Northern Territory Mental Health Coalition Submission to *Mental Health and Related Services Act 1998* (NT) Review

31 May 2021

Introduction

Acknowledgement

We acknowledge the Traditional Owners of the land on which we live, work and walk.

About Northern Territory Mental Health Coalition

The Northern Territory Mental Health Coalition (the Coalition) is the peak body for the community managed mental health sector in the Northern Territory. As a peak body, the Coalition ensures a strong voice for member organisations and a reference point for governments on all issues relating to the provision of mental health services in the Northern Territory. The Coalition provides advice and input into mental health care policy and associated challenges around service delivery to all levels of government and contributes to national mental health networks and associated peak bodies. The Coalition is a member of both the Mental Health Australia (MHA) and Community Mental Health Australia (CMHA).

The Coalition's purpose and vision is to be a strong voice for Territorians so that they have the opportunity for the best possible mental health and wellbeing.

The Coalition has six guiding principles, and they are:

1. for the common good;
2. collaboration;
3. accountability;
4. cultural respect, responsiveness and security;
5. person-centred
6. valuing of lived experience

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NORTHERN TERRITORY MENTAL HEALTH COALITION

Submission to Mental Health and Related Services Act 1998 (NT) Review

The Coalition welcomes the NT Government's decision to review the *Mental Health & Related Services Act 1998* (NT) (the MHRS Act) and the opportunity to contribute to it.

This submission is another demonstration of the Coalition's commitment to partnership with the NT Government in its mission "to establish a better understanding of mental health and mental illness by increasing mental health literacy, reducing the stigma associated with mental illness and to ensure that the mental health service system is responsive, coordinated, provides timely and high quality, culturally safe and appropriate care at the right place and at the right time."[1] (NT Mental Health Strategic Plan 2019-2025).

The MHRS Act[2] aims to provide for the "care, treatment and protection" of people with mental illness, while at the same time protecting their civil rights. In the NT Government's discussion paper for the MHRS Act review, the Coalition is pleased to see the NT Government expressing the need for "strong and contemporary legislation informed by Territorians with lived experience, their carers and families and communities". The Coalition is also pleased by the *NT Mental Health Strategic Plan 2019-2025* setting out a mission to "establish a better understanding of mental health and mental illness by increasing mental health literacy, reducing the stigma associated with mental illness and to ensure that the mental health service system is responsive, coordinated, provides timely and high quality, culturally safe and appropriate care at the right place at the right time". The Coalition welcomes such discourse and eagerly waits to see it enshrined into the MHRS Act.

The MHRS Act confers considerable powers, rights, and responsibilities on Territorians with mental illness and the networks around them. For example, apart from the *Criminal Code Act 1983* (NT), the MHRS Act is one of the only other pieces of legislation that can take away a person's rights in the NT. With the relative significance of the Act and the fact that the Act has not been reviewed since its passing in 1998, the Coalition is supportive of a significant change to keep pace with all other Australian jurisdictions and global best practice.

The Coalition feels that the current legislation can be more effective in regulating mental health treatment and care up to the point that amendments to the Act are insufficient and an entire new mental health Act is needed. The Coalition suggests that the NT Government follow other state/territory in embedding human rights into mental health legislation, such as the ACT and Queensland. Many of our participants were excited by the prospect of a modern, human rights, recovery-oriented Act, asking… *'how do we change the concept of the medical model'?* The

[1] Northern Territory Mental Health Strategic Plan 2019-2025, NT Mental health strategic Plan 2019_2025.pdf

[2] *Mental Health & other Related Services Act* 1998 (NT), https://parliament.nt.gov.au/__data/assets/pdf_file/0004/731029/Mental-Health-and-Related-Services-Act-1998-NT.pdf

Coalition and many of those we consulted with feel that the Act should be aspirational, and that *'we cannot cut out entitlements because it's too hard operationally.'*

Consultation Process

The Coalition would like to thank its members and the broader community for their invaluable insights, gained over several months through face-to-face and online consultations, individual meetings, and telephone conversations. The Coalition would especially like to thank all those with lived experience who have shared their wisdom and insights with us. We are grateful to have received a booklet of drawings and writing from a group who taught us so much - some of these drawings feature in this submission. All insights were invaluable, as good policy and good legislation should be relational, not conceptual; it is the gap between formulation and execution which matters most. Furthermore, the Coalition would like to acknowledge the contribution of the Department of Health to the consultation process.

> *'Recovery and hope need to be built into the Act to make it more contemporary.'*

> *'It needs to be more holistic.'*

The MHRS Act impacts on people when they are at their most vulnerable. Without exception, when people relayed their stories to us, their experience had been traumatising and continued to impact on their wellbeing. Perhaps by its very nature, trauma is unavoidable. But we can do better if principles of better practice and hope are embedded into the journey.

The Coalition consulted with over seventeen different organisations, including the community legal and community mental health sector, and many individuals to better understand experiences with the MHRS Act. Many of the organisations consulted work directly with people with lived experience, their families or carers. This submission acts to prioritize the voices of those we spoke to. At each consultation, extensive notes and direct quotes were taken. All insights have been de-identified as a respect to people's privacy.

Common to all consultations was the view that this was an opportunity to modernise the Act and a hope that the NT would then lead the nation in having legislation that embedded human rights principles, was trauma informed, provided cultural security, respected lived experience and was centered around recovery. We also have the opportunity to ensure the new Act is inclusive of all in the use of language e.g., gender neutral language. Most of all, the voices of people with lived experience need to be heard at every stage. In accordance with much of the feedback we received, this submission has used language that is person-centered. Although

the word 'consumer' is currently in use throughout mental health literature, this submission uses the word 'person.'

While the focus of the consultations was centered around the opportunity to amend the current Act or develop a new Act, we heard many stories and suggestions that were about the implementation of and lack of adherence to the current Act. We heard about the impact of the chronic under-resourcing in both the clinical mental health system and the community managed mental health system and how this effects service delivery. Modernising the MHRS Act is an important piece of work but without adequate resourcing for the implementation, the potential gains may never be realised. This includes ensuring the MHRS Act is seen as part of the continuum of care.

> *'No one should be losing rights as we move forward. Rights for people can't be eroded. Rights need to underpin the wellbeing of a person.'*

Northern Territory Mental Health Context

Mental health in the NT presents a complexity unfound in other states and territories in Australia due to its geographical vastness, its cultural and linguistic diversity, its concerning upstream social determinants of health and intergenerational trauma experienced by many Aboriginal people.

"We can now connect the psychobiology of trauma to the social determinants of health. Never before have we had an integrative framework that allows extensive and specialised bodies of knowledge to be connected to each other within a human rights context as well as a public health challenge."[3]

The upstream social determinants of health which play a fundamental role in the poor health outcomes for many Territorians are: family violence, unemployment, physical health, grief and trauma, unstable housing, homelessness, disproportionately high rates of imprisonment and suicide and drug and alcohol use[4] [5]. For young Territorians suffering from mental-ill health, it is estimated that 70 per cent do not seek help. This number is compounded by the fact that young people, aged 15 to 24 years represent 24.6 per cent of admissions to mental health impatient facilities.[6]

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[3] Farragher, Brian & Bloom, Sandra L 2013, Restoring Sanctuary, Oxford University Press, Cary.

[4] Department of Health 2016, Primary Health Networks Mental Health and Suicide Prevention Needs Assessment NT PHN, https://www.ntmhc.org.au/wp-content/uploads/2016/09/2016-NT-PHN-Needs-Assessment-Mental-Health-and-Suicide-Prevention.pdf

[5] Nagel, T & Thompson, C 2006, 'Aboriginal mental health workers and the improving Indigenous mental health service delivery model in the 'Top End'', *Australian and New Zealand journal of psychiatry*, vol. 14, no. 3, pp. 291–294.

[6] Department of Health 2016, Primary Health Networks Mental Health and Suicide Prevention Needs Assessment NT PHN, https://www.ntmhc.org.au/wp-content/uploads/2016/09/2016-NT-PHN-Needs-Assessment-Mental-Health-and-Suicide-Prevention.pdf

Around much of the world, the recognition of the effects of upstream determinants such as social, economic, political, and cultural conditions and their interplay on mental health are regarded as a current feature of social policy agendas[7]. This recognition is reflected in the various NT, state and national mental health plans and frameworks in existence and is also recognised as an important policy area of the NT Government.

