PUBLIC COMMUNITY VISITOR PROGRAM SUBMISSION

***MENTAL HEALTH RELATED SERVICES ACT 1998* REVIEW**

Introduction

The Community Visitor Program (CVP) provides comment and recommendations as part of *Mental Health Related Services Act 1998* (the Act) Review.

This submission applies a human rights approach that holds that all people living with mental illness or psychological distress have the right to enjoy equality of opportunity and to effectively participate in and be fully included in society. A human rights recovery focused perspective is underpinned by international conventions, legislation, quality standards and nationally accepted policies[1] that promote and protect the human rights of people with mental illness.

A strong, contemporary mental health system is grounded in a human rights approach. It is a system that is person-centred, with care, treatment and supports tailored to the person's life circumstances, personal aspirations and preferences. It supports people to live the life they want and receive services they need in the least restrictive way possible.

Public mental health services are necessary and are a valued specialist services that are established for some of the most vulnerable Territorians. The Northern Territory (NT) community relies on tertiary mental health services to be accessible and offer high quality services throughout the NT.

[1]The International Covenant on Economic, Social and Cultural Rights (1975); The United Nations Convention on the Rights of Persons with Disabilities (2006) (CRPD); The United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care; The Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT);
Mental Health and Related Services Act 1998 (NT) MHRSA.

The CVP welcomes and commends the discussion paper process to ensure the NT legislation is modernised in line with contemporary mental health practice for the benefit of the NT community.

The commitment to a focus on human rights, the introduction of the important concept of recovery and recovery-orientated practice, person centred principles, nominated person roles are positive and the strengthening of monitoring to improve the quality and safety of the public mental health service is well overdue. The Chief Psychiatrist functions will provide additional safeguards and modernise the reformed legislation.

However, we note that the Discussion Paper was prepared prior to the handing down of the Royal Commission into Victoria's Mental Health System. The findings and commentary in the Royal Commission was on a Victoria Mental Health Act passed in 2014, which contains many of the features in the current NT Discussion Paper. Very briefly, it was found that there needed to be a reset of the legislative foundations for the mental health and wellbeing system in Victoria. The CVP do not have the capacity to review the numerous volumes of this report to ascertain the learnings for the benefit of ensuring mental health and wellbeing of all Territorians. However clearly arising from this will be the next generation of mental health and wellbeing legislation in Australia.

Consent to healthcare is a fundamental health and human right for all people. Protective mechanisms such as mental health legislation exists to ensure that a person who may have impaired capacity related to their mental illness/condition receive the therapeutic care to ensure the person and the community are cared for and protected. These circumstances require significant protections and monitoring to ensure people's human and legal rights are upheld to ensure they do not experience potential violence, abuse, neglect and exploitation.

The CVP raises that legislation alone cannot improve the effectiveness and accessibility of services or change cultures within services. However, it does establish a mandatory framework for a mental health system that promotes and protects rights and supports recovery of people with mental illness and mental health conditions through assessment, treatment and care.

The CVP contends that the key function of mental health legislation is to:

- Establish the system of public mental health care and provide for the gazetting of approved treatment facilities/agencies and licensing of private mental health facilities in the NT.
- Set out the circumstances in which persons with mental illness/disturbance may be admitted to and treated in public hospital based mental health facilities either on a voluntary or involuntary basis.
- Set out the circumstances in which a person with a mental health disorder may be subject to involuntary treatment provided by a public mental health service in the community.
- Set out the legal rights of consumers, carers and other stakeholders.
- Regulate restrictive practices and some forms of mental health treatment such as Electroconvulsive Therapy.
- Establish treatment and care of Forensic consumers.
- Set out the authority, appointments and delegation of credentialing mental health staff.
- Utilise the Northern Territory Civil and Administrative Tribunal (NTCAT), to authorise and review the involuntary and other orders of persons with mental illness and mental disorders in the inpatient setting, and community management orders.
- Establish the CVP, its functions as a complaints resolution and advocacy service; to act as an advocate and report to the Minister on any significant public mental health issues, patient safety, care and treatment issues to the Minister or any other appropriate person or body.

The CVP submission draws upon the 20 years of specialist experience as a complaints resolution and advocacy service, oversighting NT public mental health services. This work is evidenced in the public CVP Annual Reports and numerous submissions. In general most feedback from consumers and carers are about a problem and negative in

nature. The CVP do receive positive feedback about staff and the services and this feedback is relayed to these services and celebrated.

The CVP highlights that the discussion paper is silent on the role and functions of the CVP and when the CVP queried the omission, it was conveyed that the role would remain as is. The CVP raise that there are various intersections with suggested reforms in the Discussion Paper such as the monitoring of the Chief Psychiatrist and nominated person roles that will require further clarification and defining to maximise the effectiveness and rights protection required with the new Act.

The CVP commentary is in line with the discussion paper questions, based on the 20 years of experience in visiting and inspecting services, talking and listening to consumers and carers about their experiences, concerns and complaints. The CVP conduct file reviews, audits, analysis on whether practices and interactions are in-line with the legislation, national mental health standards and whether the person was treated with dignity and respect. Relevant examples include:

- People on the wards not being actively involved in their care and treatment and not being advised of what their rights are including the right to be involved.
- Difficult stories and observations about Aboriginal clients not being able to communicate adequately and not having their cultural needs met.
- The negative impact of some restrictive practices on consumers, co-clients and staff.
- Decisions made that did not appear to consider the ‘least restrictive alternative’ sufficiently and interactions and interventions that were described as not helpful and re-traumatising.

The CVP statutory role and functions have a broader remit than just complaints resolution and advocacy service. The role pertains to review of quality and safety issues within the service and this is captured in the objects of the Act.

Section 3(q) of the Act provides for a principal community visitor, community visitors and community visitor panels with inquiry, complaints, investigation, visiting, inspection, advocacy and reporting powers and functions.

The CVP acknowledge the many staff who work tirelessly with care and compassion in a system that is significantly overstretched. The CVP observed the significant challenges in workforce capacity for the public mental health system and the impact on the person's care and treatment and quality of services provided. Valued, experienced and skilled staff are the greatest asset of any service. The CVP has observed the workforce struggling under increasing complex demands of patient care, reducing resources, out dated infrastructure, unrealistic expectations that affect staff morale and contribute to staff burn out.

The CVP supports efforts to streamline administrative processes in the legislation particularly where proposals ultimately benefit clients and ensure the system's transparency and accountability. However repeatedly the CVP has been told by mental health services that there is limited operational capacity to meet the growing complex service demands and compliance with legislative protections. This corresponds with the observations of the CVP and is evident in the findings of audits and analysis conducted of the experience of the people with mental illness and their carers.

The CVP strongly advocate that the new or reviewed mental health legislation should not be based on operational pressures. The reformed legislation needs to be contemporary and robust enough to ensure it provides protections to consumers for what is likely to be an extended period of years before the next review. While the legislation will inform and underpin the service delivery of mental health services its protections should not be weakened or consumer rights eroded because of operational and resourcing deficits.

Further, there is evidence that public mental health services are focussed on the crisis end. That there has been a diversion of focus and resources from prevention and early intervention and outreach services. There are some encouraging initiatives such as the community and interagency response model and new community initiatives, potential hospital in home model. The CVP strongly supports community-based services, as it is in these settings that good mental health is maintained.

The CVP support that the process in which these strategic and financial decisions are made are more transparent, include consumers/carers and sector stakeholders, are informed by evidence using best practice approaches.[2]

The CVP submission focuses on key areas of reform including:

- Rights protections
- Least restrictive practices
- Monitoring
- Assessment and treatment regarding the recovery and wellbeing of people who come into contact with the criminal justice system.

The CVP also notes that the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) is in the process being implemented in each State and Territory. Mental health legislation must ensure that provisions for independent oversight and monitoring are clear and that the requirement for mental health services to co-operate with such oversight is mandated.

CVP Recommendations

Rights Recommendations:

1. That a revised statement of rights for people undergoing care and treatment and carers, nominated person is developed with relevant stakeholders and embedded in the legislation.
2. That no current rights within the Act are eroded including the right to request an early review for involuntary admission applications (s.127).
3. The Act to set out the explicit rights as part of the information for the person being admitted including, for the person and their legal representative to receive Tribunal applications 48 hours prior to the hearing to allow procedural fairness and natural justice (with exceptions already provided in the current Act).

