



Submission in Response to Productivity Commission Draft Report – Mental Health

January 2020

About Advocacy for Inclusion

Advocacy for Inclusion (AFI) provides independent individual, self and systemic advocacy for people with disabilities. We are a Disabled Peoples Organisation (DPO) which means most of our board, members and staff are people with disabilities. We represent all people with disabilities nationally from the ACT in our policy works,

Advocacy for Inclusion works within a human rights framework and acknowledges the *United Nations Convention on the Rights of Persons with Disabilities* and is signed onto the *ACT Human Rights Act 2004*.

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AFI acknowledges and pays respect to the Traditional Custodians of the lands across Australia on which our members live and work, and to their Elders, past, present and future. We pay respect to the Ngunnawal people as the Traditional Custodians of the land on which AFI's office stands.



AFI pay respects to those amongst the lesbian, gay, bisexual, trans, and intersex communities. We honour the elders in the diverse communities of which we are a part, and we celebrate the extraordinary diversity of people's bodies, genders, sexualities, and relationships that they represent.

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RECOMMENDATIONS

Recommendation 1: The Productivity Commission to include and incorporate recent recommendations of the UN CRPD Concluding Observations of supported decision making over substituted decision making in creation of Australia's mental health reform.

Recommendation 2: Overreliance on coercion by health professionals can be an indication of a lack of alternate options. Given the concerning examples of reliance on coercion, the health workforce needs further supported decision making education and training, along with awareness-raising of the advocacy services and others who are in a position to provide practical assistance in supported decision making, as well as being able to provide training and resources.

Recommendation 3: Improve awareness of human rights and promote capacity building approaches in the health workforce to provide supports which are respectful and supportive of the autonomy, participation and dignity of consumers. Getting the type, timing and placement of supports right 'is likely to have the one of the greatest impacts in reducing all forms of coercion in the context of mental health care.'¹

Recommendation 4: NDIA act and review via a formal mechanism between Commonwealth and State and Territory jurisdictions to delineate the roles and responsibilities of the NDIA and mainstream services regardless of progress level. This should be focused on the delivery of services, plugging gaps in the event of funding disputes and disagreements of responsibility. The participant is and should remain a priority.

Recommendation 5: The NDIA should develop a separate access pathway for people with fluctuating conditions, such as psychosocial conditions. This may include distinct rules for the application of section 24 to psychosocial disabilities and mental illness. It is particularly important that the NDIA reconsiders the application of section 24(1)(c) to fluctuating conditions and ensures that activities such as self-management and self-care are assessed over weeks or months, as opposed to daily.

Recommendation 6: Existing programs serving the needs of people with psychosocial disability and slated to close (i.e. PHaMs, PIR, D2DL) should not be ceased until all clients have their plan enacted in the NDIS or have transitioned to another program. Transition must be monitored to ensure individuals are not left without community support where they are forced to seek support from clinical services or acute care.

¹Page 117 - For practical examples and further information see Gooding, Piers; McSherry, Bernadette; Roper, Cathy and Grey, Flick (2018) *Alternatives to Coercion in Mental Health Settings: A Literature Review*, Melbourne: Melbourne Social Equity Institute, University of Melbourne.

Recommendation 7: The evidence required and by whom needs to be provided from the NDIA at the beginning of the assessment process to the individual and organisation supporting the client so that they are clear and that there is an agreement on evidence needed, rather than going backwards and forwards on what evidence is needed.²

Recommendation 8: The evidence required, and by whom, needs to be provided from the NDIA at the beginning of the assessment process to the individual and organisation supporting the client so that there is an agreement on evidence needed, rather than going backwards and forwards on what evidence is needed.³

Recommendation 9: A specific NDIS item number should be developed for medical practitioners to bill assessments directly to Medicare to close gaps identified around the cost and quality of assessments by GPs and specialists.

Recommendation 10: The Draft Recommendations should be conscious in the recommendations and advice made by the Committee on the Convention on the Rights of Persons with Disabilities to the Australian Government. The Australian Government is to 'review disability assessment criteria for support schemes under the NDIS and align them with the human rights model of disability, ensuring adequate support for.... persons with intellectual or psychosocial disabilities'.

Recommendation 11: The reform of mental health in Australia must ensure wrap-around supports for participants during the planning process. This may include advocacy support for people with disabilities, alongside training in supported decision making for NDIS Planners.

Recommendation 12: A single meeting is not necessarily enough to ensure that participants obtain an adequate NDIS Plan. This is particularly true where the participant's supports are not present, where they have a trauma-background and where they have complex communication or psychosocial barriers.

Recommendation 13: Safety of individuals is essential, and thus should alternative accommodations, or care settings arise at short notice, the NDIS should make provisions to address urgent and critical situations without delay nor question under mental health.⁴

Recommendation 14: An additional framework is put in place, in advance, for the phasing out of the National Psychosocial Support Measure in time without reliance on the NDIS as a 'backup'.

² Recommendation made by University of Sydney and CMHA (2019) *Mind the Gap: the NDIS and psychosocial disability*, p.20

³ Ibid

⁴ Recommendation 44 of Advocacy for Inclusion (2019) *Submission in response to the NDIS Participant Guarantee*, Canberra.

The Draft Recommendations cannot state a 'guarantee continuity of psychosocial supports' if there is no advanced structure in place.

Recommendation 15: The phasing out of the National Psychosocial Support Measure should be prioritised as part of Draft Recommendation 12.3 in a proposed 'psychosocial disability' stream to be rolled out across all NDIS sites at the end of 2020 to allow pre-evaluations of trials and evaluations.

Recommendation 16: The need for the NDIS workforce to grow is paramount and the number of NDIS providers will need to increase to create balance and support choice, control and individualisation of services. The NDIA needs to create a national strategy between Commonwealth and State and Territory governments in addressing and improving the disability and mental health workforces.

Recommendation 17: The National Mental Health Workforce Strategy also be extended to knowledge of psychosocial disability and mental illness and due to the NDIS and cross-sector reliance.

Recommendation 18: In support for Draft Recommendation 23.3, structural reform is necessary. Mental health funding needs to be interjected into disability advocacy organisations to ensure employment of individual advocates who are experienced and trained in mental health, crisis intervention and trauma informed care.

Recommendation 19: Further funding is needed to supply additional resources to advocacy organisations if advocates are picking up the pieces when it comes to highly complex mental health situations.

Recommendation 20: National Mental Health Council (NMHC) will need to assess if the current evaluations on mental health and suicide prevention provide adequate evidence that a systems approach is likely to be successful. If it does, a separate, focused approach needs to be provided to regional and remote communities and another specific to metropolitan, due to differences in the geographical and socioeconomical needs of communities.

Recommendation 21: The Productivity Commission should consider focusing on just regional and remote Australia as part of the Rebuild Model to ensure regional and remote towns and surrounding areas are included. The RCA is to include regional areas in their funding allocation but create a specific and separate model included to ensure regional areas remain a priority. This must include disability and mental health advocacy approaches.

Recommendation 22: We recommend the Draft Recommendation 14.4 dot point 2 to be prioritised in the short term to guarantee that job service providers are stringently tested across the board to ensure more robust and rigid compliance, monitoring and reporting against obligations and outcomes.

Recommendation 23: Amend and remove extending the period that job seekers with 'more complex needs' have to consider and propose changes to their Job Plan beyond two business days. It is recommended that seven or ten days is more appropriate.

Recommendation 24: For full reform of prevention and early intervention mechanisms to reduce contact with the criminal justice system, the Australian Government needs to revisit and review the *Draft National Statement of Principles* and a response to the *Inquiry Report into the Indefinite Detention of People with Cognitive and Psychiatric Impairment in Australia*. Both documents are integral to the changes to be made to improve the way the criminal justice system treats people with cognitive or psychosocial disability who are deemed unfit to plead or found not guilty by reason of 'mental impairment'.

Recommendation 25: Implement and action Draft Recommendation 15.2 dot point 1 and dot point 2 as a matter of priority, to stop gaps upon discharge from institutional care back into the community.

Recommendation 26: All States and Territories to provide mental health and disability training for police officers and police administration staff. Training to be mandatory as a cadet subject and ongoing throughout police career with refreshers over time. Training must be provided from a leading advocacy organisation, as they are frontline in circumstances between police and individuals and are best placed to provide comprehensive training and resources.

Recommendation 27: The Australian Commission on Safety and Quality Health Services Standards also to provide oversight, regulation and evaluation of practices to healthcare settings where people can be held in custodian facilities and transferred to healthcare setting under supervision.

Recommendation 28: Given the lack of clarity around the interface between the NDIS and support for people engaged with the criminal justice system, there is a need to reconcile this between jurisdictions. The NDIA and mental health reform need to establish a unit specialising in the interaction with the criminal justice system for people with an intellectual disability, psychosocial disability and mental illness.

Recommendation 29: Advocacy support funding be extended to include disability representative organisations under both as a clause to both 22.1 and 23.1 to recognise the role of non-health supports in psychosocial supports and to create clear and transparent performance reporting requirements to ensure outcomes are central.

Recommendation 30: COAG should amend the terms of reference of the COAG Health Council to enable other COAG Councils to come to the table on a whole-of-government approach to mental health. This needs to include disability representation of people with psychosocial disability and mental illness with the NDIS.

Recommendation 31: The NMHC to also be given side responsibility under the Commonwealth Ombudsman to provide monitoring, regulation and oversight of mental health facilities under Australia's obligation to OPCAT.

Recommendation 32: The Federal Government fund the NMHC, Australian Institute of Health and Welfare (AIHW) and the Australian Bureau of Statistics (ABS) to invest in health and social datasets. The New Zealand Integrated Data Infrastructure is an example where data can lead to reform that also embraces each State and Territory's mental health practices and changes under the Rebuild Model.

INTRODUCTION

Advocacy for Inclusion (AFI) is a national systemic body representing people with disabilities in the ACT. AFI undertakes systemic advocacy and provides expert policy advice on issues affecting people with disabilities through our individual advocacy clients and membership base in the ACT.

AFI would like to thank the Productivity Commission for the opportunity to contribute to a response to the Draft Recommendations and Findings. Although AFI did not place a submission to the Commission's *Inquiry into the Social and Economic Benefits of Mental Health*, the change in our advocacy delivery and the emergence of new advocacy and support requests for National Disability Insurance Scheme (NDIS) has expanded our need to deliver advocacy support to people with psychosocial disability and mental illness tenfold in the past two years. The National Disability Insurance Agency (NDIA) has reported that nationally 2,630 active participants with an approved plan identified as having a psychosocial disability,⁵ with 19 of these plans approved within the ACT.⁶

Throughout this submission we address 'mental health' in the terminology of 'psychosocial disability and mental illness'⁷⁸⁹ as per the United Nations Convention on the Rights of Persons with Disabilities (CRPD).

This submission will address our response to the Draft Recommendations and Findings, as well as provide insight into our experience providing advocacy support for people with psychosocial disability and mental illness in the ACT. It has been AFI's experience that psychosocial disability can aggravate mental health conditions, causing further social isolation and economic marginalisation. People with psychosocial disability and mental illness are among the most disadvantaged in Australian society,¹⁰ often with accompanying health or biomedical issues.^{11 12}

⁵ COAG Disability Reform Council Performance Report - National 30 September 2019, p.11

⁶ COAG Disability Reform Council Performance Report - Australian Capital Territory 30 September 2019, p.10

⁷ The Mental Health and Human Rights Resolution of the OHCHR (2017), defines persons with 'psychosocial disabilities' as, "persons who, regardless of self-identification or diagnosis of a mental health condition, face restrictions in the exercise of their rights and barriers to participation on the basis of an actual or perceived impairment" in *Consultation on Human Rights and Mental Health: Identifying Strategies to Promote Human Rights in Mental Health* via OHCHR <https://www.ohchr.org/EN/Issues/Pages/MentalHealth.aspx>

⁸ The definition of 'psychosocial disability' has been clarified to refer to "the interaction between psychological and social/cultural components of our disability. The psychological component refers to ways of thinking and processing our experiences and our perception of the world around us. The social/cultural component refers to societal and cultural limits for behaviour that interact with those psychological differences/madness as well as the stigma that the society attaches to labelling us as disabled." in the World Network of Users and Survivors of Psychiatry (2008) 'Guide to Terminology, Definitions and Descriptions', *Implementation Manual for the United Nations Convention on the Rights of Persons with Disabilities*, p.9

⁹ World Health Organisation (2001), *International Classification of Functioning, Disability and Health (ICF)*, WHO Geneva.

¹⁰ Department of Health and Ageing (2012) *Partners in Recovery (PIR) Coordinated Support and Flexible Funding for People with Severe, Persistent Mental Illness and Complex Needs initiative - Program Guidelines for the engagement of PIR Organisations 2012-13 to 2015-16*. Australian Government, Canberra, 2012.

¹¹ V Morgan et al., 'People living with psychotic illness 2010: Report on the second Australian national survey', *Commonwealth of Australia*, Canberra, 2011.

¹² Unravelling Psychosocial Disability (2011). National Mental Health Consumer and Carer Forum, pg., 30

With this, AFI remains concerned with the continued use of involuntary orders which deprive people of their liberty and subject them to forced medical interventions and treatments. As a result, many people with psychosocial disability and mental illness experience serious breaches of their human rights.

We remain concerned that there continues to be no emphasis on the protection of the rights of people with psychosocial disability and mental illness. AFI continues to see individuals seeking advocacy to support them through a clinical process that could be more person-centred and less cold in its delivery.

For mental health care reform to work, a new and evolved system needs to work simultaneously across the board – AFI supports the Rebuild Model to deliver this. Better strategic awareness of psychosocial disability and mental illness within bureaucratic structures that deliver services to the Australian communities needs to be prioritised to ensure funded opportunities are maximised to best support the changes. The individuals who request advocacy from AFI feel alienated and disengaged from receiving support during the NDIS process or feel their needs are being not addressed by existing services. Parallel reforms in mental health, disability, primary and psychiatric health care have added to the complexities of the continuing implementation of the NDIS overall.

