Psychiatric Disability Services
of Victoria (VICSERV)

Submission on

NDIS Code of Conduct

Discussion paper

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Contact details:

Angus Clelland
Chief Executive Officer,
VICSERV

T 03 9519 7000
E a.clelland@vicserv.org.au

Introduction

VICSERV is the peak body representing community managed mental health services in Victoria.

The services provided by VICSERV members include programs funded through the Victorian Government's Mental Health Community Support Services (MHCSS), and many also receive funding through Commonwealth mental health programs.

The NDIS will have a significant role to play for many people living with serious mental illness, their families and carers. VICSERV supports the development of a risk assessment process as set out under the NDIS Quality and Safeguarding Framework and we agree that setting national standards of conduct for all providers and workers is important and will go some way to ensuring the safety and quality of supports within the emerging NDIS market.

Before the Code is finalised however, we think that more consideration needs to be provided across some areas to ensure appropriate recognition of the difficulties for many people living with a mental illness and psycho-social disability which effect decision making and management of support arrangements.

For example, we support the inclusion of case studies to illustrate how the Code can be implemented, however none of the cases provided relate to scenarios where the individual receiving NDIS supports has a psychosocial disability.

Further, one of the expectations set out under *Section 2.4 - Provide supports in a safe and ethical manner with care and skill*, details that "a provider or worker must maintain the necessary competence in the types of supports and services they provide".

Under this obligation, it is unclear how it will take into consideration additional support requirements which are based on the participant's disability. In relation to a psychosocial disability this would include complexity, for example Alcohol and Other Drug (AOD) concern and trauma.

This is made more difficult when dealing with workers delivering the core supports who may meet the 'qualification' requirement for general disability (eg. Certificate III Disability) but not have the required skill to work with a participant with a complex psychosocial disability. We have provided an example of how this issue can create challenges for service providers being able to protect their workers, and thereby apply the Code.

Our submission provides detailed discussion of these concerns, including recommendations for how we think the Code could be amended to address the concerns.

Summary of key recommendations

- That there be a standardised process implemented by the NDIA to ensure information about the Code, and how to comply, be available to all providers – registered or unregistered.
- That there be a standardised process implemented by the NDIA to ensure information aimed at educating people about the Code is made available in a variety of accessible formats and languages.
- That the process for notifying the Commission of reportable incidents be clearly articulated in the Code.
- That the NDIA more clearly articulate how unregistered providers will be required to meet the obligations set out in the Code.
- That the NDIA, as a priority, consider the level of skills and expertise that are required to provide disability support to individuals with serious mental illness, and determine how this can be acknowledged across the wider NDIS and safeguarding framework.

- That the NDIA, as a priority, consider the issues associated with service providers being required to ensure training and development for its workers despite it not being accommodated in NDIS costings.

We would also like to note our endorsement of the submission of our national peak body, Community Mental Health Australia (CMHA), which is a coalition of the eight state and territory peak community mental health organisations. CMHA, through its state and territory bodies, has a direct link and contact to mental health organisations delivering services at the community level across Australia.

Section 1.3.2 - Unregistered providers

We reiterate the importance of ensuring safeguards for self-managing consumers.

The discussion paper specifies that, as well as registered providers, unregistered providers will also be subject to the Code of Conduct if they are receiving NDIS funding for their services.

However, the onus of implementing this has been fully placed on participants (see section 1.3.2, page 10 *"Self-managing participants will be strongly encouraged to provide information about the Code of Conduct and its obligations to any unregistered providers they engage"*).

Individuals should not be responsible for risk management, regardless of whether they choose to self-manage their plans; there is a duty of care upon the NDIA to ensure that all consumers are provided the utmost protection.

As such, we recommend there be a standardised process implemented by the NDIA to ensure information about the Code of Conduct, and how to comply, will be available to all providers – registered or unregistered*.*

This is to ensure consistent quality of care and to reduce the risk of opportunistic predators.