[2] Northern Territory Government, 2015, Mental Health Service Strategic Plan 2015–2021, Department of Health.

4. Right that an advanced health plan or other record of a person's Wills and Preferences must be considered as part of the person treatment care and recovery (see Wills and Preferences section below).

Recovery Recommendations:

1. Non-exhaustive definition of recovery using a universally accepted term to provide a strong legislative framework and to influence and uphold subsequent person centred/focussed operational policies.
2. Embed 'recovery' alongside treatment and care statements to conceptualise that mental health services have a role in promoting and using recovery-orientated practices.
3. Embed trauma informed care within the object and fundamental principles in the Act to ensure that clinically evidenced based models and practices are required and implemented.
4. Embed in legislation consumer/carer input obligations into any specialist or advisory mental health mechanism.

Consent and Capacity Recommendations:

1. That there is a starting presumption of capacity and established clear criteria about capacity and informed consent in the new legislation.
2. A clear statement of the intent, to promote a person rights, liberty, dignity, autonomy and self-respect.
3. To establish a number of mechanisms to record and approve informed consent that expands the current requirement for a person to sign the approved form as the basis of consent.
4. To support rights and consumer's inclusion in treatment decisions it is recommended that documentation of consent is made on a regular basis and when any changes to treatment are made.

Wills and Preference Recommendations:

1. The form the advanced plan that records wills and preference takes should not be prohibitively proscriptive noting the *Advance Personal Planning Act* 2013 is one example.
2. The requirement to action the wills and preference of a person once recorded is clearly articulated in the legislation.

Nominated Support Person Recommendations:

1. A nominated support person should be introduced into mental health legislation.
2. A person receiving treatment should be able to nominate any person/s they feel confident with and also elect not to have a nominated support person.
3. The nominated support person should represent consumer's interests and wishes, help ensure rights are observed and be an important link to recovery after treatment. The scope of the role and rights to access information should be set out in a non-exhaustive list in the Act.

Cultural Safety Recommendations:

1. The National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023 to be written into legislation.
2. Legislation to require care and treatment to include a culturally appropriate, social and emotional wellbeing model of care.
3. During voluntary and involuntary admissions the legislation must require:
    3.1. Culturally and clinically appropriate assessment and treatments.
    3.2. Recognition and inclusion of traditional healers and cultural healers.
    3.3. Access to interpreters.
    3.4. Inclusion of SEWB model of care in treatment plans including recognition and inclusion of Elders in care.

4. The provision of an interpreter is the legal obligation of clinicians providing care and treatment and the consequences for not complying with this obligation are stipulated in the legislation.

5. Interpreter obligations are clearly articulated in the legislation during voluntary and involuntary admission as required below.

   In particular at the following points of engagement:

   5.1. Assessing capacity of the person to give informed consent.

   5.2. The initial authorised psychiatric practitioner examination.

   5.3. The second authorised psychiatric practitioner examination.

   5.4. When the explanation of rights and entitlements under the Act is given to the person.

   5.5. When the person is informed on how their rights and entitlements may be exercised.

   5.6. When the person is informed of the advocacy and legal services that are available to them.

   5.7. All ongoing authorised psychiatric practitioner examination.

   5.8. For explanation of treatment plan during admission.

   5.9. For collaboration on individual care plans.

   5.10. For legal counsel and attendance at NTCAT.

   5.11. For explanation of community management order.

   5.12. Whenever a person requests an interpreter.

6. A person receiving voluntary or involuntary care and treatment in the community must be afforded an interpreter as required below.

   In particular at the following points of engagement:

   6.1. Notification to the person of an interim community management order.

   6.2. Explanation of treatment and care under community management order.

6.3. When the explanation of rights and entitlements under the Act is given to the person.

6.4. When the person is informed of the advocacy and legal services that are available to them.

6.5. Notification to the person of revocation of community management order.

6.6. Authorised psychiatric practitioner examinations.

6.7. Community management order authorised psychiatric practitioner reviews.

6.8. Psychiatric case manager reviews.

6.9. For legal counsel and attendance at NTCAT.

7. Where written or oral notification is required to be given to a primary carer, it must be written in the primary carer's primary language or facilitated orally with the use of an accredited interpreter.

Involuntary Admission and Treatment Recommendations:

1. Removing vague phrases such as 'where possible' and 'as far as possible'.
2. Amending section 9(b) to include a requirement for the initial examination and each ongoing examination to include, as part of the examination an assessment of the persons suitability for treatment in the community.
3. A requirement for the authorised psychiatric practitioner to action the request for early review within one day, specifically, to facilitate the application to the Tribunal.
4. Amending section 9 to include the requirement for documentation such as Advance Personal Plans recording person's wills and preference to be taken into account and inform the care and treatment of a person.
5. Adding transparency to the Act by specifically addressing a person's right to refuse treatment when receiving involuntary care and treatment, and the process in place for a person to have access to external oversight when this right is not upheld.
6. That informed consent is assessed on an ongoing basis of all voluntary and involuntary admissions.

Voluntary Admission and Treatment Recommendations:

1. Admission procedures are strengthened by legislation adding a requirement to notify the persons listed in section 41(1) and 43(1) within one day of a person asserting their right to apply for early review.
2. Legislation must be in place to provide access to leave during a voluntary admission.
3. Search and seizure provisions only be included if the objective is clearly articulated, includes that only authorised people conduct searches and person being searched is supported.

Youth Recommendations:

1. Legislation to embed children and youth within it to recognise the vulnerability and specialist needs of this cohort.
2. Legislation should provide people of all ages a presumption of capacity to give informed consent.
3. Legislation should be used to create an integrated and stepped service delivery model for children in youth detention. This should include a continuation of service post release.
4. Legislative changes to prohibit the seclusion of children and young persons, in all institutional settings including Approved Treatment Facilities and the acute mental health wards.
5. Legislative changes to reduce and eliminate the use of restrictive practices including mechanical restraint of children and young people in institutional setting including acute mental health wards.

Police Apprehension and Transport Recommendations:

1. Legislate that Police use in an apprehension or transport is as a last resort.
2. Legislative provisions that prescribe that the mode and manner of each transport incident should be based on clinical assessment and undertaken in the least restrictive manner possible in consultation with the person and their family, carers, supporters or nominated support person.

3. Legislative provision that ensures mechanically restraint in vehicles comes into alignment with practices for other restricted practices. As with other restricted practices mechanical restraint in vehicles should be subject to individual presentation, clinical assessment, monitoring, recording and oversight.

4. Legislate for the use of multi-disciplinary mental health crisis assessment and treatment teams' work collaboratively with Police attending together when people are experiencing a mental health crisis.

Monitoring including Chief Psychiatrist Recommendations:

1. That the functions of Chief Psychiatrist position be defined and embedded in the Act.[3] Including the functions that involve public reporting.

2. The Chief Psychiatrist has appointments and delegation for the credentialing and authority to appoint Authorised Psychiatric Practitioners, Designated Mental Health Practitioners and Psychiatric Case Manager/Coordinator roles.

3. The Chief Psychiatrist chairs the APQAC and the membership is expanded to include consumers and carers and other appropriate members.

4. The Chief Psychiatrist has oversight and publicly reports on the NT Mental Health Clinical Service plan.

5. That the CVP monitoring functions remain and provides the complementary strengthening of oversight that is required to improve quality and safety and public confidence.

[3] Victoria State Government. Health Victoria. Chief Psychiatrist. https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist.

Restrictive Practices Recommendations:

1. Regulation of restrictive practices extended to include seclusion, chemical restraint, mechanical restraint, physical restraint and environmental restraint.
2. The restrictive practices monitoring role of the Principal Community Visitor is maintained and further broadened to include the monitoring of seclusion, chemical restraint, mechanical restraint, physical restraint and environmental restraint.
3. The relationship of the Act with other relevant legislation is articulated with primacy clearly established for the care, treatment and recovery for mental illness and underlying disabilities.

