Independent Review into Mental Health Individual Advocacy

Summary report

21 August 2023

nous

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This artwork was developed by Marcus Lee Design to reflect Nous Group's Reconciliation Action Plan and our aspirations for respectful and productive engagement with Aboriginal and Torres Strait Islander peoples and communities.

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1 Summary of findings and recommendations

In January 2023, Nous Group (Nous) was engaged by the Mental Health Commission (the Commission) to undertake an independent review of individual advocacy services delivered by mental health non-government organisations (NGOs) in Western Australia (WA) (**the Review**). The Review has two areas of focus:

- The **primary focus** is the individual advocacy services contracted by the Commission (commissioned services). The Review has sought to assess the extent to which these services are meeting community need, and identify opportunities to contemporise the delivery of these services.
- The **secondary focus** is the broader ecosystem of individual advocacy services delivered across WA, and other State and Australian Government agencies, specifically the Department of Health (Health), the Department of Communities (Communities) and the Department of Justice (Justice). The Review has sought to identify opportunities to jointly plan and co-commission individual advocacy to deliver better, shared outcomes for consumers, families and carers and the community.[1]

The Review has been guided by four key lines of enquiry (KLEs):

1. What is the current state of the individual advocacy services contracted by the Commission?
2. What is the current state of individual advocacy services contracted by other agencies in WA and nationally?
3. What does contemporary 'best practice' look like and how are similar services being contracted in other jurisdictions?
4. What is the ideal future state of individual advocacy services in WA and are there opportunities for collaboration across Government?

The KLEs and focus areas have informed a mixed-method approach to collecting and analysing information. Between February and April 2023, Nous undertook a targeted consultation process, seeking insights from a range of stakeholders, including government agency representatives, mental health individual advocacy service providers, peak bodies, and people with lived experience (consumers and carers). These consultations were informed by a desktop review of grey and published literature into 'best practice' individual advocacy services in Australia and internationally.

Individual advocacy services support some of WA's most vulnerable and disenfranchised people to understand and voice their rights, wishes and preferences

Individual advocacy, in the context of people with health and mental health issues, refers to "*services that seek to represent the rights and interests of people with a mental illness, on a one-to-one basis, by addressing instances of discrimination, abuse and neglect.*"[2] Importantly, individual advocacy services traverse several different sectors and systems beyond mental health. For example, individual advocacy services are essential supports for people living with physical or intellectual disabilities, and work to advocate for and support the human rights set out in the *Disability Discrimination Act 1992* (Cth), and the International Convention on the Rights of Persons with Disabilities. Fundamentally, individual advocacy services have five core features:

[1] Nous did not undertake consultations with other services providers commissioned by Justice, Communities and Health (i.e., those not also concurrently contracted by the Commission), and consumers and carers of those services.
[2] Australian Institute of Health and Welfare, *Individual Advocacy,* 2020.

- **Individualised**. Independent advocacy is a partnership between a professional advocate (including peer advocate) and a member of the community who is vulnerable, disempowered, or at risk of discrimination, abuse, or neglect.
- **Wholly independent**. Advocates are wholly independent, meaning they are both independent in practice, and are perceived as independent. Advocates must be independent of a 'service' the consumer or carer is accessing.
- **Flexible and person-centred**. There is no one approach to individual advocacy. The nature and intensity of support provided by an advocate will depend wholly on the wants and preferences of the individual.
- **Goal-oriented**. Individual advocacy is goal-oriented. Advocates develop a 'plan of action' with clearly defined goals, and are continuously accountable for supporting a consumer to achieve those goals.
- **Rights-based**. Individual advocacy services aim to support people whose human rights have been, or are at risk of being neglected, discriminated against, or deprived.

It is timely for the WA Government to contemporise the delivery of mental health individual advocacy

This Review delivers on a key commitment of the Commission under the State Commissioning Strategy 2022. The State Commissioning Strategy requires that all WA Government agencies responsible for the delivery of community services develop Agency Commissioning Plans (ACP). The Commission's ACP 2022-2027 outlines a set of short- and long-term initiatives to contribute toward achieving whole-of-Government goals through the contracting of community services. This Review reflects the Commission's commitment to contract contemporary individual advocacy services in partnership with Justice, Health, Communities and Aboriginal Community-Controlled Organisations to progress tailored services for priority cohorts.