Section 1.4 - How will the NDIS Code of Conduct be applied?

Whilst we acknowledge and support the inclusive process outlined in the discussion paper – that anyone will be able to make a complaint about NDIS funded supports, including breaches of the Code of Conduct (page 12) – further detail needs to be provided about how participants, family members, friends, providers, workers and advocates will be educated about the Code of Conduct.

In its current form, we consider that the Code relies heavily on individuals understanding their rights, and knowing how to report issues, etc. With this, and as mentioned above, we are concerned that the onus of implementing the Code is being placed away from the NDIA.

It will be important that family members/carers/participants are educated about the Code - how to make a complaint, their rights and the standards of care to expect, their responsibilities to build their confidence in raising and reporting issues – and we think this should be a responsibility of the NDIA, as well as providers and workers.

Further, how will incidents that are not formally reported be monitored?

We recommend there be a standardised process implemented by the NDIA to ensure information educating people about the Code of Conduct is provided in a variety of accessible formats and languages*.*

Information should include:

- Rights and responsibilities
- Standards of care
- How to make a complaint

The Code also specifies that registered providers will also be required to notify the NDIS Quality and Safeguards Commission (the Commission) of reportable incidents, including incidents involving abuse, neglect, violence and/or exploitation.

What will be the mechanism for unregistered providers in this instance? As outlined in the Code (page 10) “unregistered providers are also subject to the Code if they are receiving NDIS funding for their services”, and so should also be required to notify the Commission. If this is the case, it is not clearly articulated in the discussion paper.

We recommend that the process for notifying the Commission of reportable incidents be clearly articulated in the Code.

Section 2.1 - Promote individual rights to freedom of expression, self-determination and decision-making

VICSERV would like to reiterate the importance of maintaining existing standards, including the *United Nations Convention on the Rights of Persons with Disabilities*.

The Code of Conduct provides one of the avenues for ensuring the protection of the rights of people with a disability, including those living with mental illness.

Section 2.2 - Actively prevent all forms of violence, exploitation, neglect and abuse

This obligation is targeted towards ensuring the expectations of providers - that they be committed to eliminating violence, exploitation, neglect and abuse against people with disability, including through their own actions.

People living with mental illness constitute a particularly vulnerable cohort. They experience higher mortality rates than the general population and poorer access to health, housing, education, employment and social inclusion. They also experience higher rates of physical and sexual victimisation than the general population.

Further, there are real concerns that, without appropriate mechanisms for accountability and scrutiny, people with psychosocial disability and cognitive impairment are at greater risk to financial, and other forms of abuse in an increasingly market-based service environment.

We therefore support obligations that aim to ensure protection mechanisms are in place for this vulnerable cohort, however it is unclear how will the Code ensure unregistered providers are meeting this expectation?

We recommend that the NDIA more clearly articulate how unregistered providers will be required to meet the obligations set out in this Code of Conduct.

Section 2.4 - Provide supports in a safe and ethical manner with care and skill

This obligation includes the following expectations:

- **A provider or worker must maintain the necessary competence in the types of supports and services they provide**

Competence can be measured according to the types of supports and services – how does this take into consideration the additional requirements based on the participant’s disability. In relation to a psychosocial disability – complexity, Alcohol and Other Drug (AOD) concerns, trauma etc.).

This is made more difficult when dealing with workers delivering the core supports who may meet the ‘qualification’ requirement for general disability (eg. Certificate III Disability) but not have the required skill to work with a participant with a complex psychosocial disability.

The following case study and supporting information articulates our concern:

Complex Client Case Study

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

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

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

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

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

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

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

The complexity and risk of this client was only identified as the plan was viewed through a "clinical lens" from experienced staff– the plan itself did not highlight this information or make it obvious for the service provider or worker.

The service provider allocated an experienced support worker at their own cost. The service provider could have allocated a disability support worker with no experience or skill in working with people with complex needs and the outcome could have been much worse – severe injury to the worker, a more severe sentence for the client, huge work-cover costs to the provider, potential media coverage of the incident.