ECT Recommendations:

1. That ECT continues to be regulated.
2. That the Act is clearer in relation to ECT by the addition of a definition that included number of episodes for a treatment.
3. The role of Chief Psychiatrist in monitoring restrictive practices including ECT is established in legislation including credentialing of staff performing ECT.
4. That a centralised register of records for the use of ECT is required to be kept by the ATF,
5. The PCV ensure that a register of records kept for the purposes of ECT is inspected at regular intervals.
6. That the legislation promote a therapeutic alliance with patients, promoting the principles that people can make decision about their own health even if it is considered an unwise.
7. To establish that information about ECT must be provided to carers, significant family members and nominated support person.

Forensic Recommendations:

1. Approval process transferred from Chief Health Officer (CHO) to the Chief Psychiatrist in regard to Local Court process.

2. Tightening the requirement on who can provide advice to the Chief Psychiatrist under section 77.
3. Amendments to Local Court process to include supervision and treatment plan not just dismissal of charges.
4. Consistency in the definition of ‘mental illness’, ‘mental impairment’ and ‘cognitive impairment’ across the Act and Criminal Code.
5. Review of the indefinite nature of Part IIA of the Criminal Code supervision orders.
6. Legislative clarity for therapeutic decision making including the use of restrictive practises for prisoners and youth detainees on acute wards.

PART ONE: PRINCIPLES AND RIGHTS OF THE PERSON

Mental health legislation establishes principles for care, treatment and recovery applied for people with mental illness or mental disturbance while at the same time protecting peoples civil rights. Importantly, the objects, the principles are of fundamental importance to understanding of the purposes of the Act and are also an important guide to its interpretation and implementation to resolve uncertainty and ambiguity.

Contemporary mental health legislation embeds recovery-orientated practice including least restrictive practices, respect and protections for the human rights of those experiencing a mental illness particularly when receiving involuntary treatment and care.

The CVP highlight that the current Act's objects and principles in the main, are in line with contemporary mental health care. Many issues raised with the CVP relate to the implementation of the Act regarding quality and safety issues. However there is a need to modernise terms and conceptual models and approaches that reinforce and strengthen the key principles and rights in the reformed Act.

KEY PRINCIPLES IN CONTEMPORARY MENTAL HEALTH CARE

1.1 Recovery orientated practice

Recovery is at the centre of modern mental health services and legislation. There is no single definition of recovery, all descriptions focus on consumer empowerment, self-determination, hope and inclusion.

The National Framework for recovery-orientated mental health services: Guide for practitioners and providers[4] highlights that personal recovery is linked to patients *'being able to create and live meaningful and contributing life in a community of their choice with or without the presence of mental health issues*'.

[4] Australian Government, Department of Health (2013). A national framework for recovery-orientated mental health services: guide for practitioners and providers.

The concept of recovery and person centred care are fundamental principles and give greater weight to the views of consumers when decisions are being made about their care and treatment under the Act. The CVP consider that consumer/carer involvement has been vastly inadequate even though there are provisions in the current legislation. The CVP believes there is a need for improved mechanisms that show pro-active involvement and obligations and that this should be explicit in the legislation.

Human rights approach

Australia is a signatory to the following relevant human rights conventions:

- International Covenant on Economic, Social and Cultural Rights (ICESCR).
- The Convention on the Rights of Persons with a Disability (CRPD).
- The Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment.
- The Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

They require the NT to protect and promote "the right of every-one to the enjoyment of the highest attainable standard of physical and mental health" (Article 12(1) ICESCR) and to recognise "that persons with a disability have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability" (Article 1 CRPD) noting that disability includes mental impairment.

People receiving or being considered for involuntary treatment in mental health wards and through community mental health services are particularly vulnerable to their human rights being infringed. This has been recognised by the United Nations in a number of instruments including the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD).

Contemporary legislation goes beyond a statement of these rights in principles. It requires consideration of rights when decisions about treatment, care and recovery are made, including providing the person and their carer's with information about their rights and enabling them to exercise their rights and review decisions.

The reformed Act can significantly support human rights to be upheld and the necessary ongoing change process by ensuring that the legislation has a person-centred focus, rights focus. Supporting human rights also respects and uphold safeguards, protection and monitoring mechanisms.

Least Restrictive practices

Least restrictive practices form an essential foundation to recovery orientated approach to mental health service delivery and have been accepted internationally and nationally as best practice. The World Health Organisation's *Mental Health Care Law: Ten Basic Principles indicates that institution-based treatments should be provided in the least restrictive environment.*

The Least Restrictive Alternative principle is referred to in the current Act. It requires that a person receive the least restrictive or least intrusive treatment in the least restrictive environment possible. This means the use of voluntary treatment wherever possible as close to the person's home as possible. It also means ensuring that the person is consulted and able to participate in their treatment plan as much as possible.

RIGHTS

How can we use the legislation to promote the rights of voluntary consumer or involuntary patient when they are receiving care?

The CVP raise that the rights of people have not been systematically implemented even though they are explicit in the current legislation. This finding has been raised in the various open recommendations and CVP Annual Reports. The CVP reaffirms that each person **must** have rights conveyed in a manner that they are able to understand and continuously throughout their admission.

The current legislation has a range of mechanism that exist to promote and facilitate rights for voluntary and involuntary patients. There appears that there are various reasons why this has not been systematically done. A frequent concern raised by the service is that, on admission to a service, a person may not have capacity to understand and retain, or

willingly accept the information. The amended legislation could reinforce the continuous obligation on the service to convey rights to people using the service, and in formats they can understand, with interpreters or other supports.

There have been inadequate systems in place to facilitate the process, coupled with a lack of knowledge understanding by medical staff of their obligations under the Act and high staff turnover.

There appears a lack of understanding of and impact of the power imbalance. The CVP raises that the role of a recovery orientated, rights based service is to inform and empower. When rights are promoted and facilitated this demonstrates respect and the two-way nature of rights and responsibilities. The process is collaborative and improves the person knowledge, informs decision making and in effect is the foundation of the therapeutic relationship.

The CVP support that rights for both people who are voluntary or involuntary are necessary. The CVP notes that people receiving mental health services in the community should also have their health care rights explained to them as required of any health care service.

Involuntary patients are extremely vulnerable and often face considerable barriers in communicating with treating teams, having input into their treatment and exercising their rights. The CVP maintains that people in these circumstances are to be provided, to the greatest extent possible, with the necessary support and information to enable them to exercise their rights.

The CVP recommends that a new rights statement is developed in consultation with stakeholders. That inclusion of the language of recovery, person centred, wills and preference be used in the new legislation as suggested below:

- Be given information about your legal status, both verbally and in writing.
- See a doctor and to get a second opinion from another doctor.

- Be encouraged to participate, ask questions and be fully informed about any treatment regarding your recovery and wellbeing is provided to you and why.
- Refuse medical treatment (with some exceptions) and seek health advice and/or medical attention for general health issues.
- Right to communicate by electronic device (phone/computer) and receive visitors in hospital and see them in reasonable privacy (subject to inpatient rules) (s95, s.96, s.97).
- Have your personal possessions (with some exceptions).
- Apply to inspect and receive accurate copies of any records electronic or otherwise about you.
- Expect that your personal information will be kept confidential (with some exceptions).
- Seek legal advice on any matter.
- Contact the Community Visitor.
- Apply to the NTCAT for a review of any decision made about you that you disagree with.
- Make a complaint.
- Have your culture, special needs, gender, considered in your treatment.
- Right of Appeal to the Supreme Court (Part 16).

Rights Implementation or overlap with other areas which may not require legislation:

1. Explicit obligation on the service to convey rights on a continual basis, and in formats persons can understand, with interpreters or other supports.
2. Right to have an interpreter at key junctures of the assessment, treatment and recovery process with required documentation showing why interpreting did not take place. See Cultural Safety.

3. Clear consequence when the provision of rights information to a person being admitted does not occur.
4. Resourcing, training and support to enable that mental health staff have the capacity to undertake their statutory obligations.

Rights Recommendations:

1. That a revised statement of rights for the person and nominated support person is developed with relevant stakeholders and embedded in the legislation.
2. That no current rights within the Act are eroded including the right to request an early review for involuntary admission applications (s.127).
3. The Act to set out the explicit right as part of the information for the person being admitted including, for the person and their legal representative to receive Tribunal applications 48 hours prior to the hearing to allow procedural fairness and natural justice (with exceptions already provided in the current Act).
4. Right that an advanced health plan or other record of a person's wills and preference must be considered as part of the person treatment care and recovery (see wills and preferences section below).