In addition, AFI views the social and economic determinants of mental health to be a priority. Due to the volume of enquiries and requests for advocacy, AFI prioritises, within the scope of the Draft Recommendations, an approach to improve the access and experience for NDIS participants with psychosocial disability and mental illness, and to address interface issues between the NDIS and mainstream mental health care systems.¹³

REORIENTATING HEALTH SERVICES TO CONSUMERS

AFI strongly supports the United Nations Human Rights Council call 'to abandon all practices that fail to respect the rights, will and preferences of all persons, on an equal basis, and that lead to power imbalances, stigma and discrimination in mental health settings'¹⁴ and to 'provide care of the same quality to people with psychosocial disability and mental illness, in particular individuals using mental health services, as to others'.¹⁵

¹³ Disability Reform Council, *Communique*, 9 October 2019, p. 1. The Council welcomed the establishment of a Psychosocial Disability Recovery Framework, with a strong focus on recovery and supporting episodic needs, noting that this would be developed with states and territories.

¹⁴ United Nations Human Rights Council, *Resolution on Mental Health and Human Rights*, UN Doc A/HRC/36/L.25 (2017) p. 4.

¹⁵ *Ibid* 4-5.

In the ACT, it is the Health Services Commissioner who investigates complaints regarding health services.¹⁶ Recommendations that arise from a complaint can be broader than to resolve the initial complaint and can be given to third-parties including providers of places of detention.¹⁷ An entity that is given a recommendation by the Commission is required to tell the Commission in writing about the actions it has taken in response to the recommendation within 45 days of receiving notice, or suffer civil penalties.¹⁸

Tribunal Process in the ACT

In the ACT mental health orders are administered through the ACT Civil and Administrative Tribunal (ACAT). AFI echoes the previous findings of the ACT Human Rights Commission regarding mental health tribunals in the ACT, as in our experience we have also found that when applying the *Mental Health Act 2015* (ACT), ACAT takes 'an overly risk-averse approach' resulting in outcomes which are 'neither least restrictive nor mindful of the dignity of risk principle.'¹⁹

A person who is subject to potential orders can enter a mental health tribunal in a very vulnerable position, with little or no support. Because of this, to achieve the Reform Objective: *Ensure advocacy for people scheduled under Mental Health Acts*, AFI recommends that in regards to Draft Recommendations 16.6 and 16.7, legal and/or advocacy support to represent the person's will and preferences should be made mandatory at mental health tribunals (unless objected to by the person concerned), including reasonable time to meet with the consumer and elicit their preferences.

In cases concerning decision making capacity, although the legal framework upholds that a supported decision making approach should be taken, with the person making the decision being given the necessary support to make the decision,²⁰ mental health orders can still be enacted without any attempt at supported decision making having been made. A legal representative or advocate can be a further safeguard to promote the protection of a person's rights when they may be in a very disempowered position.

It is not enough to inform the consumer that these services are available. It should not be the obligation of a person experiencing mental illness (at what is often a highly distressing time) to arrange their own support by contacting services or making applications to legal services.

¹⁶ *Human Rights Commission Act 2005* (ACT) s 25(1)(b).

¹⁷ *Ibid.*

¹⁸ *Ibid* s 52A.

¹⁹ ACT Human Rights Commission, *Submission to the Review of Mental Health Orders and Forensic Mental Health Orders under the Mental Health Act 2015* (June 2019) p. 4.

²⁰ *In the matter of E.R. (Mental Health and Guardianship and Management of Property)* [2015] ACAT 73

UN Human Rights Council, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, 28 March 2017, /HRC/35/21, available at: <https://undocs.org/A/HRC/35/21> [accessed 19 January 2020] p. 15.

In recognition that legal representatives may not be experienced in mental health, and acknowledging the experience of non-legal advocates in assisting consumers with mental illness, AFI supports the integration of non-legal advocacy services with legal advocacy services to provide both legal expertise and knowledge and experience of supporting consumers.

Supported Decision-Making

Overall, this example demonstrates a breach to Australia's obligations to the Interpretative Declarations on CRPD Articles 12, 13 and 17. The Australian Law Reform Commission states that:

"Australia declares its understanding that the CRPD allows for fully supported or substituted decision-making arrangements, which provide for decisions to be made on behalf of a person, only where such arrangements are necessary, as a last resort and subject to safeguards".²¹

Under the differing views and 'conceptual confusion'²² of the effect of Australia's Interpretive Declaration, particularly under the 'meaning' and approach to substitute decision making processes, AFI continues to see the allowance for the continuation of involuntary orders deprive people of liberty and subject them to forced medical interventions and treatment orders in the ACT without opportunity of supported decision making for individuals. We also continue to see a lack of supported decision-making opportunities in our wider justice, health and guardianship systems, despite the Commonwealth Government 'declaring it's understanding'. What is 'understood', is clearly not put into practice. As a result, many people with psychosocial disability and mental illness experience serious breaches of their human rights.²³

AFI continues to hold a strong view against substituted decision making and have done so for several years. However, we do support substitute decision making as an option of very last resort – if all supported decision-making attempts have been exhausted and the individual has a healthy, informed-decisive support network to guide any decisions that is made in their best interests and to the best of their ability to understand. In the light of mental health reform, it is necessary for the Rebuild Model to include supported decision making as part of ensuring that individuals are aware and have input to their treatment orders, rehabilitation and continuous supports.

²¹ Australian Law Reform Commission (2014) 'Supported and substitute decision-making' pt. 2.57-2.59 in *Equality, Capacity and Disability in Commonwealth Laws* (ALRC Report 124).

²² *Ibid*, 2.59

²³ Disability Rights Now (2019) *CRPD Civil Society Report on Australia*.

In 2019, the United Nations Concluding Observations provided the Australian Government feedback on the continued practice of substituted decision making, citing that under UN CRPD Article 12: *Equal Recognition before the law*:

Despite the recommendations of the Australian Law Reform Commission, the Committee is concerned about the lack of progress to abolish the guardianship system and substituted decision-making regime, particularly in decisions concerning forced psychiatric treatment, and at the lack of a timeframe to completely replace it with supported decision-making systems.²⁴

Further recommending that the Australian Government to 'implement a nationally consistent supported decision-making framework, as recommended in the Australian Law Reform Commission's 2014 report, "Equality, Capacity and Disability in Commonwealth Laws".²⁵

Under UN CRPD Article 13: Access to Justice, they further recommended to "eliminate substitute decision-making and provide gender and culture specific individualized support, including psychosocial support for persons with disabilities in the justice system, and the provision of accessible information and community based sentencing options".²⁶

It is strongly recommended that the Productivity Commission include and incorporate recent advice and recommendations to the Australian Government under our international obligations to the UN CRPD to ensure that supported decision making in the mental health sector is fully recognised and actions through the reform.

Recommendation 1: The Productivity Commission to include and incorporate recent recommendations of the UN CRPD Concluding Observations of supported decision making over substituted decision making in creation of Australia's mental health reform.

Coercion

The enactment of powers to breach human rights in mental health legislation 'legitimizes that power and its misuse' and can be seen to have 'normalized coercion in everyday practice'.²⁷ It is apparent through our work with consumers that there is an overreliance on coercive and

²⁴ Committee on the Rights of Persons with Disabilities, *Concluding Observations: CRPD/C/AUS/CO/2-3: Principle Concerns and Recommendations*, September 2019, s.23

²⁵ Ibid, recalling its general comment No. 1 (2014), on equal recognition before the law, recommendation 24(b)

²⁶ Ibid, 26(d)

²⁷ UN Human Rights Council, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, 28 March 2017, /HRC/35/21, available at: <https://undocs.org/A/HRC/35/21> [accessed 19 January 2020] p. 6-7.

paternalistic practices by health professionals in the ACT in the treatment of patients with mental illness. This leads to human rights violations reflective of those enacted in legislation.

Case Study

A consumer suffering from an eating disorder, who was being held in hospital against her will on a restriction order, faced stigmatisation and coercion from hospital staff.

On a ward occupied by people who had eating disorders, a nurse told the consumer that "if you were adults you would eat your food" and told another patient 'how pointless it was for them to be there if they didn't want to get better.'

The nurse also threatened to ask the doctor to take away their phones as punishment.

This consumer was also refused an independent second opinion, the only option for a 'second opinion' given to them was to see the doctor who had written the application for the mental health order against them.

Despite the consumer asking repeatedly for information (such as test results) to be given to them in writing, this was not done. Even while voluntarily receiving treatment, consumers can experience coercive practices.

Case Study

A consumer asked for advocacy assistance because a health professional refused to give her a copy of a document needed for her NDIS application. The consumer had requested a copy from her file after misplacing the original. The health professional refused to release the document to the consumer, or any nominee, unless the consumer attended an appointment with them.

The consumer did not wish to meet with this health professional and was under no obligation to do so.

Although the right to 'access your own health records in accordance with the law' being listed in the ACT Charter of Rights for People who experience Mental Health Issues, and the consumer had fulfilled all requirements by law, and the request was made in accordance to Australian Medical Association Guidelines, the reasoning the health professional relied on for refusing the request was 'mental health is complex.'

Case Study – cont.

After several days and continued contact with the advocate, the health professional released the document.

AFI also highlights the need for more effort to be given to make mental health care spaces environments which enable consumers to retain dignity while receiving treatment. Health professionals and the environments in which they work must be respectful of inherent dignity, individual autonomy and the ability to effectively participate per the principles of the UN Convention on the Rights of Persons with Disabilities (UNCRPD).

Case Study

During an appointment my psychologist was concerned for my welfare and arranged for me to go straight to hospital from the appointment. When I arrived at the hospital, I was taken to the emergency psychiatric unit. Because I was a young female, I was put in a room alone and was told the door was being locked for my own safety - due to the behaviour of other patients on the ward. I waited there for several hours for a bed to become available in the mental health unit.

I could hear screaming and crying, and occasionally physical altercations. A male doctor visited the room at one stage and performed a general physical examination on me. I wasn't told this would occur or given a reason why it occurred when I was there for mental health reasons. The doctor only said he had to check my health before I stayed in hospital. – AFI Consumer

Case Study

It was almost midnight when I was taken to the mental health ward (over 8 hours had passed since my appointment with the psychologist). I was given a room and tried to sleep. A short time later someone came into the room with a flashlight, shined it on my face, then left. I didn't know at the time that this was a nurse. No one had told me that 'night checks' would be performed every hour. I couldn't sleep through the checks.

At one point in the early morning I put my jumper over my face so I wouldn't be disturbed by the checks and tried to sleep. A short while later I was woken up as the jumper was pulled off my face and a flashlight was held in my eyes. Someone said 'sorry, we have to see your face' and

Case Study – cont.

and then left. I didn't sleep again until morning, when someone came into my room and opened the curtains completely to let in the light. This person (who I later learnt was a nurse), scoffed and said 'what, are you just going to lie in bed all day?' and then left. I left the room and saw that it was 8am. No one spoke to me. I went and sat outside. No staff talked to me until a family member visited later that morning. – AFI consumer

Recommendation 2: Overreliance on coercion by health professionals can be an indication of a lack of alternate options. Given the concerning examples of reliance on coercion, the health workforce needs further supported decision making education and training, along with awareness-raising of the advocacy services and others who are in a position to provide practical assistance in supported decision making, as well as being able to provide training and resources.

Recommendation 3: Improve awareness of human rights and promote capacity building approaches in the health workforce to provide supports which are respectful and supportive of the autonomy, participation and dignity of consumers. Getting the type, timing and placement of supports right 'is likely to have the one of the greatest impacts in reducing all forms of coercion in the context of mental health care.'²⁸

Mental Health Treatment Plans (MHTP)

In cases where therapy is likely to be required long-term, the need for multiple new MHTPs becomes burdensome, and can potentially become a barrier to accessing therapy. A MHTP Review should be an opportunity to consult with the consumer about whether they are gaining any benefits from the therapy, any concerns they may have and to discuss other options. As such, if conducted well in collaboration with the consumer, a MHTP Review can be a useful evaluation tool.

When considering what information should be required to share with the consumer when completing or reviewing a MHTP, clinicians should act in accordance with the CRPD, and the catchy mantra 'nothing about us without us', by respecting that a consumer's participation is integral to decisions concerning them. Audits of Treatment Plans must include consumers viewpoints, as whether patients are being managed in line with best practice can only be measured with their input.

²⁸ Page 117 - For practical examples and further information see Gooding, Piers; McSherry, Bernadette; Roper, Cathy and Grey, Flick (2018) *Alternatives to Coercion in Mental Health Settings: A Literature Review*, Melbourne: Melbourne Social Equity Institute, University of Melbourne.

In the ACT, the Official Visitor for Mental Health has the power to visit designated health facilities and report conditions to the operational Minister.²⁹ The Visitor is obligated to report health facilities that are not compliant with the *Mental Health Act 2015* (ACT).³⁰ Reportable issues include the appropriateness of facilities, as well as the treatment of individuals and whether it is being conducted in the least possible restrictive environment.³¹ The Official Visitor may also consider complaints and may consult with individuals at designated health facilities directly.³² The Public Advocate can exercise their functions under the *Human Rights Commission Act 2005* (ACT) to advocate for the rights of vulnerable persons and enter designated mental health facilities.³³

Emergency Departments

AFI strongly supports Draft Recommendation 8.1, to provide alternatives to hospital emergency departments, as 'it is difficult to imagine an environment less conducive than a busy ED for the extended treatment of people with severe mental illness, where long stays are associated with suboptimal treatment like restraint, seclusion and lengthy periods of sedation.'³⁴ Patients with mental illness in emergency departments also face 'disproportionately' long wait times and are often inadequately triaged.³⁵ If a person has attended under police escort this also ties up police resources:

There is a cultural tendency to see mental health assessments as distinct from and less urgent than other emergency medicine responses. This leads to delays in conducting assessments. From a mentally ill person's perspective this does not accord with the dignity and rights to which they are entitled. From a police perspective it leads to a poor use of resources where police, who could be responding to calls for police services, must remain with the person in hospital emergency department waiting rooms for lengthy periods of time.³⁶

Due to the very nature of emergency departments it is hard to imagine them ever becoming places which could consistently provide a calm sensory experience with the necessary resources and supports to respond to people experiencing mental health crises. Because of this AFI emphasises its support for long term alternatives to emergency departments to be found.