List of Recommendations

The Coalition recommends that the Act:

Charter of Rights

1. Require the drafting and approval of a Charter of Rights by the Chief Psychiatrist.

2. Require that the written form of the Charter of Rights be made available to a person receiving mental health care and services at the earliest opportunity as well as their support persons, family, carers, and other reasonable persons by the appropriate mental health professional.

3. Require an oral communication of rights is made available to the person as well as support persons, family, carers, and other reasonable persons by the appropriate mental health professional.

4. Require that all reasonable steps be taken to ensure that the Charter of Rights is fully understood, such as the use of interpreter services.

5. Require that the Charter of Rights be translated and communicated to reflect the diverse cultural and linguistic NT context.

Recovery

6. Incorporate principles that promote best-practice, contemporary values and fit-for-purpose NT mental health policy so the Act has a foundation that is recovery-oriented, trauma-informed and cognisant of the latest holistic and therapeutic service delivery informed by the needs of indigenous peoples, cultures and spiritualities.

[7] Lewis, L 2009, 'Introduction: Mental Health and Human Rights: Social Policy and Sociological Perspectives', *Social policy and society: a journal of the Social Policy Association*, vol. 8, no. 2, pp. 211–214.

7. Incorporate a broad, non-limiting definition of recovery – a definition that is also trauma-informed and also considerate of relevant civil rights and human rights.

Capacity

8. Follow the practice set by Mental Health Act 2015 (ACT) when it comes to capacity, assistance, and communication.

9. Stipulate that the consideration of capacity be attributed more weight than other considerations during the crucial decision-making process of admitting a person involuntarily or not.

10. Take into account the complexities of culture and language and allow communication of consent in all forms rather than the 'approved form' as currently stipulated in Section 7(c) of the MHRS Act.

Wills and Preferences

11. Ensure Advanced Care Directives are promoted to patients and developed as early as possible and well before patients reach crisis point.

12. Ensure that Advanced Care Directives are more recovery focused and consider changing the term to Advanced Health and Recovery Directive, which is mental health focused, and more appropriate.

Nominated Support Person

13. Ensure the role of a Nominated Support Person is legislated and is available to a person whether they be voluntarily or involuntarily admitted.

14. Allow for stronger involvement of nominated support persons, independent advocates, carers and families where they are important to the persons recovery, treatment and care.

15. Allow people the option of nominating who they **do not** want as support persons.

16. Allow people the option of **up to two** nominated support persons rather than just one.

17. Make it a mandated requirement that written information be provided to people receiving care, their Nominated Support Persons and families about their treatment,

rights and responsibilities, and advocacy options. Acknowledge that there is significant work needing to be done to equip people with awareness of legal rights and responsibilities.

18. Require that interpreters be available to patients and nominated support persons, at all times and stages not just the Tribunal stage.

Community Visitor Program (CVP)

19. Recognise and expand the role of the CVP, as the independent and accessible service that helps ensure the human rights and dignity of people accessing mental health support in NT.

Cultural Security

20. Incorporate principles of Social and Emotional Wellbeing

21. Recognise and legitimise culture and spirituality in assessments, treatment, and recovery.

22. Foster stronger and consistent inclusion of registered and non-registered Aboriginal health workers and counsellors in treatment.

23. As per previous recommendations, require that interpreters be available to patients and nominated support persons, at all times and stages, especially in admission, not just the Tribunal stage.

Involuntary Admission

24. Ensure that nominated support persons, families and carers are present and are spoken to when a patient is undergoing involuntary admission.

25. Promote transparency and clarity so that the difference between voluntary and involuntary patient and the role of community management orders is more widely understood.

26. Explicitly state that involuntary admission of a patient must not be used, or proposed to be used, as a coercive or disciplinary measure.

Voluntary Admission

27. Incorporate stronger requirements that Territorians receive help before reaching crisis stages and have a better experience in trying to access that help.

Chief Psychiatrist

28. Increase the role and powers as proposed in the discussion paper, of the Chief Psychiatrist to replace the role that is currently delegated to the Chief Executive of the Department of Health. A function of the Chief Psychiatrist should be to ensure clinical expertise to provide the oversight and guidance consistent with contemporary best practice.

29. Ensure the role of the CVP is embedded in the legislation as a key independent advocate, while also ensuring the CVP is adequately resourced to be able to provide advocacy for **all** people who come into contact with the legislation.

Restrictive Practices

30. In line with the findings from the Royal Commission into Mental Health in Victoria the NT should implement a 'towards zero' use of restrictive practices**.**[8] [9]

31. Stipulate that restrictive practices – such as seclusion and restraint - are to be used as a means of last resort and when absolutely necessary and not for coercion or behavioural management.

32. Acknowledge extensive literature which largely indicates that negative outcomes of restrictive practices exceed positive outcomes, for example, use of restrictive practices may prevent injury, but it is non-therapeutic due its harmful psychological effects, detrimental to clinician/patient relationships and contrary to civil and human rights.

33. Acknowledge documentation of the other alternatives used including use of cultural advisors and best practice approaches to seclusion.

34. Require that accurate records are kept at the time of any use of restrictive practices, rather than retrospectively.

[8] Royal Commission into Victoria's Mental Health System, Final Report https://finalreport.rcvmhs.vic.gov.au/wp-content/uploads/2021/02/RCVMHS_FinalReport_ExecSummary_Accessible.pdf

[9] The NDS has released the 'Zero Tolerance' framework which a commitment to recognise, raise and respond to any deviation from the human rights of people using disability services, https://www.nds.org.au/resources/zero-tolerance

35. Ensure that, in the process of transport, the use of chemical restraint is used sparingly and only when absolutely necessary.

36. Ensure that there is a clear definition of the word 'transport'.

Workforce

37. Promote the need for clinical and tribunal staff to undergo comprehensive training and certification to ensure they have an up-to-date high-level understanding of recovery-oriented and trauma-informed principles as well as the intersection of civil and human rights into their work.

38. Emphasise the importance of resources, particularly building capacity of staff, through upskilling and training as well as the attracting and retaining of skilled staff.

39. Recognise the importance of peer workers, Social and Emotional Wellbeing Workers, Ngangkaris and Aboriginal health workers and Aboriginal counsellors as legitimate and commensurate to a holistic and recovery focused mental health system.

Part One: Principles And Rights Of The Patient

Charter of Rights

Human and civil rights need to be present and consistent throughout the legislation. One way to do this is by having a NT Charter of Rights for people receiving mental health care and services. One of the key features throughout our consultations was that people receiving care, and their families, found it difficult to self-advocate and did not know where to access information on their rights. A charter could be used to guide the development of a modern and accessible document, which will help everyone understand and safeguard their rights.

Currently, the MHRS Act is without a single mention human rights nor a Charter of Rights or Statement of Rights or any rights document at all. The principles in the Act may appear as direct substitutes for a rights document, but they are not. The target audience of guiding principles or service delivery principles is made clear in the *Mental Health Act 2009* (SA)[10] and the *Mental Health Act 2013* (TAS)[11] in that they help providers and those that work for them. Principles are important; however they do not serve to empower people in the same way as a rights document does. A mental health charter or rights document for the NT would indicate a

[10] Section 7(1), *Mental Health Act 2009* (SA): "The Minister, the Tribunal, the Chief Psychiatrist, health professionals and other persons and bodies involved in the administration of this Act are to be guided by the following principles in the performance of their functions…"

[11] Section 15, *Mental Health Act 2013* (Tas): "All persons exercising responsibilities under this Act are to have regard to…

paradigm shift towards person-centred care. The MHRS Act should ensure that every person touched by it is able to easily take away an understanding of their rights.

One of the key features throughout the Coalition's consultations was that people found it difficult to self-advocate and advocate on behalf of others because they did not know where they can get information about their rights. A safeguarding document that is modern and accessible that outlines rights, and perhaps even responsibilities and processes, presents a strong shift to person centred care.

The MHRS Act should sit in-line with the mental health legislation of other Australian state/territory jurisdictions and can go one step further. Other legislation not only allows for the establishment of rights, (either as a statement or a charter), but some even require it. Other legislation enshrines rights while others directly refer to them.

