The Royal Commission into the Violence, Abuse, Neglect and Exploitation of People with Disability

National Mental Health Commission (NMHC) Response to Safeguards and Quality Issues Paper

February 2021

About the National Mental Health Commission

The National Mental Health Commission (NMHC) provides cross-sectoral leadership on policy, programs, services and systems that support better mental health and social and emotional wellbeing in Australia. There are three main strands to the NMHC's work: monitoring and reporting on Australia's mental health and suicide prevention systems; providing independent advice to government and the community; and acting as a catalyst for change.

The NMHC's underpinning principle is the Contributing Life Framework. This framework acknowledges that a fulfilling life requires more than just access to health care services. It means that people who experience mental illness can expect the same rights, opportunities, physical and mental health outcomes as the wider community.

Response to questions

Question 1: What are the best ways to safeguard people with disability who may be at risk of violence, abuse, neglect and exploitation both when they use services and in other areas of their lives?

Question 2: How can quality services help to prevent violence, abuse, neglect and exploitation of people with disability? What are the features of those quality services?

Improvements in the safety and quality of mental health and disability services can be achieved by strengthening the role of consumers and carers as key partners in service design, delivery, governance and evaluation.

The role of consumers and carers in the design, delivery and evaluation of mental health services is critical. There must be dynamic and viable partnerships between service users, service providers and service leaders. The NMHC is currently developing a resource, the *Mental Health Safety and Quality Engagement Guide,* aimed at empowering mental health consumers and carers, health service leaders and service providers to engage in meaningful partnerships to improve the safety and quality of services.

The Guide will be released in late February 2021 however a draft could be made available earlier required.

Question 3: How could safeguarding laws, practices, or policy frameworks (including the NDIS *Quality and Safeguarding Framework)* be improved to better prevent, reduce and respond to violence, abuse, neglect and exploitation of people with disability? We are particularly interested in Australian and international examples of good practice.

The NMHC supports working towards the elimination of seclusion and restraint of people experiencing mental health difficulties in mental health and disability services.

The NMHC acknowledges that this is a multifaceted issue. We recognise that people have a right to safe and effective care, and to work in an environment that is safe and supportive. We appreciate that considerable work is underway around Australia to understand and address the factors that lead towards seclusion and restraint, and to monitor its use.

States and territories have made significant advances in relation to seclusion and should be congratulated for what they have achieved. In 2014, Disability Ministers from the Australian, state and territory governments agreed to the National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector. In 2016 the National Principles to Support the Goal of Eliminating Mechanical and Physical Restraint in Mental Health Services were endorsed by the advisory council to Australian Health Ministers. These national agreements provide guidance to governments on restrictive practices.

Restrictive practices are also monitored through the NDIS Commission for NDIS participants. Registered providers who develop behaviour support plans or use restrictive practices are required to comply with the NDIS Quality and Safeguarding Framework, which is underpinned by the same high-level guiding principles as the National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector.

In 2017, the NMHC partnered with the Australian College of Mental Health Nurses to better understand the decision making processes of mental health nurses around using seclusion and restraint. The final report from this project outlined that a number of factors influence the use of restraint.

In 2018 the NMHC continued to promote best practice in the reduction of restrictive practices. To support cultural change by nurses, the NMHC engaged the Australian College of Mental Health Nurses (ACMHN) to progress the 'Safe in care, safe at work' project which builds on the 2017 Supporting Mental Health Nurses towards cultural and clinical change: Facilitating ongoing reduction In seclusion and restraint in inpatient mental health settings in Australia project. The project responds to discussions between the ACMHN, the NMHC and key stakeholders invested in the ongoing reduction of seclusion and restraint in Australia. The project reflects a recognition of the importance of safety in care and at work and is a response to an ongoing dialogue with key stakeholders, including mental health nurses, consumers, carers and industry.

The final package is comprised of an audit toolkit for services, the Australian adaption of the Six Core Strategies checklist and a list of guiding documents to reduce seclusion and restraint. An abridged version for mental health staff and managers was developed that emphasises the use of the checklist to guide the reduction of seclusion and restraint.

Question 4: What can be done to uphold independence, choice and control for people with disability when implementing safeguards against violence, abuse, neglect and exploitation?

Question 5: What challenges are presented by the different safeguarding approaches used across Australian jurisdictions and across different types of services?

Question 6: What role does, or should, independent monitoring and oversight play in safeguarding the right of people with disability to live free from violence, abuse, neglect and exploitation? Should the NDIS Quality and Safeguards Commission be taking a more active role in ensuring service providers are adhering to the appropriate standards, particularly during the pandemic crisis?

Question 7: What safeguards are required for people who may need additional support, such as people who do not have informal supports like families or other advocates, people who face communication barriers, and people with high support needs?

In the context of the NDIS, consumers must be able to make informed choices to fully participate. Participants with psychosocial disability may need help to navigate the NDIS, engage providers and navigate other mainstream systems. Participants need a single point of contact when something goes wrong – including when a provider decides to no longer provide them with a service. Support coordination for NDIS participants with psychosocial disability has the potential to drive improvements in case management and coordination for this cohort. However, such improvements are hampered by the low uptake of support coordination in NDIS plans for people with psychosocial disability. Consistent with recommendations by Mental Health Australia, the NMHC recommends that the NDIA include support coordination as a standard item in all plans for people with psychosocial disability.