²⁹ *Official Visitor Act 2012* (ACT) s 14(1); *Mental Health Act 2015* (ACT) s 211.

³⁰ *Mental Health Act 2015* (ACT) ss 211, 212(b).

³¹ *Ibid* s 211.

³² *Ibid*.

³³ *Mental Health Act* (2015) (ACT) s 32

³⁴ Australasian College for Emergency Medicine Department of Policy, Research and Advocacy - The Long Wait: An Analysis of Mental Health Presentations to Australian Emergency Departments Report October 2018

³⁵ Australasian College for Emergency Medicine Department of Policy, Research and Advocacy - The Long Wait: An Analysis of Mental Health Presentations to Australian Emergency Departments Report October 2018

³⁶ Victoria. Office of Police Integrity & Victoria. Office of Police Integrity 2012, Policing people who appear to be mentally ill, Victorian Government Printer, Melbourne page 29-30

If Emergency Departments continue to receive people presenting with mental illness, AFI strongly recommends reform in the administrative aspects of the intake process. It is AFI's understanding that currently, when people present with self-harm injuries at emergency departments, the incident is coded per the injury. For example, regarding a laceration and necessary stitches. The presentation is not necessarily coded as a psychiatric presentation. A similar situation may occur when someone presents with physical medical complications arising from an eating disorder. The presentation may be coded as a cardiac issue, for example, which ultimately obscures the data regarding eating disorders. Coding which focuses primarily on the physical, as opposed to psychiatric, aspects of the presenting patient leads to a distortion in the statistics on presentations at emergency departments. Specifically, the data may be inaccurately skewed towards physical presentations as opposed to psychiatric presentations. In order for a more accurate picture of psychiatric presentations to Emergency Departments, the administrative aspects of the intake process must be adjusted.

Furthermore, while it is preferable for people to not be hospitalised, it can at times be necessary and lifesaving. Currently, there are an inadequate number of beds in many hospitals to cater for the people requiring such life-saving admissions. AFI is aware of two situations where people in critical conditions presented to the Emergency Department and were told to 'go home.' In one instance, a person presenting with suicidality was told that they should 'go to Bunnings on the way home and buy a safe to put any items in which could be used for suicide'. This is a fundamentally inadequate response to anybody presenting with concerns about their own safety, to an Emergency Department. Consequently, it is vital that adequate resources (including hospital beds) are available for people with mental illness when they require it.

Involuntary Measures

Where a person is deemed to lack decision-making capacity and/or where their mental illness or mental disorder is placing them or the community at significant risk, the *Mental Health Act 2015* (ACT) authorises involuntary measures to provide assessment, treatment and care for that person. ACAT is responsible for making a range of decisions under the Act about a person's mental health treatment or care.

There are several Mental Health Orders that ACAT can make under the Act including:

- Psychiatric Treatment Orders (PTOs) for people who have a mental illness;
- Community care orders (CCOs) for people with a mental disorder;
- Restriction Orders (for ordering where a person with a mental illness or mental disorder must reside/be detained or not approach places or people or do activities);

- Forensic Psychiatric treatment orders (FPTOs); and Forensic Community care orders (FCCOs).

A person who refuses to comply with the order can be taken by the police, an authorised ambulance officer, a doctor or mental health officer to an approved mental health facility for treatment.

There are situations where a person may be detained without the full mental health assessment and order process being undertaken. This is called 'emergency detention' and includes apprehension and transfer to the Emergency Department of the Canberra Hospital by a police officer, ambulance paramedic, mental health officer or a doctor. Under section 80 of the *Mental Health Act 2015* (ACT), a person can be taken to any 'approved mental health facility', but in accordance with ACT Health policy, only the Canberra Hospital Emergency Department is equipped and authorised to accept people brought in under an emergency apprehension. A doctor or mental health officer is also able to detain a person who has attended a mental health facility voluntarily, provided the person meets the criteria for apprehension.

Once detained, an initial examination by a doctor must occur within four hours, and involuntary detention and treatment may be then authorised for a period of no more than three days. A Consultant Psychiatrist can apply to the ACAT for an extension of the period of detention for a maximum of a further 11 days.

A recent review of the *Mental Health Act 2015* (ACT) addressed and reviewed the viability of the authorised period of emergency detention under section 85(3).³⁷ When the *Mental Health Act 2015* was introduced the maximum period of emergency detention was increased from 7 days to 11 days. The Act required that this section of the Act be reviewed. A period of public consultation in mid-2019 focused on involuntary orders that can be made under the Act. A final report concluded that the change in the maximum period of further detention from 7 days in the old Act to 11 days in the *Mental Health Act 2015* has had 'predominately positive effects and no detrimental impact'.³⁸

AFI recognises that 'informed consent' is integral to the right to health³⁹, and that consumers have 'the right to provide consent to treatment and hospitalization [including] the right to refuse treatment'.⁴⁰ However, in the ACT legal exceptions which allow for the infringement on a person's human rights through involuntary detainment and treatment are enacted in the *Mental Health Act*

³⁷ White, D. (2019) 'Reform on the cards as mental health detentions jump', *Canberra Times*, November 2nd 2019 via <https://www.canberratimes.com.au/story/6469303/reform-on-cards-as-mental-health-detentions-jump/>.

³⁸ See ACT Health Directorate (2019) *ACT Mental Health Act 2015: Review of the Authorised Period of Emergency Detention*, p.11.

³⁹ Article 12(1) of the International Covenant on Economic Social and Cultural Rights (ICESCR), to which Australia is a party.

⁴⁰ UN Human Rights Council, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, 28 March 2017, /HRC/35/21, available at: <https://undocs.org/A/HRC/35/21> [accessed 19 January 2020] p. 14.

2015. AFI recognises the significant trauma and distress which can result from being subject to involuntary treatment.

Case Study

"Being locked up, treated like a child and or criminal impacted my mood profoundly; but obviously, there was no way I could express this to any of the staff in fear that it would prolong my admission. There were a few staff who did treat me like an adult, but unfortunately those who didn't had the biggest impact. These staff and the way things were dealt with made me feel inferior, unheard, helpless and highly distressed... I am not the only patient who complained of this. I feel as though our grievances were not taken seriously due to perception of 'crazy minds' (for want of a better term)." – AFI Consumer

THE NEED FOR NDIS SUPPORT

There are significant challenges which must be addressed in the ongoing operation of the Scheme from our standpoint in the ACT. AFI notes key issues relate to:

- There is an over reliance on medical diagnoses rather than on functional assessments;
- Evidence from people with disability⁴¹ demonstrate that planners have developed plans which are not representative of participants' needs. They are making adverse decisions that they are not qualified to make. There are lengthy delays in receiving plans, plan reviews, and other information from the National Disability Insurance Agency (NDIA) and plan reviews have sparked unnecessary reductions in participant funding;⁴²
- Training and knowledge of psychosocial disability and mental illness by NDIS and Local Area Coordinators (LACS) on psychosocial disability;
- No oversight or regulation of support coordinators who are working with clients and have limited to no in experience of working with people with complex support needs but also do not collaborate with case managers – advocacy should not fill this gap or perform the role of LACs;
- Administration of the Scheme for people living with psychosocial disability and mental illness who are potentially eligible, including: a. Scheme engagement and application processes, and b. Scheme assessments;
- Service delivery to those living with severe mental illness who will not be eligible for the Scheme or for a multitude of reasons are not applying, and therefore need to keep receiving services

⁴¹ Joint Standing Committee on the National Disability Insurance Scheme (March 2019) Progress Report; Joint Standing Committee on the National Disability Insurance Scheme (September 2017) Progress Report.

⁴² Joint Standing Committee on the National Disability Insurance Scheme (March 2019) Progress Report.

outside of the NDIS A culture within the NDIA that is does not place the participant at the centre of the scheme;⁴³

- Organisations with expertise in psychosocial disability and mental illness are collapsing, merging or selecting not to engage with the NDIS due to inability to provide effective services due to the NDIS's pricing structure;
- Organisations losing staff with expertise in psychosocial disability and mental illness due to the level of funding provided by the NDIA for instances of care which do not match the cost of employing trained mental health staff or providing training and supervision to new staff; and
- Loss of services for people living with mental health. People ineligible for the NDIS are receiving poorer support, creating a loss of services as funding has been transferred to programs as an exclusive basis.

'Although there is a gap in the health system, the NDIS is not responsible to pick up the shortfall.' ⁴⁴ – NDIA rejection letter, regarding psychosocial disability

Case Study

A consumer had appealed the NDIA decision to reject her application and had succeeded (over a year later) in being found eligible for the NDIS. The appeal process had been highly distressing. Being required to relive past trauma to 'substantiate' her PTSD condition to NDIA staff who were lacking mental health awareness, and feeling challenged and victimised by the adversarial nature of the NDIA led to the consumer experiencing severe physical symptoms of anxiety at the thought of interacting with the NDIA. The consumer suffered a severe panic attack immediately prior to her first NDIS planning meeting.

In 2013, the World Health Organization (WHO) agreed upon an action plan to provide comprehensive, integrated and responsive mental health and social care services in community-based settings.⁴⁵ The Joint Standing Committee into NDIS Planning made 24 recommendations in the course of its inquiry regarding the provision of services for people with psychosocial disabilities and mental

⁴³The insufficient funding allocated by the Federal Government for NDIS advocacy has resulted in inequality and significant unmet need. In addition, the paucity of funded advocacy has resulted in a significant rise in fraudulent activities by providers and fee for service for reviews and appeals by the same services creating serious conflicts of interest. See also: Joint Standing Committee on the National Disability Insurance Scheme (September 2017) *Progress Report*. Footnote used from *Disability Rights Now 2019: Australian Civil Society Shadow Report to the United Nations Committee on the Convention on the Rights of Persons with Disabilities: UN CRPD Review 2019: In response to the List of issues prior to the submission of the combined second and third periodic reports of Australia* [CRPD/C/AUS/QPR/2-3] which AFI is a contributing organisation.

⁴⁴ NDIA rejection letter – Delegate of CEO NDIA

⁴⁵ World Health Organisation (WHO), *WHO Comprehensive Mental Health Action Plan 2013/2020*, Sixty-sixth World Health Assembly, Resolution WHA66/8, 2013.

illness in 2018-2019. The government had indicated its support for 21 recommendation. Since March 2019, the NDIA has only completed two of the recommendations supported, with four in progress.⁴⁶

The National Mental Health Commission's report on Mental Health Programs and Services estimated that about 700,000 Australians experience a severe mental illness in any one year. According to the NDIA, about 64,000 people with primary psychosocial disability are expected to be eligible for individual packages in the NDIS at full scheme.⁴⁷ AFI finds that people with psychosocial disability and mental illness are not only finding it difficult to access the NDIS but are also at higher risk of experiencing poorer outcomes⁴⁸ with their plan and communicating to the NDIA. These individuals are at higher risk of being denied care, services and advocacy support due to funding disputes between the NDIA and other government services.⁴⁹ ⁵⁰ ⁵¹ Due to these complexities, people with psychosocial disability and mental illness believe the slower than expected uptake is due to the increased numbers of people trying to access the NDIS, with no measures put in place to link between disability and mental health funding support.

People with disabilities, including those with a psychosocial disability and mental illness, have also been provided wrong supports as an option by staff who are ill-trained or equipped to support them and have been retained in a custodial environment, hospitals or institutional settings as there is nowhere for them to go. In our experience, we continuously find people with complex support needs are falling through the gaps and are facing a significant risk of homelessness and reoffending due to the lack of support.

AFI supports Draft Recommendation 12.1 to extend the contract length for psychosocial supports from a one-year term to a minimum of five years for care integration and coordination. This should not situate only on the NDIS, but to all services, care coordination and advocacy support services where psychosocial disability and mental illness is evident. This support is also in support for Draft Recommendation 10.4 to ensure that programs are available to match local needs, for those with severe and persistent psychosocial disability and mental illness to ensure a safety net of supports is ongoing for those who are ineligible or choose not to access the NDIS by choice.

⁴⁶ JSC NDIS, *Progress Report*, March 2019, pp. 17-30

⁴⁷ Productivity Commission, National Disability Insurance Scheme (NDIS) Costs, 19 October 2017.

⁴⁸ Joint Standing Committee on the National Disability Insurance Scheme (September 2017) Progress Report.

⁴⁹ For example, the NDIS eligibility criteria do not adequately consider the episodic nature of psychosocial disability/mental illness, and the focus on diagnosis rather than physical and psychosocial impact disqualifies many with a demonstrable need for assistance under the Scheme. See: Commonwealth of Australia (2017) Joint Standing Committee on the National Disability Insurance Scheme

⁵⁰ Joint Standing Committee on the National Disability Insurance Scheme (September 2017) Progress Report.

⁵¹ People with disability remain concerned with underspending on the NDIS, with payments expected to decrease by \$1.6 billion in 2019-20 attributed by Government to the slower than expected transition of people into the scheme. The Federal Government also spent \$3.8 billion less on the NDIS in 2018-19 than they estimated in the previous year's budget.

Case Study

One of the inadvertent aftereffects of the NDIS in the ACT has been the disappearance of well-known and outcomes-orientated group programs and community spaces for people with mental health. Since the introduction of the NDIS and additional funding, the ACT has introduced, through the Office for Disability, an Integrated Service Response Program to provide short-term support coordination for people with severe and complex mental health and disability. The disappointment is that the individual is required to be accessing an NDIS plan and have complex needs support. The capacity of staff and resources is low, with many people being declined based on priority.