The MHRS Act should firstly legislate for a Chief Psychiatrist, as mentioned in the discussion paper for the review. As part of the Chief Psychiatrist's role, they should approve a plain-language setting out:

- a person's rights while being assessed or receiving treatment in relation to his or her mental illness;
- rights of nominated support persons, family, carers, and other support persons;
- rights to make complaints;
- information as to the process by which the person will be assessed or receive treatment;
- and all other appropriate information.[12]

The MHRS Act can learn from other Australian jurisdictions and mandate that a rights document be orally explained and be made available as a written document for the person to read along with and takeaway.[13]

The MHRS Act should also stipulate that the written document should be made available to a person's support network as much as possible.[14] It should also push the taking of all reasonable steps to ensure that the rights document can be easily and fully understood.[15]

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[12] Section 12, *Mental Health Act 2014* (Vic); Section 9(1), *Mental Health Act 2009* (SA); Section 277, *Mental Health Act 2016* (Qld); Sections 74-74A *Mental Health Act 2009* (NSW)

[13] Section 15(1), Mental Health Act 2015 (ACT); Section 278, *Mental Health Act 2016* (Qld); Sections 74-74A *Mental Health Act 2009* (NSW); Section 243, *Mental Health Act 2014* (WA)

[14] Section 9(3), Mental Health Act 2009 (SA); Section 15(4), Mental Health Act 2015 (ACT); Section 277 *Mental Health Act 2016* (Qld); Sections 74-74A *Mental Health Act 2009* (NSW); Section 244, *Mental Health Act 2014* (WA)

[15] Section 15(3), *Mental Health Act 2015* (ACT); Section 9(2), *Mental Health Act 2009* (SA); Sections 74-74A Mental Health Act 2009 (NSW)

The MHRS Act must include a section to make a rights document as powerful as possible. For example, it may include a requirement to not just discuss, but to comply with and in no ambiguous terms, as is done in Section 12 of the Mental Health Act 2014 (WA): 'A mental health service must make every effort to comply (emphasis added) with the Charter of Mental Health Care Principles when providing treatment, care and support to patients.'

RECOMMENDATION:

The Coalition recommends that the Act:

1. **Require the drafting and approval of a Charter of Rights by the Chief Psychiatrist.**

2. **Require that the written form of the Charter of Rights be made available to a person receiving mental health care and services at the earliest opportunity as well as their support persons, family, carers, and other reasonable persons by the appropriate mental health professional.**

3. **Require an oral communication of rights is made available to the person as well as support persons, family, carers, and other reasonable persons by the appropriate mental health professional.**

4. **Require that all reasonable steps be taken to ensure that the Charter of Rights is fully understood, such as the use of interpreter services.**

5. **Require that the Charter of Rights be translated and communicated to reflect the diverse cultural and linguistic NT context.**

1.1 Recovery

The principles contained within the Act must reflect current discourse and best practice in the mental health profession domestically and globally and at the very least Australian state and territory jurisdictions.

For example, the Coalition recommends that the Act incorporate learnings from the Mental Health Coordinating Council's eight foundational principles of care and practice:

Understanding trauma and its impact; Promoting safety; Ensuring cultural safety; Supporting person-led control, choice and autonomy; Sharing power and governance; Integrating care; Healing happens in relationships; and Recovery is possible. [16]

When looking at the mental health legislation of other jurisdictions, it is important to note that only the *Mental Health Act 2009* (SA) gives a direct mention to trauma in its principles, or at all. Other state/territory jurisdictions directly refer to recovery more than that of the NTs. The Queensland legislation – see s5(k) of *Mental Health Act 2016 (*QLD) - goes further than the rest to actually include the term 'recovery-oriented' in its principles. The current NT Act has no mention of the word stigma in its legislation, while almost all other state/territory jurisdictional mental health legislation does.

During our consultations, the importance of a recovery-orientated focus has been paramount to addressing many of the concerns. We heard the need for recovery and holistic practices to be built into the MHRS Act, to make it more contemporary in terms of Indigenous and non-Indigenous healing practices and that the service needs to be therapeutically focused. The term recovery should be defined around a person's capability to live a more fulfilling life where they can live, work and participate in the community and to promote and assist self-reliance. Recovery is central to personal meaning and promoting choice and control principles.

"Recovery means gaining and retaining hope, understanding abilities and disabilities, engagement in an active life, personal autonomy, social identity, meaning and purpose in life, and a positive sense of self."[17]

A recovery-oriented focus is in-line with the principles of self-determination and intersects with the process of capacity and decision making. An established recovery-orientated model focuses on the people using the service and incorporates a conceptual and practical lived-experience framework. Recovery is not a destination, but a process that a person, and those around the person, are continually involved in. In clinical settings, there must be a recovery and hope focus, which enables the further development of individual value and meaning.

The Coalition applauds the Discussion Paper's section on recovery and agrees that the MHRS Act should not include a definition, due to the need to contextualise personal approaches to recovery. However, recovery needs to be more than a vague set of principles. Recovery-orientated practices, when embedded at all levels – through systems, governance, practices

[16] Mental Health Coordinating Council (MHCC) 2013, Trauma-Informed Care and Practice: Towards a cultural shift in policy reform across mental health and human services in Australia, A National Strategic Direction, Position Paper and Recommendations of the National Trauma-Informed Care and Practice Advisory Working Group, Authors: Bateman, J & Henderson, C (MHCC) Kezelman, C (Adults Surviving Child Abuse, ASCA)

[17] Northern Territory Mental Health Strategic Plan 2019-2025, NT Mental health strategic Plan 2019_2025.pdf

and discourse can work in tandem with a biopsychosocial approach to psychiatry, which can enable clinicians to work in a more holistic way.[18]

Embedding a recovery-orientated practice means engaging with the persons family/carers, engaging people with lived experience in decision making, finding a personal connection to develop meaningful conversations, using language that reflects recovery, hope, optimism, and improvement, focusing on the service user's needs (not the organisational priorities), and ensuring recovery is inclusive through all social determinants (housing, social contacts, diet and exercise, work). [19]

> *'Decisions need to be made after a co-design research process that uses a population of people with lived experience.'*

The NT is the only Australian jurisdiction that has not amended legislation to better facilitate recovery-orientated practices and enhance and protect human rights.[20] The Coalition would like to see the principles of trauma-informed care and practice embedded within the objects of the MHRS Act. The objects of the MHRS Act should be trauma-informed and recovery-orientated. A recovery-orientated Act is, by its very nature, trauma-informed and should operate in a way that gives credence to the safety of the person.

From the initial process of admissions to cultural security to the use of restrictive practices, embedding trauma-informed systems will serve to mitigate the "trauma-inducing" practices we heard about during our consultations.

Although there is no universally accepted definition of trauma-informed care, the most widely cited definition within the youth healthcare literature is based on the trauma-informed approaches provided by Substance Abuse and Mental Health Services Administration (SAMHSA) in the USA.[21]

'A program, organisation, or system that is trauma-informed:

- *Realises the widespread impact of trauma and understands potential paths for recovery;*
- *Recognises the signs and symptoms of trauma in clients, families, staff, and others involved with the system;*

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[18] RANZCP 2016, Recovery & the Psychiatrist, https://www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/recovery-and-the-psychiatrist

[19] Health Ministers Advisory Council, 2013, National Framework for Recovery-oriented Mental Health Services Australian, https://www.health.gov.au/sites/default/files/documents/2021/04/a-national-framework-for-recovery-oriented-mental-health-services-policy-and-theory.pdf

[20] Ryan, C, J 2019, 'Is legislative reform translating into recovery-oriented practices and better protection of rights?' *Australian & New Zealand Journal of Psychiatry,* vol. 53, no. 5, pp. 382-383

[21] Substance Abuse and Mental Health Services Administration 2018, Trauma-informed approach and trauma-specific interventions, *SAMHSA*, Available from: https://www.samhsa.gov/nctic/trauma-interventions

- *Responds by fully integrating knowledge about trauma into policies, procedures, and practices; and*
- *Seeks to actively resist re-traumatisation.'*

Understanding trauma works to create cultural safety for many people, including survivors of domestic violence, child abuse, LGBTIQA+ and an understanding of trauma within the cultural setting. The overrepresentation of Aboriginal people in the mental health system adds to the urgency of integrating a practice of trauma and culturally informed care. Aboriginal people have the highest rates of psychotic illness of any group in Australia. They are 1.8 times more likely to experience a psychotic illness and are hospitalised at 2.4 times the rate of non-Aboriginal people. [22]

One forum participant talked about his experience of leaving his community to travel to Darwin. He spoke about how during his travels, he became unwell due to dark spirits. He eventually sought help from a traditional healer and that helped him feel much better. He felt very strongly that traditional healers and traditional counsellors were an important part of him looking after his mental health as well as being in touch with his country.