1.1 Summary of findings

The strengths of current mental health individual advocacy represent a solid foundation for future service delivery

The six current individual advocacy services are unique and unlike in many ways. For example, some services aim to support only consumers from CaLD backgrounds, while others primarily aim to support and advocate for the rights of carers. Specifically, the following shared strengths were emphasised by stakeholders throughout the Review:

- A consistent focus on evidence-based 'representational advocacy' (in contrast with 'best interests' advocacy), where advocates focus wholly on supporting consumers and carers to explore, express and advocate for their own rights, wishes and preferences.
- The setting of goals, and accountability to those goals. Advocates work with consumers and carers to set clear goals at the outset of their support. These goals reflect a focus on outcomes and hold the advocate and consumer or carer accountable.
- The delivery of flexible, person-centred support. Individual advocacy services have recognised the importance of tailoring support to the unique needs and context of each consumer and carer. Delivers a whole-of-person, whole-of-family individual advocacy model, which recognises the central importance that family and community plays for many CaLD communities.

- Both actual and perceived independence from mental health services. Individual advocacy services are clearly separate and independent from mental health services. This independence is central to the trust and confidence built between consumers and carers, and advocates, in protecting the safety of consumers, and in building the confidence and skills of consumers and carers to self-advocate.

A consistent sentiment among stakeholders is that the effectiveness of individual advocacy services is grounded in the strength, experience, and dedication of the individual advocates themselves. Many individual advocates possess deep expertise, and effectively work to impart their knowledge to consumers and carers to build their skills and confidence. In addition, two of the six commissioned services deliver a peer-led individual advocacy model. Stakeholders consistently emphasised the unique benefit and impact of peer-led advocacy, particularly because of the ability for peer advocates to draw on their unique experience to build meaningful, trusting relationships, and help provide practical support and build capability.

The strategic intent that underpins the commissioning of mental health individual advocacy services is unclear, and has contributed to slow growth in funding for services

The breadth and variance in individual advocacy services – both in mental health and across the health and social care sectors, has contributed to a number of enduring challenges for commissioners, service providers, and ultimately consumers and carers. At present, there is no clearly defined 'community need' or associated target outcomes that all mental health individual advocacy services should aim to address as a whole, and through differentiated service responses. This has contributed to uncertainty across commissioning agencies as to how services should grow or adapt to better meet the changing needs of the community.

Some of the challenges faced by commissioners and services can be attributed to the fact that the commissioned services have not undergone a system level review by all commissioning agencies since they were originally commissioned. The absence of such a review has contributed to uncertainty in the role of individual advocacy within the broader mental health and social care systems. For example, there is a lack of clarity as to the 'purpose' of mental health individual advocacy, and the 'need' that services aim to address, as distinct from individual advocacy services in disability, aged care, housing, and child protection.

Stakeholders have identified that though individual advocacy services are similarly categorised, they are highly distinct, and were commissioned individually, to address a specific community need at a given time. While many services have been delivered for up to 20 years, their categorisation as 'individual advocacy' is as recent as 2015, following changes made by the Australian Institute of Health and Welfare to the national minimum data set for mental health non-government organisations. This is despite the fact that some elements of each service do not align with the national definition of individual advocacy.

For service providers, the uncertainty as to the role of individual advocacy has contributed to limited change to the services in more than 10 years. For each service, funding has grown at an annual rate of between 4 and 8 per cent, with some exceptions. Though there is no specific modelling of individual advocacy demand, the most recent modelling of mental health community support found that service capacity would need to increase more than **four-fold** between 2015 and 2025 to meet forecast demand. The slow relative growth in funding has contributed to ongoing capacity constraints across all services, and adverse actions by some service providers to ease those constraints. For example, one provider has closed their waitlist indefinitely in response to waiting times exceeding six months. All other providers take very few, if any active steps to promote or raise awareness for their service, noting that they do not have the capacity to respond to any growth in demand that would result from greater awareness in the community.

The roles and responsibilities of Government agencies in commissioning individual advocacy services are unclear

Non-government and government organisations deliver individual advocacy across different parts of the health, disability, housing, aged care, child protection and justice systems, among others. In different systems and sectors, there is significant variance in how the 'definition' of individual advocacy has been interpreted. In the context of this Review, many commissioned services are concerned only with supporting a person with mental health issues (i.e., the vulnerability), to express or advocate for their rights as they relate to accessing or receiving mental health services and/or challenges in navigating the health system. This can be contrasted with individual advocacy in the disability sector, which works with people with a disability to promote, protect and ensure their full and equal enjoyment of all human rights enabling community participation[3].

It is not clear why individual advocacy has been interpreted in such different ways. One challenge with the current approach is that mental health issues cannot be separated from the many health and social determinants the contribute to, or co-occur with mental ill-health. This contributes to confusion in where the role of mental health individual advocacy services differs from that of disability advocacy, or older persons advocacy.

