15 February 2013

mhcc
mental health coordinating council

PO Box 668 Rozelle NSW 2039

T 02 9555 8388
F 02 9810 8145
E info@mhcc.com.au
W www.mhcc.org.au

ABN 59 279 168 647

The Disability Services Act Review Team
Ageing Disability & Home Care
Department of Family and Community Services
Level 5, 83 Clarence St
Sydney NSW 2000

E: dsareview@facs.nsw.gov.au

Dear Sirs

Subject: Submission to Reforming NSW Disability Support: Legislative Structure and Content. Discussion Paper

The Mental Health Coordinating Council (MHCC) is the peak body representing mental health community managed organisations (CMOs) in NSW. Our members provide a range of psychosocial and clinical services, and support programs, as well as advocacy, education, training and information services with a focus on recovery orientated practice. MHCC's membership consists of 183 organisations whose business or activity is wholly or in part related to the promotion and/or delivery of services for the wellbeing and recovery of people affected by mental health conditions. We work in partnership with both State and Commonwealth Governments to promote recovery and social inclusion for people affected by mental illness, participate extensively in policy and sector development and facilitate linkages between government, community and private sectors in order to affect systemic change. MHCC also manage and conduct research projects and develop collaborative projects on behalf of the sector. MHCC is also a registered training organisation (MHCC LD) delivering nationally accredited mental health training and professional development to the workforce.

MHCC make a few points in relation to the review of the (DSA) Disability Services Act 1993 (NSW) because in our opinion they are of importance particularly in view of the impending roll-out of the NDIS which is designed to encompass the broadest interpretation of disability (to include people with psychiatric impairments, which may or may not be chronic or episodic in nature).

We also wish to advise the Department that we have provided the Senate Community Affairs Committee Inquiry into the National Disability Insurance Scheme (NDIS) with comment relating to some issues that also appear in the Reforming NSW Disability Support Discussion Paper. The two documents which may be of interest are available at the following links:

http://www.mhcc.org.au/documents/Research%20and%20Position%20Papers/Self%20Directed%20Funding%20and%20the%20Community%20Managed%20Mental%20Health%20Sector%20Opportunities%20and%20Challenges%20-%20Discussion%20Paper%20FINAL%2014%2011%2011.pdf

http://www.mhcc.org.au/documents/Submissions/NDIS-SUB-ERNS-F28.09.12.pdf

Also relevant are comments in our submission to the review of the *NSW Mental Health Act* 2007 available at the link: http://www.mhcc.org.au/documents/Submissions/Sub-Issues-under-NSWMHAct07.pdf

Questions 1-3: In the first instance we propose that the scope of the DSA legislation be as broad as possible and describe its alignment to the United Nations Convention on the Rights of Persons with Disabilities 2006 (UNCPD) expressed in Article 1, Purpose. This alignment should be contained in the Objects of the DSA as it expresses the intention of the Parliament as well as representing an overarching reference point throughout the Act.

Questions 37-41: We propose that in providing an integrated disability legal framework under the *Community Services (Complaints Review and Monitoring)* Act 1993 (NSW) (CS CRAMA) that CS CRAMA is amended to capture oversight safeguards, monitoring and auditing of community managed organisations funded by NSW Health in addition to departments covered by CS CRAMA under the disability legislation. In this way current anomalies in the system could be captured and integrated. For example the Ombudsman has oversight for some large CMOs that provide services across service systems including NSW Health (e.g. Richmond PRA) whereas another CMO providing the same service funded by NSW Health alone is not monitored for safeguards in the same way. This would enable the NSW Ombudsman to have jurisdiction for the oversight function more broadly across all services provided to people with mental health conditions.

Questions 33- 36: Further to this point we recommend an enhanced role for the NSW Official Visitor (under the current legislation, the *NSW Mental Health Act* 2007) to oversight safeguards in the community managed mental health sector, enabling them to monitor the services provided to people with psychosocial disability. The OV is more appropriate to this role than the Official Community Visitors (under the DSA), although reporting to the Ombudsman is more appropriate than the Minister for Health in these circumstances. The scope of the OVs should extend to supported accommodation contexts. Such changes will require reassessment of the jurisdiction of the OV Program as well as clarification of reporting pathways through the Ombudsman and the Ministry of Health.