To create legislation that is encompassing of culture-bound syndromes, means the mental health system is mandated to broaden its understanding of the importance of language, country, and culture and how people's cultural beliefs and practices influence their construction of illness. Other factors impacting upon clinical admissions for Aboriginal people include the concept of shame and trans-generational trauma. A trauma-informed, recovery-orientated framework works to recognise and incorporate culturally appropriate systems.

> *'The current legislation does not explicitly refer to the importance of trauma informed care. The evidence-base has grown substantially in this space. It should now be an explicit requirement within the legislation.'*
>
> *'Everyone thinks they are trauma-informed, but are there any standards? There is a need for strong culturally responsive, trauma informed training.'*

Evaluations of the application of recovery-oriented practices in facilities has proved to be challenging.[23][24] Definitions of recovery have come across as vague and have also contradicted systems and procedural practices in individual settings. Embedding recovery-orientated and trauma-informed practices necessitates a high level of understanding for clinical and tribunal

[22] Westerman, T 2021, 'Culture-bound syndromes in Aboriginal Australian populations', *Australian Psychological Society*, pp. 1–17.

[23] Waldemar, A, K, Arnfred, S, M, Petersen, L, & Korsbek, L 2016, Recovery-Oriented Practice in Mental Health Inpatient Settings: A Literature Review, *Psychiatric Services*, no. 67, vol. 6, pp. 596–602.

[24] Nardella, N, Hooper, S, Lau, R, & Hutchinson, A 2021, 'Developing acute care-based mental health nurses' knowledge and skills in providing recovery-oriented care: A mixed methods study' *International Journal of Mental Health Nursing*.

staff. The concept of recovery is not new; however, research has shown that staff in inpatient settings had difficulty articulating what recovery means and how to implement recover-orientated practices.[25] While we understand that the legislation does not reach to the ability to train and educate staff, recovery-orientated needs to move beyond the conceptual to the practical. We ask that recovery-orientated and trauma-informed practices be defined in the MHRS Act.

> *'It wasn't until I finally entered a recovery-orientated, trauma-informed treatment program a little more than four years ago, where I felt safe and respected, that I could begin to heal…Someone finally asked me 'What happened to you?' instead of 'What's wrong with you''*[26]

RECOMMENDATIONS

The Coalition recommends that the Act:

6. **Incorporate principles that promote best-practice, contemporary values and fit-for-purpose NT mental health policy so the Act has a foundation that is recovery-oriented, trauma-informed and cognisant of the latest holistic and therapeutic service delivery informed by the needs of indigenous peoples, cultures and spiritualities.**

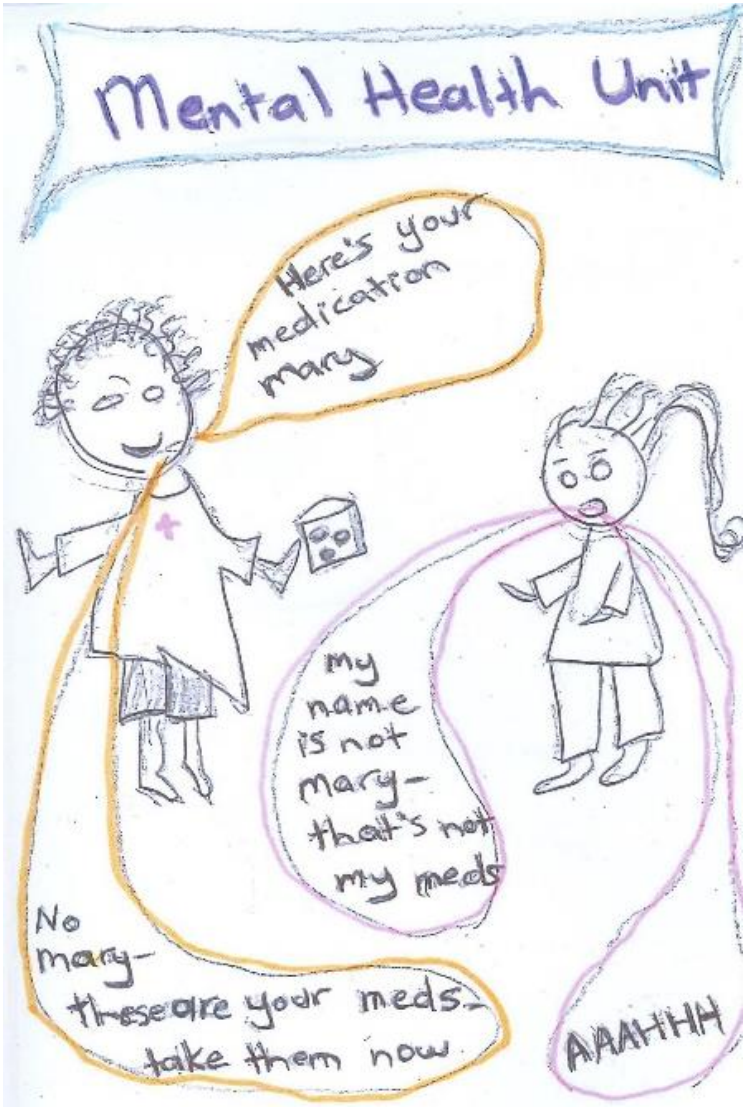
7. **Incorporate a broad, non-limiting definition of recovery-oriented care – a definition that is also trauma-informed and also considerate of relevant civil rights and human rights.**

[25] Waldemar, A, K, Arnfred, S, M, Petersen, L, & Korsbek, L 2016, Recovery-Oriented Practice in Mental Health Inpatient Settings: A Literature Review, *Psychiatric Services*, no. 67, vol. 6, pp. 596–602.

[26] Tonier C, Survivor. SAMHSA National Centre for Trauma-Informed Care (NCTIC), https://www.samhsa.gov/nctic/

1.2 Capacity

'It should not be assumed that people living with a mental illness are not intelligent individuals who are more than capable of making decisions about their life. This stems around the terminology person-centred that is not often practiced where clients are not given full autonomy on the treatment they are given.'



The issue of capacity and informed consent was a key issue raised during our consultations. We have heard from families and carers who had been left languishing without any appropriate information on what is happening to their loved one, or when their loved one has been granted leave. We have also heard from people with lived experience who did not want their families to know what is happening. This is a vexed and contentious issue and one that is hard to balance.

In terms of best practice, the Coalition notes the *Mental Health Act 2015* (ACT), with regards to the presumption of capacity and the stipulation that a person may need assistance and can communicate their decision in whatever way they can.[27] The presumption of capacity to give informed consent with the understanding that capacity may fluctuate and that it is unique to the decision, is paramount to protecting the rights and agency of a person.

What is also seen as vital to the NT context, is the ability for a person to be able to communicate in ways other than oral and written expression using English. Aboriginal peoples represent a significant proportion of NT population and they are more likely to have English as their third or fourth language rather than their first or second. Language as well as cultural traditions such as kinship ties present obstacles for capacity and all other areas of the MHRS Act, such as nominated support person. The Coalition recommends that the MHRS Act, account for the unique cultural needs of each Aboriginal person.

RECOMMENDATIONS

The Coalition recommends that the Act:

8. **Follow the practice set by Mental Health Act 2015 (ACT) when it comes to capacity, assistance, and communication.**

9. **Stipulate that the consideration of capacity be attributed more weight than other considerations during the crucial decision-making process of admitting a person involuntarily or not.**

10. **Take into account the complexities of culture and language and allow communication of consent in all forms rather than the 'approved form' as currently stipulated in Section 7(c) of the MHRS Act**

[27] Mental Health Act 2015 (ACT) s7.