Question 8: How can informal safeguards be strengthened to prevent or reduce violence, abuse, neglect and exploitation of people with disability? What are the ways in which people with disability develop personal capacity to safeguard at different stages of their lives and as circumstances change? Are there systems in place to support this capacity development?

As discussed in our initial submission to the Royal Commission, there are significant data gaps around the mental health of the youth detention population, we know that higher rates of mental illness and cognitive disability exist than in the general population. The intersection between mental health, disadvantage and the justice system is complex and concerning, as is the high prevalence of mental illness amongst those in incarceration. Not only are young people with a mental illness overrepresented in youth incarceration, just being incarcerated as a young person is associated with experiencing worse physical and mental health later in life. Often people with mental illness, cognitive disability and drug and alcohol issues end up in incarceration because there are no other alternatives available (particularly in rural and remote areas).[x] In the absence of a nationally consistent reporting system or framework we are limited in our understanding of how supports are provided to these groups once in incarceration, including how well these adhere to evidence-based practices. Regardless of the support provided, incarceration is neither an appropriate nor effective response to address mental health and cognitive disability.

Concerns have been highlighted regarding the justice systems' ability to adequately respond to the mental health needs of incarcerated youth. The Royal Commission into the Detention and Protection of Children in the Northern Territory in 2017 pointed out a number of issues:

- inadequate health assessment processes on admission to youth detention;
- inadequate healthcare for young people experiencing mental health issues;
- lack of consistency in managing behaviours initiated by a history of trauma, symptoms of foetal alcohol syndrome, ADHD, and other mental health issues in detainees; and
- youth justice officers being required to identify at-risk behaviours in detainees with minimal or no mental health training.

In light of these findings, and in line with our 2013 National Report Card, the NMHC continues to be conscious of ongoing issues regarding equity of rights and access to services. While substantial

investment is required to address these issues and create alternate pathways away from incarceration, the existing economic and social costs of youth incarceration dwarf the investment required to prevent it. Available data indicates that on average, it costs $600 per day per prisoner to incarcerate a young person. In addition, there are indirect economic costs from loss of employment and deterioration of employable skills, which in turn create a cycle of re-offending. Social impacts can include separation of families, loss of engagement with community as well as poorer health outcomes

Question 9: What barriers do people with disability face when making a complaint and what will help address these barriers? We are interested in hearing about complaints processes across a range of services and areas of life.

Stigma and discrimination is a significant barrier consumers and carers who may wish to make a complaint.

In the Productivity Commission's 2020 Review of Mental Health it was recommended that the NMHC should develop and drive a National Stigma Reduction Strategy designed to reduce stigma towards people with mental illness. The recommended stated that this strategy should target stigmatising views of those with severe mental illness and that the strategy should actively target stigma and discrimination by health professionals.

Question 10: How can safeguards and complaints processes be improved to better meet the needs of First Nations people, women, culturally and linguistically diverse people, LGBTIQ+ people, and/or children and young people with disability?

As discussed in our initial submission to the Royal Commission, the mental health system has a way to go in appropriately responding to the impact of violence and trauma, with interim findings from the Victorian Royal Commission into Mental Health citing the need for a common understanding of trauma and violence informed care. This speaks to the current models of health care that neglect to take into consideration the family and social context surrounding an individual and any co-existing issues. For example, treating mental health and substance use issues in isolation of the impact of domestic, family and sexual violence (despite the crossover of service users), is treating only the symptoms not the underlying cause of mental health and substance use issues i.e. violence.

In a statement endorsed by the NMHC, and the Mental Health Commissions of NSW, Queensland, South Australia and Western Australia following the closure of the Royal Commission into Institutional Responses to Child Sexual Abuse, the commissions outlined nine actions for the Australian and state and territory governments to implement. Many of these are just as relevant to the violence and abuse experienced by people with disability and have been adapted below.

- Recognise that violence and abuse is broader than institutional settings.
- Recognise the strength and resilience of survivors and use this, rather than an illness-based approach, to build positive outcomes.
- Build trauma capability across the full spectrum of services that recognises and responds to the specific needs of people managing the devastating impacts of abuse.
- Develop co-ordinated responses to the varied needs of consumers, including extended access to Medicare-funded counselling.
- Prepare for increased demand.
- Increase community-based support workers.
- Develop culturally appropriate services for Aboriginal people.

Although limited in their evaluation, there are promising frameworks that have the potential to address the issues of inadequacy to respond appropriately to domestic, family and sexual violence (DFSV) in the health and mental health systems and form a common understanding of trauma and violence informed care.

The Health Systems Implementation Trauma and Violence-Informed Model was developed by the

Australia's National Research Organisation for Women's Safety. Input for the model was sought from women with lived experience of DFSV, staff working in hospitals, sexual assault centres and a clinical mental health service as well as conducting a literature review of similar or related existing evidence-based models. This framework underpins both a female centred care approach and a practitioner or staff-centred service approach, where women are empowered and receive a holistic response and practitioners and staff are supported and provided with the necessary education and resources to provide appropriate care.

Insights can also be garnered from the Women with Co-occurring Disorders and Violence Study that generated a wealth of knowledge regarding the effectiveness of comprehensive, integrated and trauma-informed service models for women with co-occurring histories of violence and mental health issues. For a detailed understanding of the neurobiological impact of trauma on the body 'The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma' by Bessel van der Kolk is a valuable resource.

Question 11: What else should we know?