RECOVERY

Will incorporating the concept of 'recovery' into the legislation change how treatment and care is administered? Why do you think so?

Do you have any suggestions for how the legislation can be changed to include the concept of recovery?

The CVP supports incorporating the concept of 'recovery' and also the inclusion of 'social and emotional wellbeing' (SEWB) to strengthen a focus on the 'person' centred approach. The CVP consider this will assist in implementation of recovery orientated and holistic practices.

The inclusion of these synergistic concepts of holistic models incorporate the medical model however of are equally importance the person defines recovery and wellbeing, which humanises care and treatment and ultimately the legislation.

The recovery and wellbeing definitions align more closely with the SEWB model and principles which are a more holistic model of wellbeing care and practice.

Recovery Recommendations:

1. Non-exhaustive definition of recovery using a universally accepted term to provide a strong legislative framework and to influence and uphold subsequent person centred/focussed operational policies.
2. Embed ‘recovery’ alongside treatment and care statements to conceptualise that mental health services have a role in promoting and using recovery-orientated practices.
3. Embed trauma informed care within the object and fundamental principles in the Act to ensure that clinically evidenced based models and practices are required and implemented.
4. Embed in legislation consumer/carer input obligations into any specialist or advisory mental health mechanism.

Recovery Implementation potentially without legislation:

1. Include the right to be encouraged to participate, ask questions and be fully informed about any treatment about your recovery and wellbeing is provided to you and why.
2. Strengthen the right to cultural safety of Aboriginal and CALD by making explicit the right to receive information and communicate in a language that you understand in the fundamental principles.
3. Include peer workers as part of the multidisciplinary team and this will conceptualize that people with lived experience have valuable expertise that also will assist in reducing stigma within mental health services.

1.2 Capacity and Informed Consent - Section 7 of the Act

Do you think the legislation considers the right criteria when determining if someone has capacity?

Does the legislation need to include any other steps to make sure that a person has given informed consent? Do any steps need to be removed?

People experiencing mental illness or mental disorders have the right to be provided treatment that respects and promotes the person's rights, liberty, dignity, autonomy and self-respect. The current Act (NT) in its objects section 3(a) and (b) confirms this. However, the challenge is how to implement these rights in legislation in order to facilitate best practices of care. To achieve this the legislation should reflect concise criteria and clear guidelines for consumer protection.

Informed consent is essential to consumers' Human Rights. Underpinning informed consent is a right to information as recognised by Australian Charter of Healthcare Rights, and Professional Codes of Conduct External link. The National Safety and Quality Health Service Standards require all hospitals and day procedures services to have informed consent processes that conform to recognised best practices and comply with legislation, lawful requirements.[5]

Informed consent is defined "*as voluntary acceptance by a competent patient of a plan for medical care after a physician adequately discloses the proposed plan, its risks, benefits and alternative approaches*."[6] Doctors and other clinicians must support people to make informed decisions by providing timely and relevant information about the suggested treatment, alternant treatment, potential risks and benefits in a manner which can be understood by the patient. A failure to do so is depriving people of liberty and infringing their Human Rights.[7]

[5] Australian Commission of Safety and Quality in Health Care. (2020). The National Safety and Quality Heath Service Standards, p. 1.
[6] Krishnan, NR., & Kasthuri, AS. (2007), Informed Consent. *Medical Journal of Armed Forces India, 63*(2), p. 164.
[7] Coggon, J. , & Miola J. (2011). Autonomy, Liberty, and Medical Decision-making. *Cambridge Law Journal, 70*(3), p 523-547.

The current Act importantly provides that consumers must be given enough time to consider the information and the decision is made freely and without coercion.

The executive summary of the *Mental Health and Related Services Act 1998* Review, states from an international law perspective, a person experiencing mental illness who has the capacity to give informed consent is entitled to rightly refuse treatment the same as any person within the community. This is an important statement of rights which is consistent with legislation in other States and Territories.

The CVP considers a presumption of consent for all people demonstrates respect, works towards the protection of rights and is in accord with recovery principles. It should be recognised that the approach taken to consent has far reaching consequences for the relationship between consumers and the service. It is the initial step in the formation of therapeutic relationships and the basis for recovery oriented treatment.

Central to the treatment criteria is a person's capacity to consent to treatment. Strengthening informed consent provisions in the new legislation supports least restrictive considerations. Legislation should acknowledge and provide safeguards for consumer's capacity to change over time and be context driven. For these reasons, consent and capacity should be assessed at the time the consent is required.[8]

There should be presumption that people have capacity for informed consent. Clinicians must engage consumers with no preconceived assumption that they lack capacity to provide informed consent. Clinicians should not assume a person lacks capacity for informed consent based only on their age, appearance, condition or behaviour.

Presumption of capacity may be rebutted if it can be shown that the consumer does not have the capacity to give informed consent and the mere fact of a mental illness does not mean there is no capacity to consent.

Both the *Australian Capital Territory (ACT) Mental Health Act 2015* and the *New South Wales (NSW) Mental Health Act 2008* state a person is assumed to have the capacity to

[8] Victoria State Government, Health Victoria. *Presumption of Capacity.* https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/mental-health-act-2014-handbook/recovery-and-supported-decision-making/presumption-of-capacity.

give informed consent until which time it has been proved they do not. The other states including the Northern Territory do not directly specify “a person has the capacity to consent until proved to not have capacity”.

It is important that assessments of capacity are made regularly and in as consistent manner as possible. Under the *United Kingdom Mental Capacity Act 2005* a person has capacity to consent if they are able to understand information relevant to the decision, retain that information, use or weigh up that information as part of the process of making the decision, or able to communicate their decision (whether by talking, using sign language or any other means).[9]

The current criteria for informed consent is that a consumer must be able to **understand and retain the information.** It is important that the threshold for decisions about informed consent remains, are proportionate and appropriate to circumstances. The PBU & NJE v Mental Health Tribunal [2018] VSC 564 (1 November 2018) decision on this matter is instructive with Justice Bell saying obtaining informed consent should not become an ‘*inquiry into whether the person can make a sensible, rational or well-considered decision*’ at [182].

In both cases, (PBU & NJE v Mental Health Tribunal) assessments of the consumer’s capacity was based on their mental illness and their preference for alternative treatments were not respected. The court determined that capacity tests must be applied in a non-discriminatory manner to ensure the rights of people with mental illness are maintained.[10]

The NT *Act* states that “*except as provided by this Act a person is not to be given treatment without their consent* (pg. 13)”. It also states, however, that a person who meets the criteria for involuntary admission, may be deemed as not having capacity to give informed consent if they have unreasonably refused treatment **and** without treatment there could be deterioration of their health or serious harm to themselves or others.

The CVP raises that the legislation should be more explicit about what constitutes ‘unreasonably refusing treatment’. The CVP repeatedly are told by consumers that they

[9] *United Kingdom Mental Capacity Act 2005,* p. 3.
[10] PBU & NJE v Mental Health Tribunal [2018] VSC 564 (1 November 2018).

do not feel they have the choice to refuse medication or some therapies. The CVP acknowledge that these are complex decisions for clinicians and support a definition and improved criteria to provide guidance, consistency and transparency to when making decisions about whether the person has informed consent.

The current Act does not define serious harm. However it is understood in terms of it everyday usage of harm to reputation or relationships, financial harm, self neglect, neglect of others including children and physical harm. The CVP consider that this does not have to be included in legislation if it is included in policy to support that the concept of serious harm is consistently applied.

The criteria used in the Act that consent must be in writing, and on an approved form (s. 7(2) (c)) is too prescriptive. This only reflects consent at a discrete point in time. Using the approved form as the only basis for consent does not recognise the practice of continuous assessment and the changeable nature of a person's capacity to give consent or the health care professional's obligation to continuously provide information and assess capacity to consent and document this.

Documentation should include confirmation that all information, required by consumers to facilitate informed consent, has been provided. Additionally services should be required to document decisions to act against a person's views and preferences as expressed by them at the time, or through advance statement or nominated person.

Consent and Capacity Implementation that may not require legislation:

1. That there is oversight by the Chief Psychiatrist of decisions to continue involuntary treatment and care where a patient has capacity to consent.