As part of monitoring and ongoing funding, funding for existing programs serving the needs of people with psychosocial disability and mental illness and slated to close (i.e. PHaMs, PIR, D2DL) should not be ceased until all clients have their plan enacted in the NDIS or have transitioned to another program. Transitions must be monitored to ensure individuals are not left without community support where they are forced to seek support from clinical services or acute care.⁵²

Recommendation 4: NDIA act and review via a formal mechanism between Commonwealth and State and Territory jurisdictions to delineate the roles and responsibilities of the NDIA and mainstream services regardless of progress level. This should be focused on the delivery of services, plugging gaps in the event of funding disputes and disagreements of responsibility. The participant is and should remain a priority.

Recommendation 5: The NDIA should develop a separate access pathway for people with fluctuating conditions, such as psychosocial conditions. This may include distinct rules for the application of section 24 to psychosocial disabilities and mental illness. It is particularly important that the NDIA reconsiders the application of section 24(1)(c) to fluctuating conditions and ensures that activities such as self-management and self-care are assessed over weeks or months, as opposed to daily.

Recommendation 6: Existing programs serving the needs of people with psychosocial disability and slated to close (i.e. PHaMs, PIR, D2DL) should not be ceased until all clients have their plan enacted in the NDIS or have transitioned to another program. Transition must be monitored to ensure individuals are not left without community support where they are forced to seek support from clinical services or acute care.

⁵² Recommendation made by University of Sydney and CMHA (2019) *Mind the Gap: the NDIS and psychosocial disability*, p.11

Language of Mental Health and the Assumption of 'Recovery'

AFI continues to recognise that the practicalities of recovering from a severe, persisting or dual-disability mental illness requires integration of supports, network between organisations and a sense of control for the individual to enable choice and self-management of their lives. A national inquiry undertaken by the Joint Standing Committee on the National Disability Insurance Scheme in 2018 found that the lack of clarity around eligibility criteria, the apparent reliance on diagnosis rather than functional needs, the absence of a validated assessment tool for planners, and reported lack of skills and expertise of planners in the disability and mental health sectors were key contributors to inconsistencies in eligibility and planning outcomes for people with psychosocial disability.⁵³

Working closely with ACT Office for Mental Health and other organisations, including peak Mental Health Community Coalition, AFI are growing to ensure we have the best support capacity to advocate in ensuring people with psychosocial disability and mental illness are able to have a contributing life, manage and better participate economically and be included in their community. It becomes complicated to do this when many intake cases that indicate psychosocial disability and mental illness are cases of rejection from the NDIS when the language used by clinical and medical professionals do not reflect the understanding or the lived experience of the individual when providing evidence required for the NDIS.

Recommendation 7: The evidence required and by whom needs to be provided from the NDIA at the beginning of the assessment process to the individual and organisation supporting the client so that they are clear and that there is an agreement on evidence needed, rather than going backwards and forwards on what evidence is needed.⁵⁴

The NDIA uses the International Classification of Functioning (ICF) and the NDIS Planners use the WHO Disability Assessment Schedule to make their determinations. The language used to describe, and support disability does not translate into the mental health sphere. Fundamentally, the language of "permanency / or likelihood of permanency of impairment" which, while a core eligibility criterion for access to the NDIS, can on the surface at least, appear to conflict with a recovery approach.⁵⁵ The varying language of clinical and medical professionals often are the main culprits to this issue and create confusion or misunderstanding as to whether a psychosocial disability and mental illness is 'life-long'. It is not uncommon for health professionals to refrain

⁵³ Joint Standing Committee on the National Disability Insurance Scheme (March 2019) *Progress Report*. See also: National Mental Health Commission (2018) *Monitoring mental health and suicide prevention reform: National Report 2018*. Published by: National Mental Health Commission, Sydney.

⁵⁴ Recommendation made by University of Sydney and CMHA (2019) *Mind the Gap: the NDIS and psychosocial disability*, p.20

⁵⁵ While the NDIA uses the language of recovery in some brochures, this is contrasted jarringly with language about permanence and life-long disability: E.g. National Disability Insurance Agency, *What is Psychosocial Disability?*
<https://www.ndis.gov.au/psychosocial/products>

from providing a diagnosis in the form of a labelled condition, as it be unhelpful for the patient, or symptoms may be frequently changing (many conditions are misdiagnosed). This is particularly pertinent in the context of the NDIS because many participants are unsure what types of supports the NDIS can provide, particularly with mental health being 'new' in service provision.

The lack of experience in envisaging options in decision making processes can render the planning process particularly overwhelming. AFI has observed that feelings of overwhelm are often heightened in circumstances where the participant with disability has a dual psychosocial disability and mental illness such as bi-polar or depression. Often people with these conditions feel that hope for improvement is beyond their reach, and so they find it difficult to conceptualize supports which may lead to improvement.

Case Study

One client with bi-polar and anxiety was particularly distressed in the pre-planning process. They often stated that there was 'no point' requesting supports because they had 'tried everything'. They stated that there 'was nothing anyone could do' and that they 'didn't know where to begin' in trying to brainstorm what supports they could request from the NDIA. This client had not used many of the supports in their previous plan because they had not been granted support coordination and was not well enough to organise their own supports. Over several meetings with our organisation, the client was able to work through a pre-planning kit, identify what supports they would benefit from and even came up with ideas of their own.

The client required wrap-around support from the LAC, our advocacy organisation and two other community organisations to be able to both envisage and articulate their support needs.

Participants who have experienced trauma may be acutely aware of power-relations and susceptible to influence. This may cause them to request different supports depending on whom they are talking to. In this way, participants may present inconsistent goals and support requests, and ultimately have their requests dismissed. This behaviour is not uncommon in the planning process and can be a significant barrier to the articulation of goals and requests, particularly if the planner is not sensitive to the participant's behaviours and needs.

A client's advocates and support workers will be aware that a client provides different information to different people across various aspects of their life. NDIS Planners need to be aware of this behaviour and, where appropriate, ensure that the participant's support network is engaged in the planning process. Planners must ensure that they have a complete picture of the participant's life and are sensitive to any behaviours which need addressing in the planning process.

As raised in AFI's recent submission in response to the NDIS Participant Guarantee ('Tune Review'), the drafting planning process should involve participants in an active way to ensure the best possible supports are made and continue to be available. For there to be true participant involvement in the planning process, planners must work with participants to review their draft plans in a streamlined and timely manner to minimise any uncertainty or undue delay. Individuals with severe and complex mental illness may have already undergone a lengthy access process, so it is important that any draft planning process is sensitive to the needs of people with psychosocial disability and mental illness and the additional barriers to access that they face.

The NDIS Act consists of numerous interpretive silences. Some of these silences are addressed in the policy. For example, the NDIA has increasingly made attempts to clarify the delineative ambiguities between Health and Disability. However, there remains a problematic dearth of definitions in the NDIS Act, including for core terms such as 'conditions' and 'impairment'. Furthermore, the NDIS Act does not provide criteria for determining the severity of a person's 'reduced functional capacity', nor whether an impairment is 'likely to be permanent'.

The lack of clarity regarding the meaning and assessment criteria for 'substantially reduced functional capacity' is particularly concerning for people whose impairments fluctuate. This is because, while the NDIS Act provides that impairments "that vary in intensity may be permanent" and that persons with such impairments "are likely to require support" for their lifetime (s24(2)), it does not address the impact of such variations on the assessment of functional capacity. Rather, the NDIS (Becoming a Participant Rules) 2013, rule 5.8, considers the person's functional capacity regarding their ability to perform day to day tasks. This is concerning for people with fluctuating mental health conditions because the NDIA is often uninterested in hearing about applicant's "bad days."⁵⁶

Case Study

A client was rejected from NDIS because support letter by GP used 'when unwell' when describing the client's mental ill health as a 'functional impairment'. The NDIA planner interpreted this to mean they were otherwise 'well' the majority of the time.

Specifically, AFI has observed that applicants with fluctuating capacity are often told that their support needs are not substantial enough. For example, an applicant who experiences fluctuating

⁵⁶ O'Donovan, D. (2018). *Renewing the NDIS: Refocusing the Eligibility Debate*. Retrieved from: <https://auspublaw.org/2018/07/renewing-the-ndis-refocusing-the-eligibility-debate/>

mental health conditions was told that they did not have a substantially reduced functional capacity, despite requiring intensive support from their parents to undertake self-care and self-management on an ongoing basis. This applicant could complete tasks such as socialising, dressing, eating and showering on their 'good days'. However, the cyclical state of their mental illness meant that they were not able to take responsibility for themselves on an on-going basis. Rather, their parents were required to continually manage their financial and medical affairs and be constantly alert early warning signs.⁵⁷ The periodic loss during regular acute episodes of their capacity to "manage finances" or "take responsibility for oneself" – specifically listed as examples in the NDIA policy – can have the most serious consequences for life outcomes, such as interactions with the justice system or extreme poverty.⁵⁸

The NDIS Act also fails to provide a standard of proof for sections 24 and 34. This has raised issues with regards to the determination of whether an 'impairment' is 'likely to be permanent'. AFI notes that the NDIS (Supports for participants) Rules 2016, rule 5.1, provides that permanence arises where there is no "known, available and appropriate treatment which is likely to remedy the impairment." However, practically, the quantity and quality of evidence required for this appear discretionary, depending on the nature of the condition, the decision-maker's preferences and their medical expertise.

AFI supports a recommendation made in the *Mind the Gap* report stating that a specific NDIS item number should be developed for medical practitioners to bill assessments directly to Medicare to close gaps identified around the cost and quality of assessments by GPs and specialists.⁵⁹

Recommendation 8: The evidence required, and by whom, needs to be provided from the NDIA at the beginning of the assessment process to the individual and organisation supporting the client so that there is an agreement on evidence needed, rather than going backwards and forwards on what evidence is needed.⁶⁰

Recommendation 9: A specific NDIS item number should be developed for medical practitioners to bill assessments directly to Medicare to close gaps identified around the cost and quality of assessments by GPs and specialists.

Most pertinently, there are areas of law, policy and society in which the autonomy of people with psychosocial disability and mental illness is ignored or inconsistent with the human-rights framework of the NDIS. This means that the autonomy of individuals to exercise choice and control

⁵⁷ O'Donovan, D. (2018).

⁵⁸ Ibid

⁵⁹ University of Sydney and CMHA (2019) *Mind the Gap: the NDIS and psychosocial disability*, p.11

⁶⁰ Ibid

cannot be fully realised within the NDIS – which is where the reform of mental health needs to be cautious.

For care pathways for people using the mental health system, the Productivity Commission must heed the recommendations and advice of the UN Concluding Observations by the Committee on the Rights of Persons with Disabilities. It was recommended strongly that the Australian Government 'review disability assessment criteria for support schemes under the NDIS and align them with the human rights model of disability, ensuring adequate support for.... persons with intellectual or psychosocial disabilities'.⁶¹ The reorientating of surrounding services to people needs to reflect the possible changes and recommendations to the assessment criteria of the NDIS.

Recommendation 10: The Draft Recommendations should be conscious in the recommendations and advice made by the Committee on the Convention on the Rights of Persons with Disabilities to the Australian Government. The Australian Government is to 'review disability assessment criteria for support schemes under the NDIS and align them with the human rights model of disability, ensuring adequate support for.... persons with intellectual or psychosocial disabilities'.

Recommendation 11: The reform of mental health in Australia must ensure wrap-around supports for participants during the planning process. This may include advocacy support for people with disabilities, alongside training in supported decision making for NDIS Planners.

Recommendation 12: A single meeting is not necessarily enough to ensure that participants obtain an adequate NDIS Plan. This is particularly true where the participant's supports are not present, where they have a trauma-background and where they have complex communication or psychosocial barriers.

Recommendation 13: Safety of individuals is essential, and thus should alternative accommodations, or care settings arise at short notice, the NDIS should make provisions to address urgent and critical situations without delay nor question under mental health.⁶²

Ongoing Continuity of Supports

States and Territories, including the ACT, are withdrawing their funding for several mental health support programs and using this funding to offset part of their contribution to the NDIS. At this stage, it is unclear what supports will be available for people with psychosocial disability and mental illness who do not meet the NDIS eligibility criteria. AFI has had clients identify that

⁶¹ Committee on the Rights of Persons with Disabilities, *Concluding Observations: CRPD/C/AUS/CO/2-3: Principle Concerns and Recommendations*, September 2019, Recommendation 6(d)

⁶² Recommendation 44 of Advocacy for Inclusion (2019) *Submission in response to the NDIS Participant Guarantee*, Canberra.

community service organisations that are ineligible for NDIS are not taking on clients who were applying for the NDIS, leaving them with no support or transition to alternative programs.

AFI is aware the Partners in Recovery (PIR), PHaMs and Day to Day living supports ceased on 30th June 2019 for people with psychosocial disability and mental illness. There is now a psychosocial measure and continuity of support being put in place to ensure people with psychosocial disability and mental illness, regardless of being on the NDIS or not, have time to transition.⁶³ There is no transition if people with psychosocial disability and mental illness cannot be guaranteed to keep the same provider. For people who struggle to connect with services or build a rapport, this is a concern where a provider may no longer wish to continue the service due to loss of funding, ability to continue a program or under-resourced in materials or staff capacity.

We support Draft Recommendation 12.2 that if an individual chooses not to participate in the NDIS and seek community supports, they should be allowed through the National Psychosocial Support Measure until phased out. However, it is important that the reform of mental health is not reliant on the NDIS and nor that people be 'shifted onto the NDIS'⁶⁴ as a replacement structure. Instead, it is highly recommended that an additional framework is put in place, in advance, for the phasing out of the National Psychosocial Support Measure in time for people who are ineligible or choose not to participate in the NDIS.