Part Two: Person Centred Approach

2.1 Wills and Preferences

Almost every consultation raised the issue of planning for future relapse and admission. We heard from many people with lived experience, families and carers about issues that arose from uncertainty – particularly around who information should and could be shared with and who could be part of making decisions. When those who are important to the patient's recovery plan are better included in the treatment, the better it will be for the recovery of the individual and their connection with family.

Advanced Care Directives (ACD) were viewed as a key part of ensuring those who should be, were included in treatment plans and information sharing and that the wishes of the patient were adhered to. Having an ACD can mitigate many of the problems encountered for both the patient and their families/carers, especially around information sharing however they need to be developed before patients reach crisis point.

Many people felt that the language of Advanced Care Directives needed to be more recovery focused and that the current Advanced Care Directives was primarily written for people who may become permanently unable to make decisions on their own behalf. One suggestion put forward was the term 'Advanced Health and Recovery Directive' which would more appropriately describe the process.

> *'Where a client is currently unwell enough to consent to treatment, a plan should be made during a time when they are well enough to make a decision on the type of treatment to be given during that time. That person should also be given the right to appoint a person (e.g., Power of Attorney) who can ensure that the agreed treatment is administered when the client is unwell enough to make their own decision.'*

RECOMMENDATIONS

The Coalition recommends that the Act:

11. **Ensure Advanced Care Directives are promoted to patients and developed as early as possible and well before patients reach crisis point.**

12. **Ensure that Advanced Care Directives are more recovery focused and consider changing the term to Advanced Health and Recovery Directive, which is mental health focused, and more appropriate.**

2.2 Nominated Support Person (NSP)

Throughout our consultation, the role of the Nominated Support Person (NSP) has been a complicated issue. Some people do not want anyone to be involved in their care or treatment, and some others do not have anyone in their lives who could fill the role of an NSP.

The complexity of this situation should be taken into account with a diversity of options for the person receiving care. For those who do not have, or wish, anyone to be called upon to act as an NSP, an advocacy and support organisation, such as the Community Visitor Program, should be easily accessed.

For those who wish to nominate someone, we believe the role of the NSP should be legislated. Whether a person has chosen an NSP or advocacy and support organisation, either should be available regardless of being voluntary or involuntary. We also believe that there should be a provision for nominating two people and that a person can nominate who they do not want information shared with.

A holistic model is needed to embed recovery-orientated practices into every aspect of a person's mental health journey. We have heard in our discussions that people need help with and greater access to supports and services which provide advocacy, capacity building, care planning and quality and safeguard assurance.

> '[The legislation is] *not just about accommodating carers, it's also about excluding abusers.'*

The NSP is also an important tool for patients wanting or needing to exclude people from decision making. For many people we spoke to, this aspect of the legislation is about making sure that a person-centred and directed approach involves the decision making and capacity of the person. For some people we spoke to, involvement of family members is unhelpful at best and detrimental at worst.

The complexity of these issues is heightened when speaking with support people and carers who were involved in their loved one's care and treatment, however had great difficulty navigating the system. Many support people were unaware of their rights and their loved one's rights.

> *'How do you enact your rights if you do not know what they are?'*

We have been told that some carers are unaware of their right to appeal and that some also had difficulty advocating for their person when English is not the first language. It was

expressed to us that clinicians and staff on the ward were unaware of the rights of the person/carer and therefore could not impart information.

There is a widespread lack of access to information about treatment, care and support to assist families, carers and supporters. The Coalition asks that it be a mandated requirement to provide written information to people receiving care about the basis on which their treatment is being provided and their rights and responsibilities, and about the advocacy options available to them. This information should also be made available to Nominated Support Persons and family members.

The nominated support person needs to be in place for all patients whether voluntary or involuntary.

RECOMMENDATIONS

The Coalition recommends that the Act:

13. **Ensure the role of a Nominated Support Person is legislated and is available to a person whether they be voluntarily or involuntarily admitted.**

14. **Allow for stronger involvement of nominated support persons, independent advocates, carers and families where they are important to the people recovery, treatment and care.**

15. **Allow people the option of nominating who they do not want as support persons.**

16. **Allow people the option of up to two nominated support persons rather than just one.**

17. **Make it a mandated requirement that written information be provided to people receiving care, their Nominated Support Persons and families about their treatment, rights and responsibilities, and advocacy options. Acknowledge that there is significant work needing to be done to equip people with awareness of legal rights and responsibilities.**

18. **Require that interpreters be available to patients and nominated support persons, at all times and stages not just the Tribunal stage**.

Community Visitor Program (CVP)

The Community Visitor Program (CVP) plays an essential role as a complaint's resolution and advocacy service. Independent advocacy and support organisations exist as a way for people to access help and provide essential feedback about their treatment. Some people told us that they were afraid to complain about their service and instead put up with behaviour that was often traumatising. The Coalition believes the CVP play an important role for someone who is at their most vulnerable. The CVP protects the legal and human rights of a person under the MHRS Act, and the Disability Act. The functions of the CVP align with many parts of the Act, including but not limited to the NSP, Chief Psychiatrist, monitoring restrictive practices and quality and safety assurances.

The Coalition advocates for the widening of what falls within the purview of the CVP and a subsequent boost of resourcing of the CVP to support this expansion of their role. This includes extending their role to people with a mental illness who are detained in NT Correctional Facilities including those receiving support through the Challenging Behaviour Unit.

The Coalition insists that CVPs, are a crucial part of meeting obligations placed on the NT when it comes to their national and international commitments, noted in Part 5 of this submission.

RECOMMENDATIONS

The Coalition recommends that the Act:

19. **Recognise and expand the role of the CVP, as the independent and accessible service that helps ensure the human rights and dignity of people accessing mental health support in NT.**

2.2 Cultural Security

Throughout the Coalition's consultations we heard from many stakeholders about the importance of cultural security within the MHRS Act and as a practice. The Coalition recognises the expertise of AMSANT in this area. Notwithstanding, the Coalition would like to reiterate the importance of a multi-disciplinary approach to the understanding of health. The inclusion of Ngangkari (traditional healers) should be recognised and acknowledged as an ancillary to Psychiatrists. There should be a recognition and legitimisation of cultural and spiritual matters and a greater inclusion of registered and unregistered Aboriginal health workers and counsellors.

The importance of Social and Emotional Wellbeing (SEWB) is now common knowledge and is embedded in mental health policies and frameworks nationally. The role of SEWB has been

increasingly recognised as extending well beyond health, into education, justice, human rights, Native Title, families and communities.[28]

'Many are missing out – have to know your background – where you come from.'

This fundamental shift has also recognised the importance of language and stigmatisation. SEWB is now being recognised as the foundation which underpins the physical and mental health of Aboriginal peoples. Research from Aboriginal academics reflect the significance and fundamentality of relationality seen in the connection to land, culture, ancestry, spirituality and kinship.[29] During consultations we heard the importance of how language, country, culture & family are essential to implementing SEWB and trauma informed care.

'Assessment and treatment are where it [cultural security] is the most vital – this is the point where trauma is created.'

The Coalition commends the NTG on the inclusion of this holistic concept of health and recommends that the principles of SWEB sit within the objects of the MHRS Act.

Whilst the Coalition recognises that you cannot legislate the behaviour of staff, there are essential principles of cultural safety, SEWB and trauma informed care and practices which must be enshrined.

'[Providing care] *can only be fully effective when ALL treating staff etc. are fully trained and culturally competent.'*

The use or lack of use of interpreters was raised in multiple consultations. While the use of interpreters often happened at the Tribunal stage, it was less common during assessment and during treatment. Concerns were raised that without the use of interpreters at all stages, many people had little understanding of their treatment.

RECOMMENDATIONS

The Coalition recommends that the Act:

20. **Incorporate principles of Social and Emotional Wellbeing.**

21. **Recognise and legitimise culture and spirituality in assessments, treatment, and recovery.**

[28] Calma, Zubrick, Kelly & Walker 2014, The Evolving Policy Context in Mental Health and Wellbeing

[29] Gibson, C, Dudgeon, P, and Crockett, J 2020, 'Listen, Look & Learn: Exploring Cultural Obligations of Elders and Older Aboriginal People', Journal of Occupational Science, vol. 27, no. 2, pp. 193-203.