Question 6 -8: In discussing principles to be improved to ensure people with disability are placed at the centre of planning, decisions and delivery of support and services, is the issue of 'supported decision making.' Supported decision-making is a principle that should be included in the DSA.

a. Supported decision-making provides an alternative to guardianship or other people taking on decision-making roles. Decision-making should be supported, not substituted. In supported decision-making, consumers are actively helped to identify their values, goals and choices even at times when this is particularly difficult.

Supported decision-making is an important part of service and care coordination. A basic premise of this approach is that autonomy does not need to be replaced with substitute decision-making, but can exist alongside it. People must be assisted to identify and express their choices even when capacity is in doubt, rather than excluding them from the decision-making process.

Supported decision-making can take many forms. Those assisting a person may communicate the individual's intentions to others or help him/her understand the choices at hand. They may help others to realise that a person with significant disabilities is also a person with a history, interests and aims in life, and is someone capable of exercising his/her legal capacity. While some good models of supported decision-making exist there is no clear policy framework; and guardianship laws and practice still dominate.

b. Supported decision-making is referred to in the United Nations Convention on the Rights of Persons with Disabilities 2006 (UNCPD) in Article 12 (3) on Equal Recognition before the Law, as providing that the: 'states parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity'. Australia having ratified the UNCRPD is as such bound to uphold the Articles in the Convention. The inclusion of supported decision-making in an amended DSA will go some way towards NSW meeting the international movement towards embedding human rights in both state and national law.

MHCC recommend principles informed by those outlined in Victorian paper: Office of the Public Advocate, 2009. Supported decision-making: Background Paper, 7.2, p.20[i] and the United Kingdom, *Mental Capacity Act* 2005,[ii] which while similar, includes additional principles 3 and 5 which we recommend be included:

1. The interests of the person with a disability are paramount in supported decision-making arrangements.
2. Every adult has the right to make his or her own decisions and must be assumed to have capacity unless proved otherwise.
3. A person must be given all practicable help before treated as lacking the capacity to make their own decisions.
4. Support and assistance with decision-making should be available to any person with a disability.
5. Any supported decision-making arrangement must have the consent of the person and their supporters.
6. The person with a disability may terminate the arrangement at any time and a supporter may withdraw from the arrangement at any time.
7. Decisions made under supported decision-making arrangements cannot override the will of the person with a disability.
8. If a decision made by an individual is considered unwise, the person should not be assumed as lacking decision-making capacity.
9. Any action or any decision made on behalf of a person who lacks capacity, must be in their best interests.
10. Any action or any decision made on behalf of a person who lacks capacity should ensure the least restrictive of their basic rights and freedoms.
11. Any action or any decision made on behalf of a person must be decision specific.

Question 9: The DSA defines disability in terms of 'target group' at section 5. 1) *For the purposes of this Act, a person is in the target group if the person has a disability (however arising and whether or not of a chronic episodic nature): a) that is attributable to an intellectual, psychiatric, sensory, physical, or like impairment or to a combination of such impairments.* MHCC suggest that the term impairment /s – sits uncomfortably in terms of the language favoured by the mental health sector in the context of the person centred recovery orientated approach in mental health service delivery which is considered best practice. Our preferred language to 'impairment' is (mental health) 'condition' which may be 'severe and persistent.'

Question 13: MHCC propose that the legislation should include principles to guide the development of individual plans. We emphasise the recovery-orientated approach which is best practice in the delivery of services to people with mental health conditions.

<u>Principles of recovery-oriented mental health practice</u>

From the perspective of the individual with mental illness, recovery means gaining and retaining hope, understanding of ones abilities and disabilities, engagement in an active life, personal autonomy, social identity, meaning and purpose in life, and a positive sense of self. It is important to remember that recovery is not synonymous with cure. Recovery refers to both internal conditions experienced by persons who describe themselves as being in recovery—hope, healing, empowerment and connection—and external conditions that facilitate recovery—implementation of human rights, a positive culture of healing, and recovery-oriented services, (Jacobson & Greenley, 2001, p. 482). The purpose of principles of recovery-oriented mental health practice is to ensure that services are being delivered in a way that supports the recovery of mental health consumers.