It is likely that the current approach to funding and commissioning individual advocacy across the WA and Australian Government contributes to this challenge. At present, Health, Justice, and Communities in WA each fund one or more commissioned service provider to deliver substantively similar services as the Commission.

The siloed yet overlapping funding arrangements make it difficult to assess whether each agency's funding is achieving its intended outcomes for the same consumers and carers. These arrangements also contribute to ambiguity in accountability, which inhibits the flexibility and responsiveness of Government, and in turn service providers, to respond to changing or growing community need. It also contributes to additional administrative burden on service providers, specifically in relation to duplicative reporting.

Individual advocacy service delivery can be better tailored for many cohorts, including regional communities

Current mental health individual advocacy service delivery is not tailored or targeted to meet the needs of people from vulnerable or disadvantaged cohorts, excluding one commissioned provider who specifically targets CaLD communities. The gap in mental health individual advocacy service delivery was a common refrain of Review stakeholders, who identified four priority areas where a more targeted service response is needed.

- **There is a significant gap in accessible, culturally appropriate individual advocacy support for Aboriginal people and families with mental health issues across WA**. This can be observed in the absence of an Aboriginal-specific, Aboriginal-led individual advocacy service for Aboriginal people; the absence of Aboriginal staff working as individual advocates, or supporting individual advocates in mainstream services, and in the reactive nature of the individual advocacy service model.
- **There is a gap in proactive individual advocacy for older adults, particularly in aged care settings and hospital-based settings**. Older adults – particularly those in supported accommodations settings, are disproportionately likely to experience mental health issues,[4] and human rights issues, including

[3] Department of Social Services, 'National Disability Advocacy Program', Australian Government, 2023 [Accessed 5 June 2023]
[4] SANE Australia, *Growing older, staying well: Mental health care for older Australians*

the inappropriate use of sedatives and restraint procedures, and limited access to mental health services[5]. Despite this commissioned service providers do not proactively target this cohort.

- **Commissioned services, at present, do not specifically identify alcohol, drugs, or volatile substances (AOD) as part of their inclusion and eligibility criteria**. There is growing evidence that people with AOD issues are more likely to experience limitations or deprivations of their human rights, which in turn has a material and adverse impact on their recovery, health, and wellbeing. Whilst commissioned service providers do not actively exclude this cohort of consumers, the absence of 'AOD' in access or eligibility criteria contributes to services supporting very few people with AOD issues.
- **Commissioned service providers are not able to deliver equitable levels of service to people living in regional and remote WA**. While 'notionally' statewide, in that most commissioned service providers support "all of WA", the capacity and operating model of the commissioned services is prohibitive to providing accessible and equitable services for people living in regional and remote WA.

There are no formal qualifications, training programs or registration standards individual advocates

Despite the unique and specialised nature of individual advocacy, there is no recognised course, qualification, or training program to be become an individual advocate. Additionally, there are no state or national professional standards or registration requirements that are specific to individual advocates (i.e., the National Registration and Accreditation Scheme that applies to certain health professionals). While stakeholders identified the strengths and experience of many individual advocates, – including peer advocates – the absence of any formal professional structure contributes to several challenges, and material risks for consumers and carers, service providers, and the Commission if left unaddressed, including:

- Variance in service levels and quality, contributing to a 'lottery' effect when accessing individual advocacy services
- Risks to consumer and carer outcomes, and the wellbeing of individual advocates, when supporting consumers with increasingly complex issues, including consumers experiencing symptoms of mental health crises
- Inconsistency with core principles of individual advocacy, including unintentionally moving away from 'representational' advocacy, and toward best interest advocacy.

Review stakeholders identified immediate opportunities to leverage existing training and development programs in individual advocacy. An example is the 12-day sector-driven pilot course in 2022 organised by AWARE (Advocacy Workforce Advancing Rights and Equity), which provided specialist training and skill development for existing and potential advocates working in areas of social justice and human rights.

1.2 Summary of recommendations

The Review outlines eight key recommendations aimed at informing future contracting decisions by the Commission

This Review provides eight recommendations for the Commission to inform the future contracting of individual advocacy in WA. The recommendations detail key activities that can be implemented to

[5] Royal Commission into Aged Care Quality and Safety, '*Care, Dignity and Respect, Final Report: Royal Commission into Aged Care Quality and Safety*', Australian Government, 2021.

enhance current service delivery, and progress long-term, enduring change to the design, planning, funding, and contracting of individual advocacy to meet the needs of the WA community.