Recommendation 14: An additional framework is put in place, in advance, for the phasing out of the National Psychosocial Support Measure in time without reliance on the NDIS as a 'backup'. The Draft Recommendations cannot state a 'guarantee continuity of psychosocial supports' if there is no advanced structure in place.

A part-replacement for the phasing out of the National Psychosocial Support Measure should be prioritised as part of Draft Recommendation 12.3 in a proposed psychosocial disability and mental illness stream to be rolled out across all NDIS sites at the end of 2020. This is a viable recommendation to allow pre-evaluations of trials in South Australia and Tasmania⁶⁵ with room to improve before releasing to people with psychosocial disability, mental illness and their representative community organisations who are ineligible or choose not to access the NDIS by the end of 2020 and ongoing. If the reform is to be based on evidence-based outcomes, trial and evaluation needs to be at the forefront to ensure people are well equipped in options, choices and the transparency of changes.

⁶³ Federal Government has announced \$121.29 million for 12 months extra to ensure transition. See: House of Representatives Senate Estimates Hansards, 5th April 2019, p.30

⁶⁴ Productivity Commission (2019) *Draft Recommendations and Findings: Draft Recommendation 12.2 – Guarantee Continuity of Psychosocial Supports*, p.69

⁶⁵ Ibid. Draft recommendation 12.3 – NDIS Support for People with Psychosocial Disability.

Recommendation 15: The phasing out of the National Psychosocial Support Measure should be prioritised as part of Draft Recommendation 12.3 in a proposed 'psychosocial disability' stream to be rolled out across all NDIS sites at the end of 2020 to allow pre-evaluations of trials and evaluations.

Combining the Disability and Mental Health Workforce

We argue that there is currently an immature market framework under the NDIS – that is already well known, acknowledged and possibly burnt to a crisp where awareness is concerned. The NDIA also appears to be working in isolation and not building on existing service delivery models, which in turn, falls back into the disability advocacy organisations where capacity is overflowing. The availability individual advocacy is narrow and based on the severity of individual cases.⁶⁶

This is not surprising where the Joint Standing Committee has pointed out “there is currently no clear national strategy to grow the workforce despite the need for an additional 70 000 disability workers by 2020”.^{67 68} The Mental Health Community Coalition ACT referred to it perfectly as a ‘90/10 paradox’⁶⁹ in describing that mental health services can only afford to employ people with a lower qualification and expertise to provide NDIS services to the 10% of people with ‘complex, severe and enduring disability’ as the most experienced mental health workers leaving the sector to pursue better resourcing, client capacity and achieve recovery outcomes.⁷⁰

Both the disability and mental health sectors need interconnecting as both sectors are becoming increasingly blurred where disability, mental health and occasionally, aged care are in need of trained, trauma-informed and support specialised skills when working across a range of different support needs where diagnostic can be dual.

Recommendation 16: The need for the NDIS workforce to grow is paramount and the number of NDIS providers will need to increase to create balance and support choice, control and individualisation of services. The NDIA needs to create a national strategy between Commonwealth and State and Territory governments in addressing and improving the disability and mental health workforces.

⁶⁶ Productivity Commission 2017, National Disability Insurance Scheme (NDIS) Costs, Position Paper, Canberra, p. 34

⁶⁷ Joint Standing Committee on the National Disability Insurance Scheme (2018) Market readiness for provision of services under the NDIS.

⁶⁸ JSC NDIS, Progress Report, March 2019, pp. 67–130

⁶⁹ Mental Health Community Coalition ACT (2019) *Submission to the Productivity Commission inquiry into the social and economic benefits of improving mental health*, p.8

⁷⁰ *Ibid*, p.19-20

Recommendation 17: The National Mental Health Workforce Strategy also be extended to knowledge of psychosocial disability and mental illness and due to the NDIS and cross-sector reliance.

PRESSURE ON THE ADVOCACY SYSTEM

Since the introduction of providing funded NDIS-based advocacy on top of general advocacy provided,⁷¹ AFI has mapped a steady increase since the introduction of the NDIA in opening the NDIS to mental health. We strongly support and acknowledge Draft Recommendation 12.2 in commitment to if an individual chooses to apply for the NDIS, they should continue to be supported during the application process. However, without appropriate funding and resource, there is little capacity for advocacy organisations to do this.

In the ACT, planning and assistance regarding the NDIS have been the responsibility of Feros Care, an organisation funded and supported by NDIA to provide Local Area Coordination (LACs) to the ACT. However, there remains confusion and disparity as to the responsibility of the community organisations as to how much support we provide an individual unfunded before referring to Feros.

Currently, people with disabilities approaching AFI to seek support and assistance in navigating NDIS paperwork and requests is one of the most significant types of enquiries received.⁷² However, AFI is not funded to provide this support adequately or separately from the NDIA or FerosCare in the ACT – yet there is an expectation that this is 'advocacy' and 'support'.

Assisting individuals with NDIS pre-planning or review paperwork has fundamentally cut into the time and capacity of the advocates' availability on low funding. Issues uncovered from advocates when agreeing to assist a client with their NDIS pre-planning or review assessment have varied from guardianship constraints which the individual would like to exercise their self-determination in their plan review, child protection and family support, justice interfaces, housing modifications or equipment to live independently but need to be negotiated and so forth. As a resolution, AFI assesses each case, accordingly, prioritising internal and external review cases and whether there is the equivalent of a hidden iceberg of other issues lurking underneath and not identified in the initial intake. We use the analogy of peeling an onion: on the surface of an intake referral it is not measurable to tell how substantial the caseload may be until the onion layers are peeled to reveal deeper and more complex issues.

⁷¹ AFI provides individual case-by-case advocacy, self-advocacy development and systemic policy advocacy from the ACT.

⁷² Echoes view of Commonwealth Ombudsman: "In several locations, we were concerned to find that many participants, and even key support organisations (like advocates, peak groups and peer support groups), were not aware of the availability of LACs to assist with pre-planning work, plan implementation and/or to provide referrals to mainstream services", Submission by the Commonwealth Ombudsman (2017) Response to Productivity Commission's Issues Paper, '*National Disability Insurance Scheme Costs*', p.7

There is a continuous expectation and assumption advocacy organisations will assist to plug those gaps. Ideologically, this is possible as AFI cannot effectively deny advocacy to a growing number of people with psychosocial disability and mental illness who are both NDIS participants and those found ineligible. The NDIA also appears to be working in isolation and not building on existing service delivery models, which in turn, falls back into the disability advocacy organisations where capacity is overflowing, and the availability individual advocacy is narrow and based on the severity of individual cases.⁷³

We strongly support the Draft Recommendation 16.7 to ensure that non-legal individual advocacy organisation is available for all individual subject to involuntary treatment under mental health legislation. The dot points consider that all services should focus on facilitating supported decision-making by individuals subject to orders and be resourced to provide assistance to those who require it. Although this is welcomed, there is also difficulty in its implementation and realism as AFI already extend our advocacy services to people who identify with a psychosocial disability and mental illness.

Funding – Support for the Rebuild Model

Under the Draft Recommendation 23.2, AFI strongly agrees that each State and Territory, in our case: the ACT, take on sole responsibility for commissioning psychosocial and mental health carer support services outside of the NDIS. Structural reform is absolutely necessary to reform the architecture of Australia's mental health system and responsibility for mental health funding to be better utilised. AFI supports and recommends the Productivity Commission proceed with the Rebuild Model.

The proposed governance arrangements are appropriate. In particular, AFI welcomes the prospect that the administration of the Regional Commissioning Authorities (RCAs) would 'overcome unnecessary and inefficient care discontinuities, duplication and gaps that would otherwise persist at the interface between Australian Government and State and Territory Government responsibilities'.⁷⁴ This is a prioritised need. Pooling of funding payments from RCAs to allocate towards mental healthcare under the Commonwealth Reform Agreement would be welcomed to ensure full funding transparency.

The NDIS is currently dedicated to a funding model, with limited flexibility, and AFI believes there is a place where the RCA's can play a role to close the interface gaps between NDIA and the State and Territory health, justice, education and housing systems. There is also conflict where the NDIA is not only the funder but also holds a view of the appropriate funding model that it expects from

⁷³ Productivity Commission (2017), *National Disability Insurance Scheme (NDIS) Costs, Position Paper*, Canberra, p. 34

⁷⁴ Productivity Commission (2019) *Draft Report Vol. 1*, p.45

its jurisdictions. Moving to a fee-for-service and paid from individual packages raises the question of whether it is appropriate to use the individual plan model that may work for some participants but may worsen for others who have limited funding or are ineligible for NDIS funding.

Currently a partnership approach between the ACT Government providing the service and the NDIA funding, which is being implemented to support areas of the service delivery system under health that the ACT system any otherwise struggle to fund. From 1st July 2019, the NDIA will fund public rehabilitation, aged and community services in the ACT under Canberra Health. From here, consumers will need funds allocated in their NDIS plans to pay for these services as the funding model switches from 'in-kind' to a 'fee for service' model. Consumers are being told through a promotion that supports can be still supplied; however, without funds pre-allocated or approved in their NDIS plans. As a government entity under ACT Health, Canberra Health Services is now an NDIS Service Provider. Is this interface a conflict of interest with a jurisdictional government entity becoming an NDIS service provider and will it plug gaps?⁷⁵

Existing state and territory government processes that arise in crisis and emergencies that will cease despite the absence of formal arrangements under the NDIS is a concern as transparency is a loss.⁷⁶ Without key services that can respond to emergency crises and have expertise in linking people with complex needs to providers and services, there will be consequences where people continue to be placed in environments in which they will be stuck. The NDIA has not placed triaging systems in place to address urgent cases.

The NDIA, which has fundamentally changed previous state and territory previous funding and service structures, should be revisiting the way state and territory services used to operate in emergencies to ensure that the individual is well placed and not left in limbo. From an advocacy perspective, there appears to have been no process to ensure the provision of adequate, equipped

⁷⁵ *House of Representative Senate Estimates Hansard* 5th April 2019, p.114, regarding NDIS: "Senator WATT: So about 25 per cent of those 300,000—let's say close to 80,000 people—are waiting more than three months to receive services after, on average, waiting three months to get a plan. Then add the period of time between them first putting a form in and getting a plan.

Mr De Luca: Yes. There are two things. The first thing is that this is for payments that we make out from providers which are not in-kind arrangements. As part of the bilateral agreements with the states and territories, there were many services that continued provision of services from government organisations, which are provided in kind. Those have just continued, so the participant doesn't need to manage the activation of those. So there is a slight nuance here: there will be certain participants—in many cases in accommodation—who are continuing to get services from previous state or territory systems. So they're not getting those services; that is the first thing. The second is that there will be mainstream and community services that participants could be continuing to receive as well, which they are not paying for or are getting through other state systems.

Senator WATT: I suppose I worry, and even this conversation makes me worry, that there always seems to be a focus on data, processes and KPIs where you have them, rather than a really people-centred approach that acknowledges the emotion involved here and treating people decently."

⁷⁶ Ms Edwards in *House of Representative Senate Estimates Hansard*, 5th April 2019, p.31: "Some of our funding is for infrastructure and some of it is for a mix, but that depends on the arrangements between the jurisdictions. This is not uncommon—about how this would go. In some jurisdictions they may not need any infrastructure, and the convention that the Commonwealth will provide infrastructure and the jurisdiction will provide the staff may not apply. As we've indicated, from the department, it can't be a cookie cutter approach. Everybody's in slightly different circumstances. Some of our funding is for infrastructure and some of it is for a mix, but that depends on the arrangements between the jurisdictions. This is not uncommon—about how this would go. In some jurisdictions they may not need any infrastructure, and the convention that the Commonwealth will provide infrastructure and the jurisdiction will provide the staff may not apply. As we've indicated, from the department, it can't be a cookie cutter approach. Everybody's in slightly different circumstances".

services that manage crisis intervention and emergency service as there is no direct market and the system ultimately relies on state and territory governments. This is where the Rebuild Model would be beneficial to create strong incentives to invest in prevention, crisis management and avoiding hospitalisations.

The difficulty is also weighted with the pressure and misassumption that disability advocacy organisations should be responsible for picking up the slack where there are little to no resources in the mental health sector. There is currently no individual advocacy support for people with psychosocial disability and mental illness in the ACT mental health sector. Since the NDIS rollout, individuals have been encouraged to reach out to AFI and ADACAS as individual advocacy organisations, creating pressure and further gaps where the disability and mental health sector has been 'separate' for several years. The ramifications of increased need for advocacy support have led AFI staff to quickly be trained, informed and aware of mental health and build expertise quickly. With high and complex clients, suicide prevention and trauma informed training has been prioritised and accelerated.

Recommendation 18: In support for Draft Recommendation 23.3, structural reform is necessary. Mental health funding needs to be interjected into disability advocacy organisations to ensure employment of individual advocates who are experienced and trained in mental health, crisis intervention and trauma informed care.

Recommendation 19: Further funding is needed to supply additional resources to advocacy organisations if advocates are picking up the pieces when it comes to highly complex mental health situations.

Rebuild Regional Australia

We recognise the major changes that the mental health system will face in how it is governed and funded under the Rebuild model.

There is a concern that regional Australia will be receive the benefits of the Rebuild model slower than their metropolitan counterparts, despite the strong Draft Recommendation 23.3 indicating structural reform is necessary. In the Draft Report, there was a single chapter dedicated to living in regional and remote areas that equated to 3 paragraphs⁷⁷, but did not detail the urgency and importance of regional and remote mental health and suicide nor a focus on services and advocacy in regional areas, barely scratching the surface of the issue despite numerous submissions made prior to the Draft Report by regional and remote focused organisations.