Consent and Capacity Recommendations:

5. That there is a starting presumption of capacity and established clear criteria about capacity and informed consent in the new legislation.
6. A clear statement of the intent, to promote a person rights, liberty, dignity, autonomy and self-respect.

7. To establish a number of mechanisms to record and approve informed consent that expands the current requirement for a person to sign the approved form as the basis of consent.
8. To support rights and consumer's inclusion in treatment decisions it is recommended that documentation of consent is made on a regular basis and when any changes to treatment are made.

PART TWO: PERSON CENTRED APPROACH

2.1 Wills and Preferences

The CVP support the central premise as highlighted in the discussion paper that consumers and carers are both major stakeholders in the planning and delivery of health care. That they have rights to be fully involved in their recovery and this means they are actively involved in the decisions about treatment and care and who they wish to support them.

In the context of mental health legislation the ascertaining and recording of an individual's wills and preference is vital to advancing a person's autonomy and human rights. People have a right to engage in or refuse treatment free from persuasion and coercion. Failure to ascertain and advance a person's wills and preference impact the therapeutic relationship and recovery. Research suggests that mandated treatment is less effective than treatment that consumer's engage with freely and collaboratively. In order to ascertain consumer's wills and preference it is important that services provide all relevant information and engage individual's in conversations about what they want.

If the requirement is for the mental health service to ascertain and implement a person's wills and preference in the new Act, the following need to be included:

- How and who would be involved in ascertaining the persons wills and preference.
- How are they to be recorded and the use of them by the mental health service if the person becomes unwell after they have been recorded.

As the discussion paper sets out currently the NT has an Advance *Personal Planning Act* 2013 which provides for Advance Personal Plans. The question is, is this fit for the very specific purpose of recording wills and preferences in this context.

Wills and Preferences Implementation potentially without legislation:

1. The mental health services to coordinate advance statement conferences as part of discharge planning. These meeting will be learning opportunities for the service and carers where wills and preference can be documented.
2. In some cases an independent advocate may be required to investigate and determine the wills and preference of an individual consumer.

Wills and Preference Recommendations:

1. The form the advanced plan that records wills and preference takes should not be prohibitively proscriptive noting the *Advance Personal Planning Act* 2013 is one example.
2. The requirement to action wills and preference of a person once recorded is clearly articulated in the legislation.

2.2 Nominated Support Person

Should the Northern Territory introduce a 'nominated support person' into the mental health legislation?

The CVP supports the new nominated support person role which complements the role played by family, carers and the CVP. Consistent with a human rights approach, the nominated support person is appointed by the patient and is a person of their choice.

In line with this approach, the CVP supports that the person may elect not to have a nominated support person also.

The NT should introduce a nominated support person into mental health legislation. The nominated support person model should be flexible. This approach recognises the diverse needs of people and allows people to be supported by family, friends, a case worker or some other person in whom they have confidence. This initiative helps facilitate consumer's self-determination, understanding of rights and coordination of care post discharge.

The Royal Commission Victorian Mental Health Services Final Report 2021 (RCVMHS) noted the low number of consumers that have nominated support people following legislative changes in Victoria. To promote the uptake of support person nomination the principle will require consumer education and, as the RCVMHS discussed:

- Training for the mental health workforce to facilitate work with consumers' families, carers and supporters.
- Expanding models of care that involve families, carers and support networks

What kind of roles should the nominated support person have?

In order to provide consumer's a sense of security the role of a nominated support person should be to ensure the consumer's interests and wishes are taken into account in decision making and that their rights are observed.

The nominated persons should receive notification from services when:

- an Assessment Order, Court Assessment Order, Temporary Treatment Order or Treatment Order is made, varied, revoked or expires.
- A Court Assessment Order is completed.
- A consumer's right to communicate is restricted.
- A restrictive intervention is used on a person (Chemical, environmental, seclusion, physical, mechanical).
- A consumer is absent without leave from a designated mental health service.
- The authorised psychiatrist grants, varies or revokes a consumer's leave of absence.

- A second psychiatric opinion report is made (and reasonable steps must be taken to provide the nominated person with a copy of the report).
- The Chief Psychiatrist reviews a consumer's treatment following an application for review after a second psychiatric opinion report is made (and reasonable steps must be taken to notify the nominated person of the outcome of the review in writing).
- The Chief Psychiatrist makes a written direction to a designated mental health service in respect of the mental health services provided to the person.
- NTCAT lists a matter for hearing.
- NTCAT grants or refuses to grant an application for the performance of electroconvulsive treatment.

How many nominated support persons should an involuntary consumer have?

Because of the diverse roles and responsibilities of being a nominated support person the consumer should be encouraged to nominate persons who they wish to support them and fulfil this role. The CVP consider that the person should be able to determine this however for practical reasons, a limit of three nominated persons at any one time.

What do you think about the current provisions relating to the use of interpreters?

Because it is a health care professional's obligation to understand consumers the current provisions under the Act support consumers rights and should not be eroded. The Act however, can be strengthened for consumers requiring interpreters to be:

- Independent and accredited.
- Provided by recognised interpreter service.
- Potentially set out in the regulations that Aboriginal Interpreter Service or Translating and Interpreting Services (TIS National), and then various Auslan services are to be used.

(See the cultural safety section for further discussion of interpreters).

Nominate Support Person Recommendations:

1. A nominated support person should be introduced into mental health legislation.
2. A person receiving treatment should be able to nominate any person/s they feel confident with and also elect not to have a nominated person.
3. The nominated support persons should represent consumer's interests and wishes, help ensure rights are observed and be an important link to recovery after treatment. The scope of the role and rights to access information should be set out in a non-exhaustive list in the Act

2.3 Cultural safety

The discussion paper limits questions about Cultural Security to interpreters however the CVP provides further examples of where cultural safety needs to be included. A commitment to Cultural Security in provision of services is commendable however without a legislative framework supporting this the intention to embed Cultural Security into structures, policy and workforce attributes is not ensured.

Cultural Security strategies must ensure that all people receive care and treatment with regard to their individual cultural needs and differences. In the NT Aboriginal people make up a significant percentage of the population and the legislation must recognise that by requiring that care and treatment delivered under the Act is culturally safe for Aboriginal people. The predominantly non-Aboriginal composition of the workforce further complicates the delivery of a culturally safe service.

A key aspect of the CVP work has been the review and assessment of how services facilitate cultural safety and how core elements of culture inform and enrich the service for Aboriginal people in both the inpatient setting and community treatment and care.

The CVP acknowledges that in the public mental health service there is evidence of culturally safe initiatives. Support and initiatives such as some access to traditional healers, Aboriginal positions embedded in inpatient multi-disciplinary teams and the welcoming of family boarders to stay in the inpatient units for remote consumers. These

are necessary and positive initiatives however there is a need for structural reform in the new Act to strengthen cultural safety.

The right to receive care and treatment in a culturally safe and appropriate way requires more than the use of interpreters. It requires that the concept of a social and emotional wellbeing framework is embedded into the legislation.

The National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing[11] provides a model of care that is not only culturally appropriate to Aboriginal people but is intended to guide and support mental health policy and practice. It is viewed as 'an essential component of the national response to Aboriginal and Torres Strait Islander health' with Federal Ministers supporting the framework.

> "By ensuring cultural considerations are embedded in practice, Aboriginal and Torres Strait Islander peoples will have much better access to culturally safe, responsive, person-centred services provided by a culturally competent and confident workforce".[12]

The review of the Act provides the opportunity for the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023 to be written into legislation. Requiring care and treatment to include a culturally appropriate, social and emotional wellbeing model of care, in collaboration with a medical model of care, is required and would ensure that the human rights of Aboriginal and Torres Strait Islander people are respected.

Mental health and social and emotional wellbeing affects all people regardless of cultural background. Legislating that this model of care be considered alongside the medical model will benefit all people receiving care and treatment. It will assist in preventing Aboriginal concepts of health being minimised by clinicians and ensure that

[11] Australian Government. (2017). The National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023.
[12] Australian Government. (2017). The National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023. p. 1.

Aboriginal people's cultural norms are taken into consideration during examinations and treatment.

Mental health legislation must require:

- culturally and clinically appropriate assessments and treatments
- recognition and inclusion of traditional healers and cultural healers
- access to interpreters.