A list of recommendations is set out in Table overleaf; these recommendations are described in more detail on Page 31 onwards.

Table 1 | Recommendations

SERVICE MODEL AND SERVICE ENABLER RECOMMENDATIONS	
Recommendation 1	Develop 'key service requirements' and a supporting program logic to guide the short-term commissioning of mental health individual advocacy. Key service requirements clearly outline the 'core' elements of service delivery required to maintain quality and consistency of care, whilst still promoting service providers to pursue innovation and flexibility in service delivery. Both mechanisms should ensure that all services are grounded in contemporary, evidence-based principles of individual advocacy, reduce variance in service delivery and consumer experience and guide ongoing monitoring, evaluation and improvement of individual advocacy services.
Recommendation 2	Progress key actions to improve the awareness and understanding of individual advocacy services across the health system and the broader community. Key initiatives to be considered and progressed include the development of a comprehensive, publicly available self-advocacy toolkit to enable consumers to build their own skills, capabilities, and confidence to self-advocacy. Additionally, the Commission should enable contracted service providers to undertake community outreach and education to raise awareness of individual advocacy services, and explore opportunities to centralise the availability of information related to individual advocacy in a single, easily accessible online platform or website.
Recommendation 3	Progress key initiatives aimed at strengthening and 'professionalising' the individual advocacy workforce to ensure safe, high quality and accountable service delivery. These initiatives include: • Identify actions and initiatives to increase the number of peer advocates in all individual advocacy services, and ensure appropriate safeguards to protect peer workers from harm. • Establish a core competency framework that describes the skills, behaviours and qualifications that are essential and important (but not essential) for an individual advocate, directly informed by key service requirements. • Ensure training for all individual advocates in the Commission's contracted services, informed by a core competency framework. • Ensure that all consumers of mental health individual advocacy are made aware of and are afforded the opportunity to make a complaint about an individual advocacy service through an appropriate mechanism (i.e., the Health and Disability Complaints Office).
Recommendation 4	Implement mechanisms to improve the way that health services and clinicians work with individual advocates. This may help to remove some of the barriers that individual advocates currently face when attempting to advocate to a clinician on behalf of an individual. These actions should include embedding the requirement to work with, and share information with individual advocates, in service agreements with Health Service Providers.

COMMISSIONING RECOMMENDATIONS	
Recommendation 5	Progress key actions to clarify roles and responsibilities of all WA Government agencies for the planning, funding, and commissioning of individual advocacy in WA. These actions should include: • Articulate clear outcomes to be achieved with Government funding, both for each individual agency, and for the WA Government as a whole, to identify clear gaps, duplication, and opportunities for co-commissioning. • Map individual advocacy services across all sectors to inform discussions as to the roles and responsibilities of each agency and guide a whole-of-system approach to service design and commissioning. • Progress immediate co-commissioning opportunities.
Recommendation 6	Develop a multi-agency funding strategy in partnership with the Departments of Health, Justice and Communities. The purpose of the funding strategy should be to identify the funding priorities of each agency, and develop an approach to maximise that likelihood that investment proposals submitted through the annual budget process are successful. The funding strategy should include an evidence-based approach to estimating unmet need, and a subsequent process to prioritise and sequence investment requirements, to ensure effort is allocated to areas of greatest need.
Recommendation 7	Progress short- and medium-term initiatives to expand the accessibility of individual advocacy for vulnerable cohorts. As a priority, actions should be progressed to improve the appropriateness and accessibility of individual advocacy for: • Aboriginal people and families, focused on commissioning a specialist Aboriginal-specific individual advocacy service; • People with AOD issues, through expanding the eligibility criteria of all commissioned service providers to support people with AOD issues; • People living in regional and remote WA, through innovative service models and an uplift in baseline funding; and • Older persons, in partnership with the Australian Department of Health and consultation with the Older Persons Advocacy Network.
Recommendation 8	Work toward expanding and contemporising the provision of legal advocacy for people with mental health issues in two key areas. Firstly, informed by ongoing reform related to legal assistance services, progress an investment proposal to expand the provision of legal advocacy for people with mental health issues, and rights-based matters, with a focus on broadening the scope of service delivery to include matters in criminal law, tenancy, family law and employment law, and stronger reach into regional and remote WA. Secondly, the Commission and Department of Justice should assess the feasibility of an integrated legal and non-legal advocacy model for Mental Health Act matters, informed by learnings and experiences of Victoria and New South Wales in progressing similar models.

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