⁷⁷ Productivity Commission (2019) *Draft Report Volume 1: Inquiry Background and Approach*, p.165-168

This is now an empty void where services are not readily available to assist in urgent situations where mental health is prevalent and places additional strain on disability advocacy organisations which are more in numbers than mental health advocacy supports and services. It is essential that the RCA's, focusing on closing interface gaps in health, housing, education and justice, include disability funded advocacy organisations to assist in closing the gaps where advocacy is needed in regional and remote areas and how best, to assist in crisis intervention where needed.

There is currently no individual advocacy support adequately available in regional Australia that allows for travel between regional towns and cities. AFI has a complex situation of housing recently which emphasises the need for regional Australia to have a separate focus:

Case Study

A client that is not in AFI's catchment area was referred by a regional real estate agent in Yass, New South Wales, seeking individual advocacy support to assist with a housing eviction. The real estate agent had exhausted all options to find emergency housing and the landlord wished for the individual to be removed due to unpaid rent. The client had a high and complex mental illness.

AFI assisted the client and real estate agency to find an individual advocacy organisation within the regional area. Upon calling four organisations close to Yass, organisations cited they were either not 'funded' to attend regional areas outside their catchments unless it itemized to a specific focus (i.e. aged care), were 'overcapacity' or those unaware that Yass and its surrounding areas was within their advocacy commitments said it was 'too far'. It became apparent that there is no individual advocacy of disability or mental health was available within 340km radius or available between Canberra and Albury/Wodonga.

Case Study – cont.

The client has since been evicted without a solution to their situation. AFI, as an individual advocacy organisation, was at a limited position to assist but uncovered a gap that created more restriction on the client, the referee and our organisation to assist. Upon further investigation of services available, it was found that the ACT currently has ONE individual advocacy organisations for mental health, disability and aged care but did not cover the Yass or surround areas in which the client was in.

Under the RCA model, it is expected that the Federal Government and State and Territory Governments will work constructively to ensure greater regional control and responsibility for mental health funding in regional and remote areas to close gaps.

There is a need for regional planning, rather than a top-down approach from Government and a focus on community needs as well as communities to be involved in the design of services they require, need and can deliver. AFI recognises a priority area of the *Fifth National Mental Health and Suicide Prevention Plan* 'Achieving integrated regional planning and service delivery'⁷⁸ seeks to achieve a unified mental health system by undertaking joint regional needs assessment, development of regional plans and examining funding models that would best fit regional service delivery to bridge gaps. Whilst the trials and evaluations are yet to be completed by mid-2020⁷⁹ on mental health and suicide prevention across Australia (metro and regional), the NMHC, in its new role as the national body for mental health and suicide prevention evaluation will need to assess if these evaluations provide adequate evidence that a systems approach is likely to be successful. If so, this approach should be implemented across all Australian regions, but a separate, focused approach needs to be provided to regional and remote community needs.

Recommendation 20: National Mental Health Council (NMHC) will need to assess if the current evaluations on mental health and suicide prevention provide adequate evidence that a systems approach is likely to be successful. If it does, a separate, focused approach needs to be provided to regional and remote communities and another specific to metropolitan, due to differences in the geographical and socioeconomical needs of communities.

There is concern that regional and remote areas that require much attention will continue to miss out, due to the lack of advocacy availability or assistance organisations placed in regional areas. This is considering gaps in the availability and funding of adequate and accessible clinical services and effective mental health, suicide prevention and intervention programs, to meet local level demand. It will be the responsibility of the RCA in each State and Territory to include regional areas in their funding allocation but there needs to be a specific and separate model included to ensure regional areas remain a priority.

Recommendation 21: The Productivity Commission should consider focusing on just regional and remote Australia as part of the Rebuild Model to ensure regional and remote towns and surrounding areas are included. The RCA is to include regional areas in their funding allocation but create a specific and separate model included to ensure regional areas remain a priority. This must include disability and mental health advocacy approaches.

⁷⁸ COAG Health Council (2017) *The Fifth National Mental Health and Suicide Prevention Plan*, Adelaide.

⁷⁹ Productivity Commission (2019) *Draft Report Volume 2: Suicide Prevention*, p.869

INCOME SUPPORT

In Australia, people with disability are nearly twice as likely to be unemployed as people without disability.^{80 81} We acknowledge that Newstart is a tax-funded allowance that provides a safety net for people whilst looking for employment and has increased twice a year each year in line with the Consumer Price Index (CPI). Yet, the demand to raise the rate of Newstart is not new, and it is disappointing that continuous campaigning from grassroots advocacy organisations, that work with people on the ground and are privy to stories of poverty, inactive job service providers and choice over basic living necessities, are still being reproached by the Federal Government.⁸²

For people with disability, including psychosocial disability and mental illness, finding continuous and engaging employment can be difficult when navigating limited job prospects, transport, equipment and support. The notion of the Federal Government's claims that 'the best form of welfare is a job',⁸³ is a utopian notion at best, particularly when the current systemic barriers for people with disabilities living on Newstart and related payments are profoundly inadequate. The barriers to employment for people with disabilities have always been high, and jobs are not suited to their wellbeing, capacity and genuine health setbacks. Many people continue to be stuck on Newstart as a form of welfare as the DSP is restrictive in criteria.^{84 85 86}

The changes to the eligibility processes of the DSP, shifting people onto Newstart and related payments, have further complicated the process of sourcing employment. Furthermore, additional support is not a prerequisite for Jobactive providers to deliver – people with disability are treated the same as everybody else and given no special treatment – thus people with disabilities are on Newstart far longer than necessary and are condemned to long-term unemployment.

Regarding Information Request 14.2, AFI supports the proposal of increasing the weekly hour limit above which no DSP is payable from 30hrs to 38hrs, but retaining the requirement that a person will lose eligibility for the DSP if they work for more than 30 hours per week for more than two years.⁸⁷ We agree with the Productivity Commission's view that it would be ideal for the income support system to more flexibly support people with episodic mental illness by enabling them to transition on and off income support as their health needs change,⁸⁸ but recognise that the two

⁸⁰ Australian Bureau of Statistics (ABS) (2012), Disability and Labour Force Participation, cat. 4433.0.55.006.

⁸¹ Australian Human Rights Commission (2016), *Willing to Work: National Inquiry into Employment Discrimination Against Older Australians and Australians with Disability*; ISBN 978-1-921449-76-5

⁸² See Advocacy for Inclusion (2019) *Adequacy of Newstart and related payments and alternative mechanisms to determine the level of income support payments in Australia*, Submission.

⁸³ Prime Minister, Scott Morrison in *APH House of Representatives Hansard*, 29th July 2019, p.44

⁸⁴ Mesén Vargas, J, & Van der Linden, B, (2018). *Is there always a trade-off between insurance and incentives? The case of unemployment with subsistence constraints*.

⁸⁵ O'Campo, P, et al., (2015). Social welfare matters: A realist review of when, how, and why unemployment insurance impacts poverty and health. *Social Science & Medicine* 132:88–94.

⁸⁶ Meyer, Bruce D., and Wallace, KC Mok. 2018. "Disability, earnings, income and consumption", *Journal of Public Economics*, <https://doi.org/10.1016/j.jpubeco.2018.06.011>

⁸⁷ Draft Recommendations and Findings, p. 74

⁸⁸ Productivity Commission, *Draft Report Overview & Recommendations* (2019) p. 39.

year timeframe is reasonable for other individuals who have steady, ongoing employment and a supportive workplace. Ongoing development of employment initiatives will need to further consider the fluctuating needs of participants with psychosocial disability and mental illness.

In addition, if an individual needs to go back onto the DSP after two years, consideration must be reviewed for the present circumstances of the individuals, not reliant on (previous capacity to sustain meaningful employment) information.

It is anticipated that will need to fit in with the incentives Reform Area 4 to 'reconnect people with mental illness into workplaces... to improve workforce participation and reduce future reliance on income support'.⁸⁹ In addition, we support that mental health should be 'explicitly included in workplace health and safety, with codes of practice for employers developed and implemented'⁹⁰ to ensure a breakdown in workplaces where inflexible structures, stigma and unawareness of mental health can be a factor to people with psychosocial disability and mental illness reconnecting with the workforce.

The issues that require breakdown is further encompassed when Newstart requires 20 jobs to be applied for in a month⁹¹ with no flexibility or understanding of circumstances as to why training is incomplete, and jobs are wholly unsuitable to the individual, even though jobseekers in Disability Employment Services (DES) is dependent on their capacity. ACOSS and Jobs Australia found that only 32% of people with disability in 2017 were successfully employed after participating in Jobactive after 3 months.^{92 93}

Case Study

Adam was on Newstart, but with the assistance of an AFI's advocate, he attended an assessment that determined him to then be suitable for the DSP as he had trouble meeting the job search requirements due to his health and mental health.

Adam, with mental health/dual health issues, struggled to pay for his ongoing mental health and medical treatments on top of daily living requirements. He would forgo his medication above his rent, food and utility bills.

⁸⁹ Draft Recommendations and Findings, *Reform Area 4: assistance for people with mental illness to get into work and enable early treatment of work-related mental illness*, p.3

⁹⁰ Ibid

⁹¹ Australian Government (2019) Job Search – Setting Job Search Requirements – General, *Social Security Guide*, v.1.257.

⁹² ACOSS (2018) *Faces of Unemployment: Figure 14: Proportion of people employed 3 months after participating in jobactive during 2017*, Australian Council of Social Service and Jobs Australia, p.5

⁹³ Department of Jobs and Small Business (2018) *The next generation of employment services*, Appendices.

Case Study – cont.

Adam's employment prospects were dismal as job agencies and services could provide minimal support to him. Staff were also untrained and inexperienced in working with people, like Adam, with complex needs and additional support requirements. This made matters worse for Adam in accessing employment that was right for him, as well as safe, supportive and within his skill capacity.

In our experience, job agencies and services⁹⁴ offer little support to people with disabilities and complex needs that cannot fill standard employment positions such as cleaning, support work, machinery or administration.⁹⁵ The Federal Government's focus is on 'helping people move from welfare into work' by 'driving growth in the economy and generating jobs'⁹⁶ yet the reality of people with disabilities trying to access an appropriate role is dire when the number of roles suited is dismal.

Ensuring that people with disability enter positions that interest and motivate them is crucial if it is expected that they work. In our experience, we have found positions that are offered by DES or Jobactive are inappropriate to people with disabilities, driving low skill development, causing further demoralisation, lack of motivation to continue and low self-esteem.

Training organisations also don't provide alternative learning styles or assessments for people with disabilities, causing drop-out rates and incomplete training development due to training staff being untrained and ill-resourced to work with people with disabilities and mental health.⁹⁷ Trainers are disinclined to provide or seek reasonable adjustments for individuals, thus remaining ignorant to mental health needs and options due to the 'invisibility' of mental health.

We strongly support dot point 2 to assess more systemically whether employment providers are meeting their obligations to provide personalized Job Plans that go beyond compliance, targeted at job seekers with complex needs. There is a profoundly strong need to assess employment providers. We recommend this accountability measure to ensure that job service providers are stringently tested across the board to guarantee more robust and rigid compliance, monitoring and reporting against obligations and outcomes.

⁹⁴ Employment programs accessed by clients of AFI include Disability Employment Services, Community Development Program (for remote Aboriginal and Torres Strait Islander communities), wage subsidies, Transition to Work (for young early school-leavers), and Youth Jobs PaTH (for young unemployed people)

⁹⁵ AFI looked at the jobactive websites to check highest mentioned positions on offer by job agencies and services – these were the top results.

⁹⁶ APH House of Representatives Hansard, 31st July 2019, p.48

⁹⁷ APH (2019) *Jobactive: failing those it is intended to serve: Final Report*, Commonwealth of Australia

It also appears that the Draft Recommendation 14.4 is more focused on the service providers being able to achieve their KPIs and obligations to provide Job Plans rather than placing the person first and centered in their job search. AFI has seen firsthand the impact that of NDIS planners refusing to make small changes to NDIS plans in short amount of time, not allowing the person with disability flexibility or fairness within a reasonable timeframe. Two days for 'more complex needs' is not a reasonable amount of time nor a fair expectation.

Recommendation 22: We recommend the Draft Recommendation 14.4 dot point 2 to be prioritised in the short term to guarantee that job service providers are stringently tested across the board to ensure more robust and rigid compliance, monitoring and reporting against obligations and outcomes.

This said, we profoundly reject dot point 3 of the Draft Recommendation 14.4 for income support recipient's mutual obligation requirement. The proposed two days is an incredibly short amount of time and for people with 'more complex needs' they will require more time, more consultation and more flexibility under the Targeted Compliance Framework. Episodic fluctuations and crises in mental health can often last for days-weeks and are unpredictable at best. Given the purported long term aims (to find long-lasting employment) individuals should be given more than two days to review their mutual obligation, but at least have seven to ten days as a benchmark for the provider. At best, two days is unrealistic and more likely punitive.

Recommendation 23: Amend and remove extending the period that job seekers with 'more complex needs' have to consider and propose changes to their Job Plan beyond two business days. It is recommended that seven or ten days is more appropriate.

JUSTICE SYSTEM

AFI has been heavily involved in disability justice advocacy and welcomed the release and commitment of the ACT Disability Justice Strategy in mid-2019. We have been also highly involved in the ACT Healthy Prisons Review to ensure ACT prisons and remand complexes remain as human rights compliant as they claim to be to assist detainees' rehabilitation, integration to society and their ongoing support needs. To capture the number of detainees with disability, including psychosocial disability, the ACT Inspectorate of Corrective Services (ICS) conducts a self-identifying survey to capture data of disability where the ACT Corrective Services do not.

There remain significant issues with legislative, policy and practice frameworks which remain unfair and unethical to people with psychosocial disability and mental illness across Australia.