22. **Foster stronger and consistent inclusion of registered and non-registered Aboriginal health workers and counsellors in treatment.**

23. **As per previous recommendations, require that interpreters be available to patients and nominated support persons, at all times and stages, especially in admission, not just the Tribunal stage.**

Part Three: Admission And Treatment

3.1Involuntary Admission

There was a clear lack of understanding or transparency about the difference between being an involuntary or voluntary patient. People spoke about seeking help multiple times only to be turned away – and then being involuntarily detained. We heard many stories about the 'threat' of involuntary admission being used to control behavior. There was also confusion for some about whether they were on community management orders or not and the problem of people being traumatically evacuated from their community, taken to Darwin/Alice Springs told they do not fit the criteria, then returned to community with no support.

There was a feeling of anger from some participants where clinicians have pointed to behavior from some time ago which is then used to involuntarily detain a person. Involuntary admission should always be the last resort and should never be used to coerce anyone… *'even when involuntarily detained it has to be doing good.'* When involuntary admission is used, there was a strong feeling from some that the nominated person, families/carers should be present.

'What does this person look like when they are unwell?'

Families and support systems are being left in the dark. They are desperate to be given information about what is happening and how to help their loved one, however we have heard that many people are not getting any help or information.

We have heard that the ward can be a scary space, which is exacerbated by the power difference between person and clinician.

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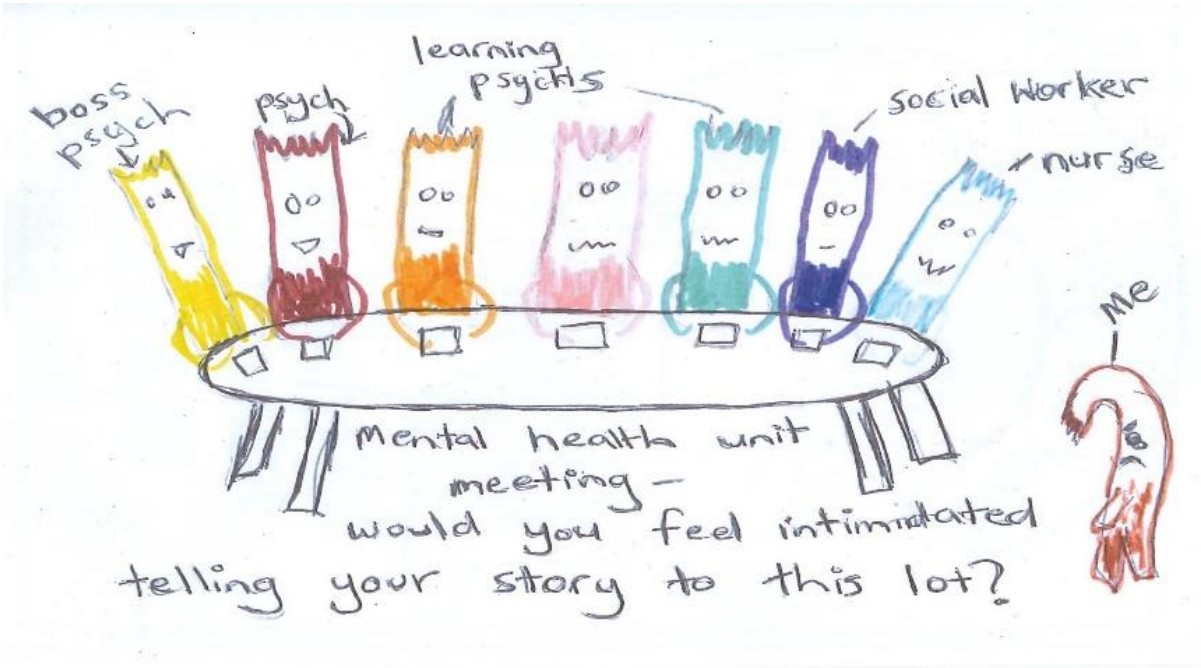


RECOMMENATIONS

The Coalition recommends that the Act:

24. **Ensure that nominated support persons, families and carers are present and are spoken to when a patient is undergoing involuntary admission.**

25. **Promote transparency and clarity so that the difference between voluntary and involuntary patient and the role of community management orders is more widely understood.**

26. **Explicitly state that involuntary admission of a patient must not be used, or proposed to be used, as a coercive or disciplinary measure.**

3.2 Voluntary Admission

'There seems to have to be a multitude of requests for help from parents before anything happens.'

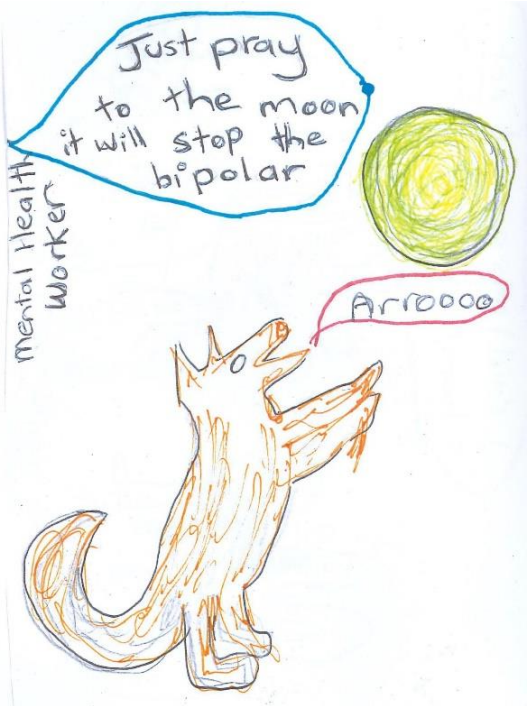
We have heard many troubling stories from people about their experiences when trying to admit themselves or a loved one. The experiences we heard, speak to the acute problems of trying to get help before things escalate, or being re-traumatised in the process of trying to get help.

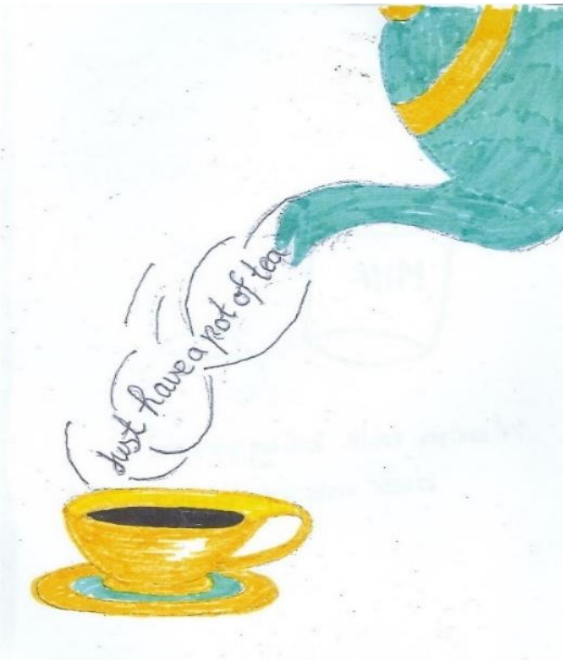
'There is a cycle – reach out to get help – told to go home – mental health worsens – behavior escalates – back to ward – professionals see it as 'attention seeking' – finally get admitted - then modify behavior to get out of ward instead of getting better because the psych ward is not a safe place.'

Another person spoke about a time when they called to get help for their loved one and were told *'if they don't have a rope around their neck, there is not much we can do for them.'* People we have spoken to have expressed dismay over the way they have been spoken to either on the phone or in person when trying to admit a loved one.

One person told us that when they called the Mental Health Access Team (MHAT) team about someone who was unwell, the MHAT team member said, 'they sound ok,' the person had to then hold the phone out to hear their loved one escalating and causing damage to then be taken seriously. If a person is not able to access voluntary admission, they should be assisted to develop a care/safety plan in response to their expressed needs and vulnerabilities, rather than simply being dismissed.

'There is a disconnect between messages. Come and see us if you are unwell – but then you are told we don't have the resources to help you.'