This example also highlights implications for complex clients and their access to the service provider market – providers in the future may choose not to accept clients with high needs due to the risks. Increasing the risk of these clients falling through the gaps.

Prior to the NDIS, case management has been an important aspect of many consumers with complex issues and this has allowed full knowledge of their support needs (noting that Support Coordination under the NDIS does not fill this role) clients will inevitably fall through holes in the system.

The case study noted above is not an isolated incident - there are more examples emerging of providers getting no background on clients. Disability support workers are visiting the homes of clients that even clinical service workers deem too unsafe to visit.

We recommend that the NDIA, as a priority, consider the level of skills and expertise that are required to provide disability support to individuals with serious mental illness, and determine how this can be acknowledged across the wider NDIS and Quality and Safeguarding framework.

- **A provider must offer reasonable supervision and take reasonable steps to ensure workers are competent and supported to perform their role.**

Again, how is "reasonable" determined? The needs of clients who have a psychosocial disability will differ across individuals and the level of competency required to ensure the client is supported will vary. As a result, the level of supervision required will also vary.

In addition, NDIS pricing is geared towards the skill level of the worker (i.e. provision of disability supports) and not the level of complexity of a person with psychosocial disability which differs for individuals and results in different needs.

Providers may consider level of competence in delivering 'core support' is fairly low because the skill required to deliver this support is not complex (e.g. taking the individual shopping), even if the participant has complex needs that may require a higher level of skill and experience in some situations.

How will a support worker be protected if they are put into situations that have other risk factors that cannot be measured under the framework of the code of conduct?

In order to meet the obligations set out in the Code, service providers will need to ensure that staff are not put into a situation where they do not have adequate level of skills to perform their role – for example, working with an individual who has complex needs as highlighted through the case study above.

Whilst we acknowledge the role of service providers in ensuring their staff have appropriate supervision and training, an ongoing issue that VICSERV has raised previously in other submissions, is that the NDIS pricing structure **does not include allocating time for training**. Further, within the NDIS pricing structure currently, the basic rate for support work is $43.58 per hour.

This imparts several challenges for mental health organisations, such as:

- A significant decrease in the level of salary providers will be able to afford to pay staff
- Difficulty in being able to afford time for essentials such as supervision and professional development
- Workplace health and safety concerns for staff working in isolation and in uncontrolled environments such as people's homes, etc.
- Providers shifting to a more casualised workforce and the impact this has on being able to provide a consistent worker for individuals who seek this
- An inability to retain the highly skilled workforce employed currently and who have experience working with complex clients.

We understand that the Code itself is not the appropriate avenue to address issues of concern with the NDIS pricing structure however it is difficult to look at these concerns in isolation to issues with the wider structure of the scheme.

We recommend that the NDIA, as a priority, consider the challenges for service providers in meeting this obligation - ensuring training and development for its workers despite it not being accommodated in NDIS costings.

- **A provider or worker must not provide supports of a type that is outside his or her expertise or training, or provide supports or services that he or she is not qualified to provide.**

Currently, the ‘qualification’ requirements for delivering the core supports are not specifically defined – he or she is qualified to provide core supports with anything from a Certificate III to Diploma level. These same supports can be delivered by a worker trained in disability, aged care or mental health.

How will this type of obligation be monitored and reported?

Under the current NDIS scheme and pricing structure, an obligation such as this raises challenges for mental health service providers because disability support cannot be isolated from the complex needs of the client.

Whilst we understand that this obligation is reasonable and acknowledge its requirement in a code of conduct, we are concerned about the implications for complex clients whereby some service providers may choose to opt out of providing supports to some participants due to the challenges and risks.

Again, we recommend that the NDIA, as a priority, consider the level of skills and expertise that are required to provide disability support to individuals with serious mental illness, and determine how this can be acknowledged across the wider NDIS and Quality and Safeguarding framework.