into account in the drafting of the Code, however, nothing is explicitly mentioned about the responsibilities of visitors and consumers of the services to ensure they do not contribute to the environment in a negative way. They are responsible for their actions and behaviour whilst using the services and should not do anything that would adversely affect the safety of the workers and service providers. Self-managed NDIS participants are essentially the employers of service providers and workers, yet there is nothing in the Code that acknowledges this relationship and the implications.

Where the discussion paper refers to 'A provider or worker must maintain the necessary competence in the types of supports and services they provide', competence can be measured according to the types of supports and services but this needs to take into consideration the additional requirements based on the participant's disability. For example, in relation to a psychosocial disability and other complexities including alcohol and other drug concerns, trauma etc. This is made more difficult when dealing with workers delivering the core supports who may meet the 'qualification' requirement for general disability (e.g. Certificate III Disability) but do not have the required skill to work with a participant with a complex psychosocial disability.

The below case study from VICSERV articulates these concerns. The complexity and risk of the client in this example was only identified when experienced staff examined the plan – the plan itself did not

Room 1.06, Level 1, Griffin Centre
20 Genge Street, Canberra City ACT 2601
t: (02) 6249 7756 f: (02) 6249 7801
e: abresnan@cmha.org.au w: www.cmha.org.au

highlight this information or make it obvious for the service provider or worker. The example also highlights implications for complex clients and their access to the service provider market – providers in the future may choose not to accept clients with high needs due to the risks.

Complex Client Case Study

- NDIS Client with a history of violence, assault and drug use and known to forensic services.

- The client had moved to another region of Victoria – NDIS plan contained core supports around social skills, accessing a psychologist and some background information on diagnosis.

- Limited direction was initially included in the plan to the service provider to highlight the risk or history of the client – this would become available later after the service provider put in time to chase up reports (time not funded by NDIS).

- Experienced worker from a service provider (a qualified clinical nurse) reviewed history of client and could recognise diagnosis and convened an internal meeting to discuss next steps. At the organisation's own cost ("only able to do it because we still have MHCSS funds") they allocated a degree-qualified worker with "decades of experience in mental health" to the client.

- The worker was driving the client from an appointment and the client became aggressive and attacked the worker. The client later reported she had taken ICE prior to the appointment.

- The worker was able to remove herself from the situation, escaping with minor injuries. She was then able to call the police and managed the situation as appropriately as possible based on her skill and experience in working with clients with complex mental health presentations.

- The provider recommended that this client receive supported accommodation due to her high needs and dual disability, but this did not end up in her NDIS plan. This client had been transient for many months, her history revealed that in her past she had been given a substantial Multiple and Complex Needs Initiative package, at one time resided in a CCU, and at another time had been incarcerated. The client's history showed she had been receiving services as a child from 3 years of age.

Compliance with the Code of Conduct

The 2017-18 Federal Budget announcement on the Commission states that this body will implement the NDIS Quality and Safeguarding Framework, which the Code of Conduct aligns with. The discussion paper states that the Commission will provide further guidance on compliance with the expected requirements when the Code of Conduct is finalised. CMHA has raised a number of questions about the Code of Conduct and would be concerned if guidance on compliance is not determined in consultation with the sector before it is finalised.

The implementation of the NDIS has experienced many challenges and problems, in many instances due to details on processes not being developed before the scheme is rolled out and after problems have emerged and sometimes become systemic. The Code of Conduct should not become another process developed without detail, as in its current form, it is very unclear about how it will be implemented, who is ultimately responsible and how the costs will be met. The Code of Conduct must be finalised based on full information and this full information must be available to providers to make informed input.

Room 1.06, Level 1, Griffin Centre
20 Genge Street, Canberra City ACT 2601
t: (02) 6249 7756 f: (02) 6249 7801
e: abresnan@cmha.org.au w: www.cmha.org.au

Discussion paper scenarios

The Code of Conduct is unclear about how the Commission and the Code of Conduct will operate with existing structures or oversight agencies in state and territories for people to make complaints or register concerns with a service, such as Official or Community Visitor Schemes, Human Rights Commissions; or Mental Health Commissions. A number of the scenarios discuss people making a complaint to the Commission, but not how state or territory bodies might interact in these processes. While acknowledging that a scenario cannot outline processes in each jurisdiction, this is the sort of detail that must be described as a part of the Code of Conduct as it is relevant as to how it will operate and be effective.

A number of the scenarios also articulate that if people had a complaint, including if this was made to a Local Area Coordinator (LAC), they the person or the LAC would proceed straight to the Commission. There is no articulation of an LAC or a participant being supported to resolve disputes or complaints with providers before needing to elevate to the Commission. This would seem to be a responsible consideration to be noted in the information accompanying the Code of Conduct.

The scenario about providing supports in a safe and ethical manner with care and skill, relates back to a significant issue the community managed mental health sector has raised about the pricing structure and providing high quality services for high level complexity within this pricing structure. A central issue CMHA has raised on many occasions is the mismatch between benchmark costs and actual costs of packages for people living with a mental illness in a disability structured market. The skills and knowledge required are different with the NDIS pricing structure able to fund disability support, while being unclear about its reach into more complex supports. Therefore, retaining a highly qualified mental health workforce for the NDIS is a concern. As noted earlier, the hourly rates included in the NDIS pricing structure demonstrate a lack acknowledgement and understanding about the level of skills and expertise that are required to provide disability support to individuals with serious mental illness. As has also been noted earlier, the NDIS pricing structure does not include training and development.

CMHA is therefore concerned that obligations and expectations relating to providers or workers maintaining necessary competencies; offering supervision; and providing supports outside expertise and training are a part of the Code of Conduct when the NDIS pricing structure does not adequately or at all in many instances incorporate non-client facing time. Increasing these requirements and making them compulsory without acknowledging the existing impact the pricing structure is already having on retaining a qualified workforce is a significant concern.

Room 1.06, Level 1, Griffin Centre
20 Genge Street, Canberra City ACT 2601
t: (02) 6249 7756 **f:** (02) 6249 7801
e: abresnan@cmha.org.au **w:** www.cmha.org.au