These requirements and obligations must be evident in the legislation for both voluntary and involuntary admissions in the Approved Treatment Facility and in the community for people accessing or receiving care and treatment under the Act.

What do you think of the current provisions relating to the use of interpreters?

In the NT there is a wide cultural demographic and a person's access to a qualified interpreter, when English is not the persons primary language, is a right that must continue to be in the Act. Two-way communication is critical in ensuring therapeutic, recovery based care and treatment but cannot occur if a person is unable to actively engage in communication with treating clinicians due to language barriers.

Further interpreter access should not differ for voluntary or involuntary admission.

The current legislation has enabled inefficient, ineffective and weak implementation of the requirements. It has not afforded people the appropriate level of protection. Phrases such as 'as far as is practicable' have allowed mental health services to avoid this obligations. They must be removed and a reversal of the reporting that reporting occurs if an interpreter is not used.

It must be clear that the provision of an interpreter is a legal obligation and is not a discretionary matter. An interpreter obligation must be clearly articulated throughout the legislation particularly at the following points during admission:

- Assessing capacity of the person to give informed consent.
- The initial authorised psychiatric practitioner examination.

- The second authorised psychiatric practitioner examination.
- When the explanation of rights and entitlements under the Act is given to the person.
- When the person is informed on how their rights and entitlements may be exercised.
- When the person is informed of the advocacy and legal services that are available to them.
- All ongoing authorised psychiatric practitioner examination.
- For explanation of treatment plan during admission.
- For collaboration on individual care plans.
- For legal counsel and attendance at NTCAT.
- For explanation of community management order.
- Whenever a person requests an interpreter.

Further, there is a gap in legislation not explicitly requiring access to interpreters for people receiving care and treatment in the community. Although access to interpreters is inferred by the principles of the Act this is insufficient to ensure that the rights of people requiring interpreters are upheld in the community setting.

An interpreter obligation must also be clearly articulated for care and treatment in the community. The person must be afforded an interpreter during:

- notification to the person of an interim community management order.
- explanation of treatment and care under community management order.
- when the explanation of rights and entitlements under the Act is given to the person.
- when the person is informed on how their rights and entitlements may be exercised.

- when the person is informed of the advocacy and legal services that are available to them.
- notification to the person of revocation of community management order.
- authorised psychiatric practitioner examinations.
- community management order authorised psychiatric practitioner reviews.
- psychiatric case manager reviews.
- for legal counsel and attendance at NTCAT.

Current legislation requires that at certain junctures, notifications are made to primary carers, either ‘orally or in writing but must be in a language that can be understood by the receiver of the notification’. Unfortunately in practice this frequently defaults to English and protections must be legislated to ensure that a primary carers’ right to receive information is upheld and as the Act intended.

Where written notification cannot be made in the primary carers’ primary language notification must be facilitated orally. An interpreter obligation must be legislated for communication with primary carers. Primary carers must be afforded an interpreter during:

- at every notification required by the Act
- when information is required by the Act to be given to the primary carer.

Accountability for the obligation to protect and respect a person’s right to an interpreter could be underpinned by legislation that requires the documentation of all efforts to facilitate access to an interpreter in a person’s record and a requirement to notify NTCAT and the Principal Community Visitor when an interpreter was not provided for:

- the second authorised psychiatric practitioner examination.
- informing the person of their rights and entitlements under the Act informing the person on how their rights and entitlements may be exercised.
- informing the person of the advocacy and legal services that are available to them.

The same stringency must be evident in legislation for people who are hearing impaired. Appropriate, qualified interpreter services, such as Auslan, must be provided at the same junctures outlined above for language interpreters.

If a person requires more than one form of interpreter it should be regulated that they are provided both.

Cultural Safety Recommendations:

1. The National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023 to be written into legislation.
2. Legislation to require care and treatment to include a culturally appropriate, social and emotional wellbeing model of care.
3. During voluntary and involuntary admissions the legislation must require:

   3.1 culturally and clinically appropriate assessment and treatments

   3.2 recognition and inclusion of traditional healers and cultural healers

   3.3 access to interpreters.

   3.4 Inclusion of SEWB model of care in treatment plans including recognition and inclusion of Elders in care.
4. The provision of an interpreter is the legal obligation of clinicians providing care and treatment and the consequences for not complying with this obligation are stipulated in the legislation.
5. Interpreter obligations are clearly articulated throughout the legislation during voluntary and involuntary admission, particularly at the following points:

   5.1 Assessing capacity of the person to give informed consent.

   5.2 The initial authorised psychiatric practitioner examination.

   5.3 The second authorised psychiatric practitioner examination.

   5.4 When the explanation of rights and entitlements under the Act is given to the person.

5.5 When the person is informed on how their rights and entitlements may be exercised.

5.6 When the person is informed of the advocacy and legal services that are available to them.

5.7 All ongoing authorised psychiatric practitioner examination.

5.8 For explanation of treatment plan during admission.

5.9 For collaboration on individual care plans.

5.10 For legal counsel and attendance at NTCAT.

5.11 For explanation of community management order.

5.12 Whenever a person requests an interpreter.

6. A person receiving voluntary or involuntary care and treatment in the community must be afforded an interpreter during:

6.1 notification to the person of an interim community management order.

6.2 explanation of treatment and care under community management order.

6.3 when the explanation of rights and entitlements under the Act is given to the person.

6.4 when the person is informed of the advocacy and legal services that are available to them.

6.5 notification to the person of revocation of community management order.

6.6 authorised psychiatric practitioner examinations.

6.7 community management order authorised psychiatric practitioner reviews.

6.8 psychiatric case manager reviews.

6.9 for legal counsel and attendance at NTCAT.

7. Where written or oral notification is required to be given to a primary carer, it must be written in the primary carer's primary language or facilitated orally with the use of an accredited interpreter.

PART 3 – ADMISSION AND TREATMENT

3.1 Involuntary Admission

What do you think about the current process of assessment and examination for involuntary admission?

The CVP consider that the current legislative process for assessment and examination is in line with other international and national criteria for involuntary admission. The process and review requirements are clearly set out. However broad terms such as, 'reasonable period', are open to interpretation. This term and language used should be explicit and clear to reduce any ambiguity.

Legislated timeframes in the Act must be consistent. Currently section 36(5) (b) allows for a person to be held for 72 hours at an 'approved temporary treatment facility' prior to *transport* to an Approved Treatment Facility for examination. This is inconsistent with section 34(3) (d) that allows a person to be held for 'up to 24 hours' only prior to examination by an authorised psychiatric practitioner.

Since 2011 the CVP have had an open recommendations related to persons being advised of their rights during the process of admission. Currently the Act requires that there is an explanation of the right to apply to NTCAT for early review of the decision to detain the person for a further period. In practice, people frequently report to the CVP that they are not made aware of this right by the authorised psychiatric practitioner. The Form 10 data analysed by the CVP supports this feedback.

Legislation specific to a person's right to early review must be strengthened, not weakened, by the 'operational pressures' of the mental health services or the Tribunal. Amending the legislation to require; an authorised psychiatric practitioner to action a person's request for early review, and; forward the application to the Tribunal, within specific timeframes would strengthen the legislation.

What is not clear in the current legislation is the point at which a person must be informed of their rights. Legislation needs to clearly state that at the time of involuntary admission

the authorised person must inform the person of their rights. There must also be a requirement that this obligation is ongoing and revisited by the authorised psychiatric practitioner at each ongoing review to ensure that the person is able to receive and comprehend the information on their care, treatment and recovery journey. The CVP raise that these discussions are part of a therapeutic process that should be viewed as empowering and respectful to the person. It also acknowledges the inherent power imbalance that needs to be addressed and the legislation could do this by promoting and supporting the partnerships between mental health services and the persons who use them by requiring this continuous rights dialogue.

During an involuntary admission a person's ability to give informed consent shifts. It is acknowledged that the concept of informed consent is complex however recovery is not a linear journey for a person. This means clinicians must be committed to revisiting a person's ability to consent and not apply a stagnant approach dismissing the possibility for a person to demonstrate personal autonomy based on the initial assessment. The CVP advocates for the requirement for a person's ability to give informed consent to be reviewed regularly during their admission.