There are at least 100 people detained across Australia without conviction in prisons, psychiatric units and forensic detention services under the 'mental impairment' legislation.^{98 99}

At the 2016 UPR129, Australia made a voluntary commitment¹⁰⁰ to improve the way the criminal justice system treats people with psychosocial disability and mental illness who are unfit to plead or found not guilty by reason of mental impairment. In 2016 Australian Governments¹⁰¹ tabled the *Draft National Statement of Principles Relating to Persons Unfit to Plead or Found Not Guilty by Reason of Cognitive or Mental Health Impairment*. However, three years later, these Principles are yet to be consulted on, endorsed or implemented. The Australian Senate also tabled its *Inquiry Report into the Indefinite Detention of People with Cognitive and Psychiatric Impairment in Australia* in 2016.¹⁰² The Australian Government is yet to respond to the Report.

Recommendation 24: For full reform of prevention and early intervention mechanisms to reduce contact with the criminal justice system, the Australian Government needs to revisit and review the *Draft National Statement of Principles* and a response to the *Inquiry Report into the Indefinite Detention of People with Cognitive and Psychiatric Impairment in Australia*. Both documents are integral to the changes to be made to improve the way the criminal justice system treats people with cognitive or psychosocial disability who are deemed unfit to plead or found not guilty by reason of 'mental impairment'.

Under Draft Recommendation 15.2, we strongly support dot point 1 that each State and Territory should commit to a nationally consistent formal policy of no exits into homelessness for people with psychosocial and mental ill health who are being discharged from institutional care, including hospitals and prisons. We support dot point 2 that the people with mental illness who exit institutional care receive a comprehensive mental health discharge plan, with services to meet their needs. From a justice perspective, these programs must integrate care coordination and access to accommodation upon release.

Recommendation 25: Implement and action Draft Recommendation 15.2 dot point 1 and dot point 2 as a matter of priority, to stop gaps upon discharge from institutional care back into the community.

⁹⁸ Commonwealth of Australia (2016) *Senate Standing Committee on Community Affairs, Report: Indefinite detention of people with cognitive and psychiatric impairment in Australia*.

⁹⁹ Persons found not criminally responsible due to mental impairment or diagnosed with severe mental disabilities and/or mental health conditions requiring inpatient care are transferred to mental health facilities where appropriate mental health supports and responses can be provided'. Human Rights Standards for the ACT Corrective Services Paper, *Detainees with severe mental health conditions*, p.4

¹⁰⁰ See: Human Rights Law Centre, Australia's 2nd Universal Periodic Review: Voluntary Commitments. See also: Law Council of Australia, Australia's International Human Rights Obligations.

¹⁰¹ The former Law, Crime and Community Safety Council (LCCSC) consisted of ministers with responsibilities for law and justice, police and emergency management. As a result of a Council of Australian Governments (COAG) review conducted in 2016-17, COAG decided to replace the LCCSC with a separate Councils for Attorneys-General, and a separate Council for Police and Emergency Management.

¹⁰² Commonwealth of Australia (2016) *Senate Standing Committee on Community Affairs, Report: Indefinite detention of people with cognitive and psychiatric impairment in Australia*.

Police and Crisis Responses to Mental Health

AFI has a collaborative working relationship with ACT Police and works to raise awareness of disability, create resources¹⁰³ under the ACT Disability Justice Strategy to foster understanding between individuals and police, and is committed to deliver ongoing training.

Police are often the first responders to people experiencing mental health crises or acute symptoms of mental illness. While police do not provide direct mental health services, they are an important part of the broader service system response for people living with mental illness. Too often police are not just the first response, but the only response.

Some of the issues which arise for clients from police responses to mental health crises include the criminalisation of mental illness, overrepresentation of people with mental illness in the criminal justice system, escalations of situations, assault against police, and injury and fatality for people with mental illness.¹⁰⁴ A police response to a non-criminal event also raises issues of dignity of the person involved.¹⁰⁵

These issues are more concerning again in relation to young people, who have raised concerns about 'how the police have treated them/themselves/friends when in a state of mental health crisis,' as 'ACT Police have been reported to exacerbate mental health crises in some instances, rather than calm them.'¹⁰⁶ Police responses to young people experiencing mental health crisis raise further concerns of vulnerability, early contact with the criminal justice system and stigmatisation.

Case Study

Peter has autism and mental health diagnosis. He was at his local shopping centre playing Pokémon Go. He had earlier sent his mother another text message with reference to suicide which he admits doing when he wants attention. His mother then contacted the police who later saw him leaving the shopping centre.

¹⁰³ AFI has developed, in conjunction with ACT Police, a Police Wallet Card in Easy English format as a resource for people with disabilities to interact positively with police when approached. On the flipside, there is information for police of contacting advocacy organisations to assist in communicating with the individual or providing support. The Wallet Card has been highly regarded as a positive resource and is available from AFI in batches upon request.

¹⁰⁴ Office of Police Integrity, Victoria, *Policing People Who Appear To Be Mentally Ill*, Parliamentary paper, session 2010-12, no. 190 p. 15.

¹⁰⁵ Mental Health Council of Australia, *Not For Service: Experiences of Injustice and Despair in Mental Health Care in Australia*, First Report, 30 March 2006, Commonwealth of Australia 2006, Canberra, 2005.

¹⁰⁶ Youth Interact, Youth Advisory Council, ACT Government, *Our Voice Our Impact 2018 ACT Youth Assembly Report* (2018) p. 12.

Case Study – cont.

When Peter saw the police, he took off his glasses so they would not recognise him. Peter advised that the police then approached him asking if he was Peter which he denied as he was worried what they would do as he had previous negative experiences with them. After some back and forth communication including Peter asking them to leave him alone as he isn't doing anything wrong, there was an altercation and the police proceeded to handcuff Peter and put him in their vehicle to take to the hospital out of concern for his mental health.

Peter arrived at the hospital very heightened and was put into a secure facility where he apparently waited hours to see someone from mental health. This case is ongoing.

Case Study

Sally has an intellectual disability and mental health which includes self-harming and high anxiety. After a brief relationship over Facebook after meeting at an employment agency, Sally decided to end the relationship as she was not feeling comfortable. Alex, who Sally had been texting, started sending her threatening and disturbing messages which impacted greatly on her mental health. With support, Sally was able to take out an interim protection order, however the threatening text messages continued.

With further support, Sally went to the police station to provide a statement. The police officer attending to Sally's report of Alex breaching the order and who had completed the required training to take statements from vulnerable people, proceeded to tell Sally that there is not much they can do as Alex also has a disability before explaining what support could be offered to her.

Upon hearing the first part of what the police officer said, Sally became highly anxious and proceeded to run out of the interview room into the police station where she was surrounded by other police officers with one officer distinctly putting his hand on his firearm.

The support person attending with Sally was able to defuse the situation and supported Sally to return to the interview room and finish the interview which included further discussions of what support could be provided and what measures could be put in place to ensure she is feeling safe.

Case Study – cont.

A positive outcome to the case study was the police officer called the AFI advocate directly to acknowledge that his reaction was immediate and impulsive. In addition, he thanked the support person for defusing the situation and stated that if she hadn't been there to support Sally, the situation would have been 'much worse'.

The impact of being first responders to mental health crisis must also be considered for police, who are put in the position of being exposed to traumatic, emotional and frustrating situations;¹⁰⁷ potentially without the skills, training or supports to inform their response. Further complicating the role of police is the context in which they are responding, of 'inadequate health service accessibility alongside the use of more rigorous legal standards for involuntary treatment.'¹⁰⁸

In support of Draft Recommendation 16.1, full support for States and Territories is needed to implement a support presence and alternative diversion point for police and other first responders similar to Queensland's model.¹⁰⁹ If all States and Territory Governments are supported by the Federal Government under the Rebuild Model to respond to mental health crisis situations in a coordinated matter, the outcome benefits would be enormous.

Recommendation 26: All States and Territories to provide mental health and disability training for police officers and police administration staff. Training to be mandatory as a cadet subject and ongoing throughout police career with refreshers over time. Training must be provided from a leading advocacy organisation, as they are frontline in circumstances between police and individuals and are best placed to provide comprehensive training and resources.

Mental Healthcare Standards

AFI strongly supports Draft Recommendation 16.2 and 16.3 to ensure mental healthcare standards are upheld in correctional facilities and on release. Under OPCAT, it is necessary that the Australian Commission on Safety and Quality Health Services Standards be appointed to ensure oversight, regulation and evaluation of practices. Rather than correctional facilities, this should

¹⁰⁷ Beyond Blue Ltd. (2018). *Answering the Call National Survey*, National Mental Health and Wellbeing Study of Police and Emergency Services – Final report P. 116.

¹⁰⁸ Office of Police Integrity, Victoria, *Policing People Who Appear to Be Mentally Ill*, Parliamentary paper, session 2010-12, no. 190 p. 16

¹⁰⁹ Mental health clinicians are co-located in the police communications centre, supported by an on-call forensic psychiatrist; mental health staff accompany police and provide on-site clinical interventions; and police, health and ambulance services partner to identify issues, discuss complex cases and develop preventative interventions, alternative referral pathways and review procedures. Productivity Commission (2019) *Mental Health Draft Report Vol.1*, p.23

also be applied to healthcare settings where people can be held in custodian facilities and transferred to healthcare setting under supervision.

Mental health care settings are not so clear-cut in relation to whether deprivation of liberty is or could be occurring. One example is geriatric wards in hospitals where wing doors may be secured to prevent patients from wandering. Palliative care units are also potentially relevant sites. It is not just a matter of whether a patient can, in theory, voluntarily discharge themselves from a hospital.

Several submissions to the Australian Human Rights Commission's Inquiry on OPCAT in Australia explicitly refer to hospital settings (beyond secure mental health units) as falling within the scope of the OPCAT, including emergency departments (where people present with mental health disorders, substance abuse issues, and a range of conditions that prohibit them from freely leaving). Detainees usually held in custodial facilities may be transferred to hospitals for treatment and are under custodial supervision during this time (usually escorted by custodial officers and handcuffed for some or all the time).

Recommendation 27: The Australian Commission on Safety and Quality Health Services Standards also to provide oversight, regulation and evaluation of practices to healthcare settings where people can be held in custodian facilities and transferred to healthcare setting under supervision.

Correctional Services

AFI has advocated for the ACT Correctional Services (ACTCS) facilities to reflect all adequate training of all criminal justice and healthcare professionals, as a fundamental requirement to ensure successful identification, safety, respect, management and community reintegration of detainees with disabilities and mental health.¹¹⁰ Correctional staff have acknowledged that they are not adequately trained on disability or mental health, nor on distinguishing between behaviour from lack of support and accommodation, particularly during crisis intervention.^{111 112}

Primary and mental health services are involved in the admissions process. They attend the admissions centre to assess each new detainee. These assessments are included in and attached to the initial questionnaire which assists staff to determine an appropriate placement for the

¹¹⁰ Ali, S. and Galloway, S. (2016) "Developing a screening tool for offenders with intellectual disabilities – the RAPID", *Journal of Intellectual Disabilities and Offending Behaviour*, Vol. 7 Issue: 3

¹¹¹ Human Rights Watch (2018), "*I Needed Help, Instead I Was Punished*": *Abuse and Neglect of Prisoners with Disabilities in Australia*, *ibid.*

¹¹² Bartels, L. (2011). "Police Interviews with Vulnerable Adult Suspects". *Research in Practice Report No. 21*. Australian Institute of Criminology, Canberra, ACT, p.13; Parliament of Victoria Law Reform Committee (2013) *Inquiry into Access to and Interaction with the Justice System by People with an Intellectual Disability and their Families and Carers- Final Report*. quoting the Submissions of the Legal Services Commissioner, Villamanta Disability Rights Legal Service, Victorian Advocacy League for Individuals with Disability Inc.

detainee. However, 57% of detainees surveyed reported that what they perceived to be urgent health issues were not dealt with at admission.¹¹³

The prison population is high with people with disabilities and mental health Australia-wide.^{114 115 116} In the ACT, 30% of detainees self-identified as having a disability.¹¹⁷ ACTCS does not currently systematically capture data on the prevalence of disability in the AMC. A question is asked on the induction form: do you have a disability? This relies on self-reporting. There is currently no question about whether someone receives a Disability Support Pension. Detainees may not be willing to self-report a disability or may not consider themselves to have a disability. They may never have been diagnosed with a disability or diagnosis may be complex. There may also be cross-cultural barriers to acknowledgement or disclosure.¹¹⁹

The ACT Inspectorate for Correctional Services agreed with the recommendation made by AFI¹²⁰ for ACTCS to adopt a practical screening method that applies to all detainees early in the admission process (thereby avoiding the issue of those not wishing to identify), that captures cognitive/intellectual disability, low-literacy and comprehension and independent living skills. This would appear to be the way forward. Assessment tools have been successful RAPID Assessment Tool in the UK or the Hayes Ability Screening Index (HASI) is necessary within the four healthy prison areas. Justice reform, as a human rights compliance, must seek a practical screening method that correlates aptitude and adaptive behaviour to capture cognitive/intellectual disability, psychosocial disability and mental illness, low-literacy and comprehension and independent living skills.^{121 122 123 124}

In our view, appropriate data capture should not wait for all resources to be secured first. Data can help understand the scope of the issue, assist with strategic planning and has relevance to multiple areas of ACTCS operations, including program and education design, recreation opportunities and staff training content. Good data can also inform options with low or no

¹¹³ ACT Inspector of Correctional Services (2019), *Report of a healthy prison review of the Alexander Maconochie Centre*, Canberra, p.34

¹¹⁴ Advocacy for Inclusion (2017) *Submission to: Senate Community Affairs Reference Committee Inquiry to address outcomes of National Disability Strategy 2010-2020*, http://www.advocacyforinclusion.org/Senate_CARC_Submission_to_address_outcomes_of_NDS_FINAL.pdf

¹¹⁵ Advocacy for Inclusion (2013) *Submission to the Australian Human Rights Commission: Access to justice in the criminal justice system for people with disabilities*.