The following should be included as a guide to the development of individual plans under the DSA:

1. Uniqueness of the individual
Recovery oriented practice:

- recognises that recovery is not necessarily about cure but is about having opportunities for choices and living a meaningful, satisfying and purposeful life, and being a valued member of the community
- accepts that recovery outcomes are personal and unique for each individual and go beyond an exclusive health focus to include an emphasis on social inclusion and quality of life
- empowers individuals so they recognise that they are at the centre of the care they receive

2. Real choices
Recovery oriented practice:

- supports and empowers individuals to make their own choices about how they want to lead their lives and acknowledges choices need to be meaningful and creatively explored
- supports individuals to build on their strengths and take as much responsibility for their lives as they can at any given time
- ensures that there is a balance between duty of care and support for individuals to take positive risks and make the most of new opportunities

3. Attitudes and rights
Recovery oriented practice:

- involves listening to, learning from and acting upon communications from the individual and their carers about what is important to each individual
- promotes and protects individual's legal, citizenship and human rights
- supports individuals to maintain and develop social, recreational, occupational and vocational activities which are meaningful to the individual
- instils hope in an individual's future and ability to live a meaningful life

4. Dignity and respect
Recovery oriented practice:

- consists of being courteous, respectful and honest in all interactions
- involves sensitivity and respect for each individual, particularly for their values, beliefs and culture
- challenges discrimination and stigma wherever it exists within our own services or the broader community

Questions 20-21: MHCC propose that restrictive practices be regulated by law and in relation to people with mental health conditions that the DSA refer to *the NSW Mental Health Act* 2007 for guidance on regulations concerning seclusion and restraint. These matters are under review at present. MHCC propose that the key principles outlined in the National Plan for Reducing Harm 'National Safety Priorities in Mental Health: a National Plan for Reducing Harm' be used as a guide for the development of restrictive practices to be regulated by law.[iii]

Question 27: MHCC recommend that the DSA refer to agreed state and national standards for specialist disability services, including mental health services. This would include The National Standards for Mental Health Services (2010) revised to include the Principles of Recovery Orientated Practice. [iv] With regards to Delivery of care – Standards, it is necessary that that the principles are supported by the mental health standards that incorporate recovery principles into service delivery, culture and practice providing consumers with access and referral to a range of programs and services that will support sustainable recovery (Standard 10). [v]

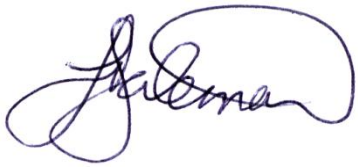
Question 28: MHCC propose that the DSA 'minimise risk of mainstream providers who are not monitored or regulated' by specifying that a recipient of for example services under the NDIS can only choose an unregulated services where the service provided in non-health related.

Question 29: MHCC are concerned that the legislation provide appropriate safeguards for people who may be vulnerable particularly in relation to the accountability of new commercial providers likely to enter the market following the introduction of the NDIS.

On the other hand we are keen to see that the legislation reflects an understanding of dignity of risk and how supported decision making, and advance directives are ways in which consumers could be empowered to advocate for themselves and make their goals and complaints heard. The legislation must clearly identify what represents coercive or abusive practices and identify complaints mechanisms for people who may experience difficulties advocating for themselves at certain times or in certain ways.

MHCC thank the Disability Services Act Review Team for providing us with the opportunity to comment on the Reforming NSW Disability Support: Legislative Structure and Content, Discussion Paper. For further information on this submission please contact Corinne Henderson, Senior Policy Officer at E: corinne@mhcc.org.au or T: 02 9555 8388 # 101

Yours sincerely



Jenna Bateman
Chief Executive Officer

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[i] Office of Public Advocate, 2009, Victoria. Available: http://www.publicadvocate.vic.gov.au/file/file/Research/Partnerships/Managing_risk_in_community_services.pdf

[ii] Government of the United Kingdom. *Mental Health Capacity Act* 2005. Available: http://www.legislation.gov.uk/ukpga/2005/9/contents

[iii] National Mental Health Working Group, 2005,' National safety priorities in mental health: a national plan for reducing harm, Health Priorities and Suicide Prevention Branch', Department of Health and Ageing, Commonwealth of Australia, Canberra. Available: http://www.health.gov.au/internet/main/publishing.nsf/content/mental-pubs-n-safety

[iv] Recovery principles: http://www.health.gov.au/internet/main/publishing.nsf/content/DA71C0838BA6411BCA2577A0001AAC32/$File/servpri.pdf

[v] National Standards Mental Health: http://www.health.gov.au/internet/main/publishing.nsf/content/DA71C0838BA6411BCA2577A0001AAC32/$File/servst10v2.pdf