There must be an acceptable balance between 'duty of care' and the active support of people who are receiving involuntary care and treatment but are determined to make informed choices which align with their personal values, culture and preferences.

What are your thoughts about the process to involuntarily admit somebody on the grounds of mental illness, or mental disturbance or complex cognitive impairment?

The CVP supports the different involuntary admission pathways in recognition of least restrictive alternative considerations and the conditions, circumstances and subsequent treatment processes.

Complex Cognitive Impairment

The CVP believes the Act should continue to have provisions for the assessment, care and treatment of people with complex cognitive impairment who require urgent assessment and stabilisation. The CVP has identified people with complex cognitive

impairment as requiring rights and particular support in legislation that has not been provided as expected in the *Disability Services Act 1993* due to the Secure Care Services policy changes. This has meant that a significant number of people with complex cognitive impairment have prolonged admissions at mental health facilities.

Currently it is unclear to the CVP, where people with complex cognitive impairment would be able to access urgent assessment and treatment in a health facility if they are not subject to a Forensic order or intervention. However, modernised legislation needs to include an acknowledgement of the complexity of providing mental health care, treatment and recovery to people with complex cognitive impairment.

> *'Between one and three per cent of people in the community have a developmental or intellectual impairment. Many have coexisting mental health problems consequent to their disabilities, such as stress, anxiety, depression and sometimes psychosis. Their situation exemplifies the very considerable diagnostic and service access problems for people with complex disorders... in the UK and parts of the USA psychiatrists specialise in the treatment of this group – in Australia, they fall through the gaps in service provision because they don't neatly fit into eligibility criteria...they don't "fit" because of their cross agency, cross-professional needs....in Australia few psychiatrists have the inclination, the skills or the expertise to be involved, this is a huge unmet need, clinicians don't know how to help this group—how to serve their best interests.'*[13]

Legislation should include provisions related to the assessment, treatment, care, rehabilitation and protection of people with complex cognitive impairment. Legislation must refer to the need for specialised treatment practices that are least restrictive and informed by human rights principles. For these reasons, there should be consistency between the Mental Health legislation and the safeguards provided under Commonwealth and Territory National Disability Insurance Scheme (NDIS) legislation.

[13] Parliament of Australia, Chapter 5 - Addressing the diversity of mental illness and treatments. https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Former_Committees/mentalhealth/report/c05.

Updating legislation also creates an opportunity to create clear NDIS pathways and relationships that will significantly reduce the time people with complex cognitive Impairment spend at approved treatment facilities.

Children and Young People

Unlike the Voluntary admission process the Act does not specifically address persons under 18. While section 26(1) (b) stipulates that 'if appropriate and possible' children should receive treatment and care 'separately from persons who are 18 or over' if appropriate and possible. A similar requirement is necessary in the involuntary admission section of the new legislation.

The experience of admission to an adult ward or with adults may further increase the distress experienced by children and their families during a mental health crisis. The vulnerability of children, and the specialist skills required to provide appropriate trauma informed treatment and care to children, requires that children must receive treatment and care 'separately from persons who are 18 or over and as a last resort on an acute involuntary adult mental health ward.

Involuntary Admission and Treatment Recommendations:

1. Removing vague phrases such as 'where possible' and 'as far as possible'.
2. Amending section 9(b) to include a requirement for the initial examination and each ongoing examination to include, as part of the examination an assessment of the persons suitability for treatment in the community.
3. A requirement for the authorised psychiatric practitioner to action the request for early review within one day, specifically, to facilitate the application to the Tribunal.
4. Amending section 9 to include the requirement for documentation such as Advance Personal Plans recording persons wills and preference to be taken into account and inform the care and treatment of a person.
5. Adding transparency to the Act by specifically addressing a person's right to refuse treatment when receiving involuntary care and treatment, and the process in place for a person to have access to external oversight when this right is not upheld.

3.2 Voluntary Admission

Approach to voluntary consumers refusing treatment

In practice people frequently say that they are told they are not allowed to refuse treatment and if they do, they may be given treatment against their will with the use of force or that they do not have a review process open to them. This is disempowering for the person and is a direct contradiction of the principles of recovery oriented mental health practice.

Do you have any feedback on the current voluntary admission process?

A fundamental principle of mental health care and treatment is that it is the 'least restrictive' possible. For acute services, this principle comes into focus from the point at which admission is considered. The first decision is whether care can be provided in the community. If this is not the best option, the service will consider if a person can be admitted on a 'voluntary' basis.

Voluntary engagement with mental health services is a good foundation for recovery. The CVP has observed that the majority of people receiving public mental health services are receiving voluntary treatment in the community. The introduction of a requirement that a person's suitability for voluntary treatment in a less restrictive environment (community setting) into legislation, empowers the person by responding to their needs in a way that promotes a level of autonomy and self-reliance.

The legislated rights of voluntary consumers recognise that a person can make informed choice to admit themselves to hospital for mental health treatment. Part of the current rights is that the person can change their mind and discharge themselves 'at any time'. The current legislation also provides extensive guidance on the meaning and application of informed consent.

Unfortunately, the CVP has observed during visits and cases raised that voluntary consumers are sometimes not afforded a 'least restrictive' approach to acute in-patient

admissions. This issue is most strikingly highlighted by cases where voluntary consumers no longer want to be admitted to hospital.

Leave provisions in legislation for voluntary consumers

The legislation should be amended to include provisions for access to leave for voluntary admissions. Currently leave for voluntary admissions is limited to leave in the context of discharge. This has resulted in ongoing issues for voluntary clients who want to leave the ward, but not be discharged, and then return to the facility. Leave during a voluntary admission should not be subjected to the same requirements and level of restriction as leave during an involuntary admission. Nor should attempts to access leave result in a person's voluntary admission ending prematurely without sound clinical justification.

Legislation must make it clear that compliance with a person's rights is not discretionary and Approved Procedures must be in line with the legislation. Organisational policy must respect a person's legal right to leave from the Approved Treatment Facility and not diminish this right.

The CVP is aware that currently there is a policy where no leave is authorised in the first 48 hours of an admission irrespective of whether the person has a voluntary or involuntary status. Additionally, a person who chooses to leave the Approved Treatment Facility for a period of time and their intention is clearly to return, must be protected from the mental health service discharging them if they elect to assert their right to take leave from the ward.

The CVP acknowledge that leave decisions are clinically informed. For voluntary consumers, however, these decisions must also be collaborative between the doctor, the consumer and as appropriate their carer, supporters. It would appear that there is a widely held view within the service that legislation is not required for leave during voluntary admissions because access to leave is inherent within the rights of a voluntary consumer. This proposition may appear logical however, it is not sufficient to rely on what is *not* contained in the legislation to ensure a person's rights.

To protect the rights of people during a voluntary admission legislation must specifically address access to leave during a voluntary admission and the right to return to the ward after leave.

A further issue is the role of others such as adult guardians in voluntary admissions, Section 27(2) (a) enables the voluntary admission of a person with adult guardian or decision makers' application. The CVP has observed issues when the person is not willing to be admitted. The CVP maintain that the decision to admit any person must be one based on assessment and clinical decision making relevant to the specific criteria of the Act. The CVP raise that the capacity to give consent has been observed on numerous occasion when people are under guardianship, who are assessed to not have capacity to give consent or do not agree to an admission. The CVP ask that this contradiction be reviewed in line with the person's human rights and inclusion and consideration of will and preference and/or supported decision making principles.

3.5 Leave

What do you think about the current approach under the MHRS Act that grants leave to involuntary patients?

Access to leave during an involuntary admission is an important part of a person's discharge planning and transition from the supervised ward environment to their usual place of residence. Leave frequently features in discharge planning and allows the person an opportunity to spend time outside the hospital environment.

The Act currently has provisions for access to leave for involuntary clients and outlines the regulation of a person absent without approval. These sections must be maintained in line with the therapeutic objective that discharge home is likely to happen at some stage. The person's right to access leave during involuntary admission should not be eroded and that these decisions are based on sound clinical decision making in consultation with the person and their careers.

See the above submission regarding the requirement for leave for people admitted on a voluntary basis.

3.6 Search & Seizure Powers

What do you think about regulating the power to search someone and seize property under the MHRS Act?