During our consultations, we heard that many people who were desperately seeking help, did not feel believed, or were told… *'what do you want me to do about it? You need to exercise. Self-care.'* For many people, not being believed added to accumulated trauma… *'you don't feel believed in your pain.'* Furthermore, some people who had attempted suicide were actively told that *'people who want to die just do it. They don't talk about it.'*

The issue of substance use/abuse and mental health was raised by both individuals and organisations – primarily as a barrier to admission. Examples of refusal to admit people as voluntary or involuntary because they had consumed substances in the lead up was seen as a regular occurrence. The fact that a person has imbibed alcohol or used an illegal substance should not be an adequate reason to exclude them for assessment of their mental health needs. People talked about substance abuse as a result of the mental health issues they were seeking assistance for. An example provided was seeking support for a client who was severely unwell and threatening harm but being told to come back in 24hrs. This is also perceived as related to a lack of resources and capacity of the staff to take the time to understand the complexity of issues. More broadly the issue of dual diagnosis was raised as an example of systems which can be siloed in their approach and further traumatise people.

RECOMMENDATION

The Coalition recommends that the Act:

27. Incorporate stronger requirements that that Territorians receive help before reaching crisis stages and have a better experience in trying to access that help.

3.3 Youth

During our consultations, it became apparent that there are significant gaps around the area of youth. We heard stories of young people feeling scared about being in the same ward as older

people. One young person was sexually assaulted on the ward and was told by staff members *'to be careful of what clothes you wore as to not sexually arouse people.'* Although this example pertains to poor and traumatising practices, this example feeds into the bigger picture of non-safe environments for young people.

'The psych ward is not safe.'

The Act itself is very limited in what it says on youth. Our consultations heard stories of youth with mental health issues in juvenile detention with self-harming/suicide ideation, which was exacerbated due to their environment and lack of mental health and trauma-informed knowledge and practices.

Some youth in detention who have expressed suicidal ideation are put into isolation, making them worse. We heard stories of people who have had to hide their emotions, so they are not deemed to be "at risk" and put into isolation. We heard that this behaviour of hiding emotion would then lead to being labelled a sociopath.

Most of the issues raised around the needs of young people are covered in other areas of this document.

Part Four: Monitoring

4.1The Chief Psychiatrist

In general, there was support for the legislation to be amended (as proposed in the discussion paper) to increase the role and powers of the Chief Psychiatrist, and to replace the role that is currently delegated to the Chief Executive of the Department of Health. The Coalition supports the functions of the Chief Psychiatrist which are set out in the Discussion Paper, including the powers of direct intervention and power to initiate investigations by the Chief Psychiatrist own motion.

Discussion about the role and powers of clinicians did prompt some concern about the overarching powers of clinicians in the process and the concerns that the voices of the patient and their families not being heard or respected. It is often also difficult for people to understand what is happening and to challenge decisions. There was particular concern for patients who did not have strong family and carer support around them during this time. One option proposed was to fund independent advocates who would be able to provide information and advocacy support for patients. This would ensure all patients had access to independent advocacy at all stages of their stay, not just when they were appearing before the tribunal.

RECOMMENDATIONS

The Coalition recommends that:

28. **Increase the role and powers, as proposed in the discussion paper, of the Chief Psychiatrist to replace the role that is currently delegated to the Chief Executive of the Department of Health. A function of the Chief Psychiatrist should be to ensure clinical expertise to provide the oversight and guidance consistent with contemporary best practice.**

29. **Ensure the role of the CVP is embedded in the legislation as a key independent advocate, while also ensuring the CVP is adequately resourced to be able to provide advocacy for all people who come into contact with the legislation.**

4.2 Regulating Restrictive Practices

The use of restrictive practices was raised in many of the consultations, particularly by people with lived experience. We heard stories from people where the use of restrictive practices was used as a behavior management tool – a way of coercing the person to modify their behavior. The experience of restrictive practices and coercion has continued to cause trauma to the individual long after. It was noted by one person with lived experience that things have improved in her time and that the use of seclusion has decreased, however the NT still has a higher than average reliance on the use of restraints and seclusion in comparison to other Australian jurisdictions.

The CVP 2019-2020[30] annual report also recognises that restrictive practices have decreased in the Top End, however practices have increased in Central Australia. Alice Springs saw an 86% increase in one year, however it is not possible to see if this increase was due to a higher acuity of people experiencing recurring restrictive practices. In the NT, 72% of people who were secluded were Aboriginal. This rate has progressively increased over the past three years.

All practices must be '*a service of least restriction*' - chemical restraint processes with checks and balances must be strictly adhered to and there must be tight boundaries around all types of restrictive practices, including:

- Taking away the 'grounding tool' or 'treasured possession' of the patient and refusing to give it back until the patient complies with directions.
- The use of seclusion as a behavior management tool. One person spoke about enjoying the peace of seclusion but it being used as a reward if the person engaged with others.
- Several people spoke of the common practice of using cigarettes as the bargaining tool.

Whilst we understand that seclusion and restraint are generally used in the hope of preventing injury and reducing distress, studies have reported the prevalence of harmful physical and psychological effects on both patients and staff. Seclusion & restraint have also been shown to be non-therapeutic, a breach of human rights, detrimental to the therapeutic relationship/trust between person and clinician and can be reduced.[31]

Another problematic element of restraint and seclusion is the serious concerns about the accuracy of record keeping. This includes retrospective recording, which the CVP has noted is occurring more frequently in the Top End. Keeping accurate records at the time of an event is

[30] Community Visitor Program Annual Report https://cvp.nt.gov.au/__data/assets/pdf_file/0005/948722/cvp-annual-report-2019-2020.pdf

[31] Melbourne Social Equity Institute, Seclusion & Restraint Project Overview https://socialequity.unimelb.edu.au/__data/assets/pdf_file/0017/2004722/Seclusion-and-Restraint-report.PDF

not only required by law, but it is also an essential part of monitoring the provision of quality and safe services for consumers.[32]

The use of medication to treat symptoms associated with mental ill-health has caused confusion. There needs to be clarity about the distinction between chemical restraint and appropriate pharmaceutical treatment. There is considerable confusion in the sector about this issue which is exacerbated by the by the NDIS Quality and Safeguards Framework. The *Mental Health* Act 2013 (Tas) provides a definition of chemical restraint which helps to articulate the ambiguity…'medication give n primarily to control a person's behavior, not to treat a mental illness or physical condition.'[33]

Furthermore, the NT Government supports the 'National Principles to Support the Goal of Eliminating Mechanical and Physical Restraint in Mental Health Services,'[34] developed by the Restrictive Practice Working Group of the Australian Health Ministers' Advisory Group.

It is recommended that the use of seclusion and restraint to be phased out in accordance with the Victorian Royal Commission into Mental Health's recommendation,[35] and that record keeping, and documentation be vastly improved, through real-time recording and transparency.

It is recommended that the definition of restrictive practice is aligned with the NDIS legislation which provides a broader definition of restraints.

It is recommended that the monitoring, reporting and notification process of the use of restraints is increased to improve transparency and accountability.

Legislation and policy related to restrictive practices must be supported by human rights and trauma informed care principles.

> *'People have been chemically restrained and no one is told - then they go back to community and get injected again.'*
>
> *'A person's key support or nominated person should be notified and/or present if restrictive intervention is required to prevent serious and imminent harm to themselves or another person.'*

[32] Community Visitor Program Annual Report https://cvp.nt.gov.au/__data/assets/pdf_file/0005/948722/cvp-annual-report-2019-2020.pdf

[33] Discussion Paper for the *Mental Health and Related Services Act 1998* Review

[34] Australian Government National Mental Health Commission, National Principles to Support the Goal of Eliminating Mechanical and Physical Restraint in Mental Health Services

[35] Royal Commission into Victoria's Mental Health System, Final Report https://finalreport.rcvmhs.vic.gov.au/wp-content/uploads/2021/02/RCVMHS_FinalReport_ExecSummary_Accessible.pdf

Regulation might ensure that if chemical restraint is to be used, it is done transparently, with appropriate protections, and only if less restrictive alternatives have been exhausted.[36]

One of the most raised use of restrictive practice was its use in transporting people to a mental health facility. While there were concerns raised about transporting people in the back of police vehicles, there was significant concern raised about the transport of people from remote settings on airplanes. We heard many stories about patients being automatically chemically restrained through the use of sedation and intubation because of concerns for the safety of others during the journey. While there seemed to be some level of acceptance that this practice may at times be necessary, there was also a strong view that it is not always necessary. Background information from family and others such as the local health clinics are vital for making decisions about the history of the patient and the level of risk.