¹¹⁶ Baldry, E. (2012) *People with Intellectual and Other Cognitive Disability in the Criminal Justice System*, Department of Families and Community Services NSW; NSW Law Reform Commission (2012) *People with cognitive and Mental Health Impairments in the Criminal Justice System: Diversion*, Report No. 135, NSW LRC

¹¹⁷ Dias, et al (2015) 'Co-occurring mental disorder and intellectual disability in a large sample of Australian prisoners', *Australian & New Zealand Journal of Psychiatry* 47(10)

¹¹⁸ Detainee survey results. ACT Inspector of Correctional Services (2019), *Report of a healthy prison review of the Alexander Maconochie Centre*, Canberra, p.96

¹¹⁹ Ibid

¹²⁰ Advocacy for Inclusion (2019) *Submission in Response to ACT Healthy Prison Review*, Canberra, p.2

¹²¹ Ali, S. and Galloway, S. (2016) "Developing a screening tool for offenders with intellectual disabilities – the RAPID", *Journal of Intellectual Disabilities and Offending Behaviour*, Vol. 7 Issue: 3

¹²² Hayes, S. (2000) *Hayes Ability Screening Index (HASI) Manual*, University of Sydney: Department of Behavioural Sciences in Medicine, Sydney.

¹²³ Gudjonsson, G.H. and Joyce, T. (2011), "Interviewing adults with intellectual disabilities", *Advances in Mental Health and Intellectual Disabilities*, Vol. 5 No. 2

¹²⁴ Sondenaa, E., Palmstierna, T. and Iversen, V.C. (2010), "A step-wise approach to identifying intellectual disabilities in the criminal justice system", *European Journal of Psychology Applied to Legal Context*, Vol. 2 No. 2.

budgetary implications, for example, working out areas where accessible communication is needed such as signage or easy English versions of handbooks etc.

The purpose of early screening allows for an initial comprehensive assessment in what supports should be provided. It is a practical suggestion of all detainees to undergo initial assessment to bypass the issue of people wishing not to identify with disability or mental health – it is applied to all detainees. Early assessments allow continuous oversight to provide supports and services within the prison and ensure accessibility requirements at the beginning of a detainee's prison experience and upon release. It is also cost-effective in determining how big the issue of disability and mental health is in a prison population and diverting costing to removing barriers, identifying appropriate rehabilitation and preparing detainees for release.

In addition, the ACT Government has highlighted challenges in relation to detainees that are on an NDIS package in the community, including regarding them receiving appropriate supports in custody and then connecting with appropriate supports on release.¹²⁵ Moreover, they have emphasised the need to improve processes around identifying and supporting detainees who do not currently have an NDIS plan, but may be eligible and benefit from an NDIS package post release, or other supports to transition out of prison and remand complexes. This needs to be accelerated if mental health reform is to be reliant on NDIS support for people with psychosocial disability and mental illness or through transition of new and emerging programs and supports for those found ineligible.

Recommendation 28: Given the lack of clarity around the interface between the NDIS and support for people engaged with the criminal justice system, there is a need to reconcile this between jurisdictions. The NDIA and mental health reform need to establish a unit specialising in the interaction with the criminal justice system for people with an intellectual disability, psychosocial disability and mental illness.

Mental Health Under OPCAT

AFI has been heavily involved in the national work surrounding OPCAT. The OPCAT has an instrumental place in the reforms for mental health. There are a range of civil and de facto places of detention in the ACT, and in other jurisdictions, that may fall under the scope of the OPCAT. These include mental health orders, mental health facilities, hospitals, aged care, community services and disability institutional settings.

¹²⁵ Office for Disability (2019) *Towards a Disability Justice Strategy*.

The OPCAT is a human rights treaty that requires State Parties to open all places of deprivation of liberty to independent monitoring, in order to prevent torture and ill-treatment. The OPCAT aims to provide a concrete and practical mechanism to fulfil the international prohibition against torture contained in the United Nations (UN) Convention Against Torture, which includes an obligation to take effective measures to prevent torture and ill-treatment.

New mental health reforms must include the OPCAT as a side-focus to ensure transparency and wholly independent-of-government agencies that create the policies in which the OPCAT fights against. Under Australia's obligations, the Commonwealth Ombudsman as the National Preventative Mechanism (NPM) must carry out preventive rather than reactive monitoring – and this must be carried through changes where oversight is required by the advice of the Productivity Commission. State and Territory NPMs, under the Commonwealth Ombudsman, must visit regularly to assess risk and then work collaboratively with service providers and units that detain individuals to provide recommendations that assess risk. NPM functions are focused on systemic issues and do not respond to individual complaints.

The ACT Government has not yet indicated potential NPMs that will be required to conduct preventive oversight of its places of deprivation of liberty. Yet AFI has noted in some instances, the boundaries between health and the criminal justice system may be porous and necessary of oversight as gaps are large. For example, people detained within the criminal justice system may at times receive treatment within a hospital and persons charged with criminal offences but deemed not mentally fit to plead may be detained in forensic mental health facilities without having been found guilty of an offence in the ACT.

Australia's Interpretative Declarations on Convention on the Rights of Persons with Disabilities (CRPD) Articles 12 and 17 allow for the continuation of guardianship and mental health laws that deprive people of liberty on the basis of disability and subject them to forced medical interventions, both in institutions and in the community. While there have been some reviews and amendments to these laws in the ACT, there has been no action to end involuntary internment based on disability or to end forced medical interventions. As a result, many people with intellectual, cognitive, psychosocial disability and mental illness experience serious breaches of their human rights in the ACT, that require NPM oversight at a jurisdictional level.

GOVERNANCE, RESPONSIBILITIES AND CONSUMER PARTICIPATION

The National Mental Health Commission proposed in their Vision 2030 paper¹²⁶ for a national agreement that is 'clearly defined and implementable through formal agreements(s) that outline

¹²⁶ National Mental Health Commission (2019) *The Vision 2030; Key Concept Consultation Paper*, Australian Government: Canberra, p.6

mental health funding, delivery and outcome responsibilities for all levels of government'. In the Draft Recommendations and Overview, there is currently 8 individual Strategies mapped for reform in short-term and long-term periods:

- The National Mental Health Workforce Strategy
- A Broader National Medical Workforce Strategy
- Student Mental Health and Wellbeing Strategy
- National Stigma Reduction Strategy
- National Suicide Prevention Implementation Strategy and proposed National Mental Health and Suicide Prevention Agreement
- Whole-of-Government Mental Health Strategy to integrate services and supports
- A Data Linkage Strategy for Mental Health Data
- Potential development of another Strategy just to fill data gaps (unclear)¹²⁷

This is a lot of 'strategies' within a reform agenda and they all interlock with each other. There is hope that independent strategy will produce outcomes, a way forward and not become a lost footnote of missing recommendations yet to be implemented. AFI strongly supports the whole-of-government Mental Health Strategy and hope that it would pull all State and Territories agreements and individual strategies into line to ensure that active contribution of outcomes, reporting of progress and transparency is high-standard.

AFI supports dot point 2 of the Draft Recommendation 22.1 for creation of a *National Mental Health and Suicide Prevention Agreement* that all stakeholder groups, including government, 'recognises the importance of separating funding and governance arrangements of mental health from those of physical health to strengthen the accountability of individual jurisdictions for mental health outcomes'.¹²⁸ This must include disability stakeholders who require a voice when providing advocacy for a sector that it never previously aligned to.

Dot point 4 of 22.1 proposes to introduce new 'funding and governance arrangements between both tiers of government for mental health services and supports, including the mechanism for establishing funding allocation'. We also support the Productivity Commission's preferred approach to the Rebuild Model which would establish 'Regional Commissioning Authorities' under Draft Recommendation 23.1. We support both proposed recommendations, however request that advocacy support funding be extended to include disability representative organisations under both as a clause to recognise the role of non-health supports in psychosocial supports and to create clear and transparent performance reporting requirements to ensure outcomes are central.

¹²⁷ Draft Recommendations and Overview, p.109

¹²⁸ Ibid, p.99

Recommendation 29: Advocacy support funding be extended to include disability representative organisations under both as a clause to both 22.1 and 23.1 to recognise the role of non-health supports in psychosocial supports and to create clear and transparent performance reporting requirements to ensure outcomes are central.

We wholly agree with the Draft Recommendation that COAG should amend the terms of reference of the COAG Health Council to enable other COAG Councils to come to the table in a whole-of-government approach to mental health. This includes disability representation of people with psychosocial disability and mental illness within the NDIS. We also argue that this approach is instrumental in closing the gap between the NDIS and health interface in which people with psychosocial disability and mental illness continuously get trapped within. We also see alarming cases of people being admitted to hospital, healthcare or aged care facilities and not being released (or placed under guardianship arrangements) due to lack of support staff available to assist daily.

Within these practices, AFI can attest that handover processes are lacking or unprovided, compromising the care and support of the individual. Despite participants being eligible and having access to NDIS, the question of what happens when sudden care changes occur, and they cannot be cared for in their own homes remains pertinent. Without the NDIS and limited care options available in the community for family or providers, there has been no choice but to admit them to a hospital or an institutional setting arrangement.

If the NDIA does not have the capacity nor the willingness to actively respond to crises in jurisdictions, including the ACT, that actively requires the health system to intervene, how can they actively develop a 'service response' in time and with a limited capacity of staff? The COAG Health Council opening conversation of this matter would nip the issue in the bud faster than individual conversations twirling around the Strategy itself.

Recommendation 30: COAG should amend the terms of reference of the COAG Health Council to enable other COAG Councils to come to the table on a whole-of-government approach to mental health. This needs to include disability representation of people with psychosocial disability and mental illness with the NDIS.

The building of a stronger evaluation culture is critical to the governance, responsibilities and consumers responsibility in the overall whole-of government approach. For mental health reform, it has been sorely needed and overdue. With transparency and progress, it is necessary to allow consumers and carers to have the opportunities to participate in the design of government policies and the Strategy itself under Draft Recommendation 22.3.

We support Draft Recommendation 22.4 in that the COAG Health Council must agree on a set of targets that specify key mental health outcomes that Australia should achieve over a defined period. Involvement with consumers and carers is instrumental to this as well as ongoing collaboration with mental health and disability organisations that provide advocacy support to get to the root of the issues in order to define targets that are ongoing.

We also welcome the recommendation that the National Mental Health Commission should be responsible for the monitoring and reporting of the Strategy's implementation annually, under Draft Recommendation 22.2 and in line with 22.5. We support the entire Draft Recommendation of 22.5, however recommend that that the NMHC work alongside the Commonwealth Ombudsman, the national NPM, and include OPCAT as part of their evaluation, monitoring and reporting of closed mental health institutional settings as a interjurisdictional statutory authority.

Recommendation 31: The NMHC to also be given side responsibility under the Commonwealth Ombudsman to provide monitoring, regulation and oversight of mental health facilities under Australia's obligation to OPCAT.

MONITORING, REPORTING AND EVALUATION

In support of the NMHC responsibility to monitor and report the whole-of-government Mental Health Strategy and the preferred Rebuild Model, AFI strongly supports Draft Recommendation 25.2 that the Australian Government support the ABS in conducting a National Survey of Mental Health and Wellbeing no less than every 10 years. This survey must also include psychosocial disability and mental illness as a 'vulnerable population sub-group'.¹²⁹

AFI is trying to remain practical in understanding the economic ramifications that an overhauled mental health reform in Australia would require. We are also cognisant of the changes to current monitoring, reporting and evaluation practices required to achieve such reform. A difficulty in mental health reform is the lack of linked and collected of data that can highlight a benefit of increased spending on mental health. As community care interventions can reduce hospitalisations, quantifying the savings can be difficult as there is no transparent linkage of patient of funding data across various settings.¹³⁰

In addition, social determinants of health are well established but there remains no linkage of data across wider social jurisdictions such as health, education, housing/homelessness, community support programs, advocacy, justice and income support where the benefits of mental health

¹²⁹ Draft Recommendations, p.108

¹³⁰ KPMG and Mental Health Australia (2019) Investing to Save: The Economic Benefits for Australia of Investment in Mental Health Reform, p.10

reform is more difficult to estimate. New Zealand has an Integrated Data Infrastructure,¹³¹ a national database that carries de-identified data on New Zealand citizens. Its benefits continue to grow beyond original expectation for government departments and consulting bodies, academics and NGOs due to its usefulness in monitoring, reporting and evaluating datasets that can be recycled among a number of social sectors without repetition.

Better data collection and analysis of social and health determinants relevant and impactful to people with mental ill health and psychosocial disability and mental illness needs to be prioritised to aid monitoring, reporting and evaluation across reform.

Recommendation 32: The Federal Government fund the NMHC, Australian Institute of Health and Welfare (AIHW) and the Australian Bureau of Statistics (ABS) to invest in health and social datasets. The New Zealand Integrated Data Infrastructure is an example where data can lead to reform that also embraces each State and Territory's mental health practices and changes under the Rebuild Model.

CONCLUSION

In conclusion, AFI welcomes the overall approach that the Productivity Commission is taking to improve and reform the mental health sector for all Australians. We look forward to continuing to work positively with the Commonwealth Government and ACT Government to ensure full reform of mental health is actioned, and we look forward to continuing future collaboration following this submission.

Throughout, we have expressed the desire to remove current and detrimental coercive practices that are deeply entrenched in all levels of the mental health system. The Rebuild Model will require widespread cultural change that will aid supported decision making, choice and control, upholding of human rights and a recognition for inherent dignity and autonomy.

It is the strong belief of AFI that the Rebuild Model should be focused on increasing meaningful and tangible support for people with psychosocial disability and mental illness to exercise self-determination, tied with vigorous accountability, transparency and monitoring systems across the board. Importantly, people with psychosocial disability and mental illness must continue to be engaged as designers and co-designers in all recommendations moving forward.

¹³¹ Stats NZ (2018) *Integrated Data Infrastructure* via <https://www.stats.govt.nz/integrated-data/integrated-data-infrastructure/>