During our consultations, there was a clear lack of clarity around the word *transport* and concerns around the use of restrictive measures when someone is being transported. Many people thought that there was an overuse of sedating and intubating, which was perhaps caused by the misunderstanding of the word transport. If a person is being transported form Palmerston to Darwin, are they sedated?

Workforce

While the mental health workforce may not be a focus on the review of the MHRS Act, they are an essential part of the implementation of any new legislation and regulations. So many of the stories we heard were about poor practice, overstretched systems and lack of skilled workers.

> *'We have got to build structures and systems that aren't reliant on an individual person.'*

The NT branch of RANZCP has acknowledged that staff practicing in the Northern Territory are at greater risk of burnout and poor morale. During our consultations, we heard many stories of this being the case. There are also some issues that affect the workforce, such as mental health-related stigma among health professionals. We have heard that staff working in the mental health department of the hospital are treated poorly and stigmatised by other staff. The sometimes toxic and high-pressured environments in which people work is contributing to workforce demands.[37]

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[36] Health & Community Services Complaints Commission https://www.hcscc.nt.gov.au/wp-content/uploads/2019/08/FINAL-INVESTIGATION-REPORT-DE-IDENTIFIED-2018-00066-67_13B49.pdf

[37] RANZCP, Principles for the treatment of persons found unfit to stand trial, https://www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/persons-found-unfit-to-stand-trial#:~:text=According%20to%20the%20Principles%20for,treated%20in%20the%20least%20restrictive

The Productivity Commission report (2020) voiced the importance of the availability of high-quality workers with the right skills for a functioning mental health system. Staff need to be allocated to tasks that use their skills efficiently, and the shortage of psychiatrists and mental health nurses, underutilisation of peer workers. Negative workplace cultures in some services expose workers to stigma, stress and burnout, lead to high staff turnover and poor outcomes for consumers.[38]

We recognise that workforce issues including attracting and retaining skilled staff, are issues right across the NT and across most sectors - mental health is not unique. However, a new modern MHRS Act will not resolve many of the concerns expressed by people if there are not adequate resources allocated to the implementation.

The use of peer workers is underutilised and should be recognised as a necessary part of a recovery-oriented and trauma-informed mental health system. Peer workers are an essential part of 'The Fifth National Mental Health and Suicide Prevention Plan' priority area 6, [39] as well the Productivity Commission Inquiry report into Mental Health, which states that studies found that the inclusion of peer workers reduced the use of emergency services, decreased admissions to inpatient units, and reduced the rate of readmission.[40]

RECOMMENDATIONS

The Coalition recommends that:

30. **In line with the findings from the Royal Commission into Mental Health in Victoria the NT should implement a 'towards zero' use of restrictive practices.**

31. **Stipulate that restrictive practices – such as seclusion and restraint - are to be used as a means of last resort and when absolutely necessary and not for coercion or behavioural management.**

32. **Acknowledge extensive literature which largely indicates that negative outcomes of restrictive practices exceed positive outcomes, for example, use of restrictive practices may prevent injury, but it is non-therapeutic due its harmful psychological effects, detrimental to clinician/patient relationships and contrary to civil and human rights.**

[38] Productivity Commission 2020, Mental Health, Report no. 95, Canberra

[39] Australian Government National Mental Health Commission, Fifth National Mental Health and Suicide Prevention Plan, https://www.mentalhealthcommission.gov.au/getmedia/0209d27b-1873-4245-b6e5-49e770084b81/Fifth-National-Mental-Health-and-Suicide-Prevention-Plan

[40] Productivity Commission 2020, Mental Health, Report no. 95, Canberra

33. **Acknowledge documentation of the other alternatives used including use of cultural advisors and best practice approaches to seclusion.**

34. **Require that accurate records are kept at the time of any use of restrictive practices, rather than retrospectively.**

35. **Ensure that, in the process of transport, the use of chemical restraint is used sparingly and only when absolutely necessary.**

36. **Ensure that there is a clear definition of the word 'transport'.**

37. **Promote the need for clinical and tribunal staff to undergo comprehensive training and certification to ensure they have an up-to-date high-level understanding of recovery-oriented and trauma-informed principles as well as the intersection of civil and human rights into their work.**

38. **Emphasise the importance of resources particularly building capacity of staff through upskilling and training as well as the attracting and retaining of skilled staff.**

39. **Recognise the importance of peer workers, Social and Emotional Wellbeing Workers, Ngangkaris and Aboriginal health workers and Aboriginal counsellors as legitimate and commensurate to a holistic and recovery focused mental health system.**

Part Five: Forensic Provisions

5.1 Procedure for Summary Criminal Offences (Local Court)

The Federal and NT Governments are signatories to international conventions and strategies that set out their commitments to protect the human rights of forensic patients, such as the Standard Minimum Rules for the Treatment of Prisoners, also known as Mandela Rules, which recognises that:[41]

'persons who are found to be not criminally responsible, or who are later diagnosed with severe mental disabilities and/or health conditions, for whom staying in prison would mean an exacerbation of their condition, shall not be detained in prisons, and arrangements shall be made to transfer them to mental health facilities as soon as possible.'

[41] Report on the review of Forensic Mental Health and Disability Services within the Northern Territory, David McGrath, January 2019

According to the 'Principles for The Protection of Persons With Mental Illness And For The Improvement Of Mental Health Care' (United Nations General Assembly, 1991):[42]

'all persons have the right to best available mental health care' and 'every patient shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient's health needs and the need to protect the physical safety of others.'

Australia has also ratified the 'United Nations Convention on the Rights of Persons with Disabilities' (2008) (The Convention), which also applies to forensic patients and commits states/territories to take all necessary measures to combat stigma and enable disabled people to fully participate in society. Australia also ratified the 'Optional Protocol' which provides a monitoring mechanism for breaches of the Convention.

Alongside Australia's international obligations, are national and territory policy documents which influence legislation and practice. The Northern Territory Government is a signatory to the Fifth National Mental Health Plan, which acknowledges Australia's commitment to meet agreed international standards. Furthermore, the Australian Health Ministers Advisory Council's (AHMAC) 'National Statement of Principles for Forensic Mental Health' offers a set of 13 principles which are necessary to be applied to forensic mental health services. The NT Government participates in AHMAC through the Chief Executive of Health and the national statement is a policy commitment of the NT Government.

The Coalition recognises the expertise of the Northern Territory Legal Aid Commission (NTLAC) and Northern Australia Aboriginal Justice Agency (NAAJA) in this area. The Coalition also recognises previous work done by the Law Reform Commission and the McGrath Report and acknowledges their extensive expertise. The Law Reform Commission published a list of overarching principles such as:[43]

- Wherever possible, orders should favour treatment in a therapeutic environment rather that in a correctional environment;
- If an individual is not guilty by way of mental health impairment, their condition is clearly serious enough that it is best met by the health care system;

[42] RANZCP, Principles for the treatment of persons found unfit to stand trial, https://www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/persons-found-unfit-to-stand-trial#:~:text=According%20to%20the%20Principles%20for,treated%20in%20the%20least%20restrictive

[43] Northern Territory Law Reform Committee, Report on the Interaction between people with Mental Health Issues and the Criminal Justice System, Report No. 42 May 2016

- The improvement of community safety and reduction of recidivism by the diversion of mentally ill persons from the criminal justice system and into appropriate treatment and support;
- Consistent with the treatment of the *MHRS Act,* involuntary detention and treatment should be the last resort;
- There is a need for appropriate resourcing, training and materials to be provided to staff working in the field so that they can adequately explain the processes to victims and the community.

The Coalition supports the aforementioned principles and acknowledges recommendations set out in the Law Reform Committee report, as well as the recommendations set out in the McGrath report. In particular, the Coalition would like to note the lack of therapeutic pathway and stepped resource model for those subjects to Part IIA. If a person is subject to Part IIA, appropriate treatment must be offered instead of languishing within the system. Some people on Part IIA have spent a far greater time in a correctional centre than they would have, had they been found guilty of their original offence.[44]

[44] Report on the review of Forensic Mental Health and Disability Services within the Northern Territory, David McGrath, January 2019