The introduction of search and seizure powers into mental health legislation raises human rights concerns as they may place limitations on a person's human rights including a person's right to privacy, dignity and to be treated with respect, these cannot be eroded arbitrarily.

Search and seizure provisions must only be considered if there is a legitimate objective to the introduction of such powers. Any actions authorised must be reasonable, necessary and proportionate to achieving that objective.

The scope and when the powers are to be used must be clearly articulated in the legislation, including who is authorised to conduct search and seizures, utilising the concept of authorised officers. Further, the type of searches authorised by the legislation should be limited to the least invasive form of search.

The legislation would also need to include provision for adequate information about and explanation of the powers and also that people being subjected to them have the right to be supported if they are to be used on them by family, carers, supporters or nominated person.

Where criminal activity is suspected then police should conduct such searches and seizures.

All persons accessing treatment and care at a public hospital should be afforded the same level of protection of their legal and human rights regardless of whether they are on a medical ward or a mental health ward.

Voluntary Admission and Treatment Recommendations:

1. Admission procedures are strengthened by legislation adding a requirement to notify the persons listed in section 41(1) and 43(1) within one day of a person asserting their right to apply for early review;
2. A requirement for the authorised psychiatric practitioner to action the request for early review within one day, specifically, to facilitate the application to the Tribunal.
3. Legislation must be in place to provide access to leave during a voluntary admission.
4. Search and seizure provisions only be included if the objective is clearly articulated, including that only authorised people conduct searches and person being searched is supported.

3.3 Youth

Consent, Rights and Voice of Children

The CVP position is giving people, of all ages, the presumption of capacity demonstrates respect and protects rights. In particular a presumption of capacity helps embody the Gillick principle (1985) that children and young people are able to intelligently consider, understand and be competent to give consent to treatment. The implementation of the Gillick approach sets out principles to be individually applied to children and young people, including the approach to young people right to refuse treatment being respected.

This approach is also required by and any amendments need to comply with Article 12 of the UN Convention on the Rights of the Child (1989) which protects the rights of a child or young person who is capable of forming their own view to express them freely, and for these views on matters that affect the child or young person to be given due weigh in accordance with their age and maturity.

Over 20 years of practice the CVP has advocated on issues for children and young people who have been admitted on Mental Health Wards some for extended periods. The key to

ensuring timely transitions is listening carefully to the voices of children, young people and their families and involving them in decision-making.

The United Nations Principles for the Protection of Persons with Mental Illness Principle 2 requires legal protection of the rights of minors including, where necessary, the appointment of a personal representative other than a family member. The ACT *Mental Health Act and Children's Services Act* supports and promotes children and young people's voices through a model of supported decision-making and the appointment of an independent advocate.

The CVP endorse the supported decision making process facilitated by an independent advocate, delivered in a trauma informed practice, recognises the vulnerable nature of these individuals and their distinct needs.

The CVP upskilled staff in regard to youth specific mental health issues when the Youth Inpatient Unit opened, and has a commitment to ongoing skill development in child and youth development, engagement, mental health and social and emotional wellbeing.

Restrictive Practices: Seclusion of children

There is currently inconsistency in the legislation regulating restrictive practices for children and young people in the NT, while seclusion of children or young people with disabilities within the NDIS framework is unlawful in the Northern Territory and throughout Australia, the seclusion of a child or young person in acute mental health crisis is currently authorised under the mental health legislation.

Legislative changes should be made to bring these two systems into alignment and to help reduce and eliminate seclusion of children in institutional settings including hospitals.[14]

[14] CVP Annual Report 2019/2020.

It is accepted as found in the Royal Commission into the Protection and Detention of Children in the Northern Territory (2017)[15] that the isolation of detained children causes 'suffering' and in some cases enduring 'psychological damage'.

Youth in Detention

The McGrath Review[16] discussed the issue of youth access to appropriate mental health services whilst in detention after the Royal Commission into the Protection and Detention of Children in the Northern Territory (2017) identified that an increase in therapeutic approaches and early intervention is required for youth in detention in the NT.

Whilst recommendation 12 of the McGrath review is largely operational, and some of the current service provision is by an Aboriginal Controlled Health organisation. Legislation should be used to create an integrated and stepped service delivery model for children in youth detention. This is required to facilitate quality mental health screening, assessment and the development of mental health care plans that include psychiatric assessment and treatment. Similarly, there needs to be continuation of treatment following release and the facilitation of interagency collaboration. This would create service delivery equity with adult correction services.[17]

Youth Recommendations:

6. Legislation to embed children and youth within it to recognise the vulnerability and specialist needs of this cohort.
7. Legislation should provide people of all ages a presumption of capacity to give informed consent.
8. Legislation should be used to create an integrated and stepped service delivery model for children in youth detention. This should include a continuation of service post release.
9. Legislative changes to prohibit the seclusion of children and young persons, in all institutional settings including Approved Treatment Facilities and the acute mental health wards.

[15] Royal Commission *into* the *Detention* and *Protection* of *Children in the Northern Territory. (2017). Final Report Volume 1, Executive Summary. P. 22.*
[16] McGrath, D. (2019). Report on the *review* of *forensic mental health* and disability services within the Northern Territory.
[17] CVP Annual Report 2019/2020 and CVP Annual Report 2018/2019.

10. Legislative changes to reduce and eliminate the use of restrictive practices including mechanical restraint of children and young people in institutional setting including acute mental health wards.

3.4 Apprehension by Police, including transport generally

The World Health Organisation (2005) suggests legislation should empower Police to explore least restrictive alternatives for people they detain for treatment at mental health services. Some people encountered by the Police, who do not appear to need treatment and care may be taken to a place of safety and legislation should reflect this. Places of safety could include the person's residence, some other accommodation or a medical surgery.[18]

As indicated in the Discussion Paper the presence of Police has potential to escalate already highly emotive situations. As such legislation should recognise and address this potential. A possible avenue is legislated training for Police. Approaches in other jurisdictions such as New Zealand and Memphis USA, have successfully implemented Police training and engagement models which have had a number of positive results including reduced response times, reduced restraints and reduced officer injuries.[19]

A further approach and one which has been trialled in the NT, and which could be placed in legislation, is to include multidisciplinary teams when police attend a person or a situation where mental illness is a contributing factor, either an incident or request for assistance.

The mental health services are currently running a Co-response pilot project. Interagency cooperation and collaboration allows for streamlined early response to situations determined by police or ambulance to require mental health input. This type of strategy affords person centred and recovery oriented clinical assessment, advice and

[18] World Health Organisation. Resource Book on mental health: Human rights and legislation. (2005). https://ec.europa.eu/health/sites/default/files/mental_health/docs/who_resource_book_en.pdf.
[19] Springvale Monash Legal Service Incorporated. (2005). Police Training and Mental Illness – A time for change. https://www.parliament.vic.gov.au/images/stories/committees/lawrefrom/warrants/submissions/Warrant_32S_-_Springvale_Monash_Legal_Service.pdf

interventions, targeting frequent and complex behaviours requiring the use of emergency and mental health services[20].

Early response to mental health crisis is critical to positive outcomes for people in crisis. A requirement that mental health services are involved in collaborative, interagency early interventions in the community setting is in line with least restrictive care and treatment and likely to reduce the frequency of people being transported under section 32A of the Act.

Transport

Transport to an Approved Treatment Facility (ATF) involves considerable risk and is an important area for legislation. Considerations for legislation in the area of transport to ATF are dignity, welfare, safety and the least restrictive option possible for the person involved. The mode and manner of each transport incident should be based on clinical assessment and undertaken in the least restrictive manner possible in consultation with the person and their carers. Any use of restricted practice, including chemical restraint, should be based on a person's presentation and clinical assessment.

In order to minimise trauma associated with transport to an ATF, legislation and transport decision making should reflect the National Safe Transport Principles (2008); respect, consumer and carer involvement in decision-making, decision support for transportation processes, functional efficiency of transport system, timeliness of the transport process and staff competency.

The National Safe Transport Principles provide a hierarchy of transport intervention modes that should be considered. The adoption of the least restricted transport option minimises the stigma involved in transport to an ATF. As already noted Police involvement should only occur as a last resort and be consistent with their role to ensure public safety. If Police transport is necessary then mental health staff or the multi-disciplinary team should be in attendance and available to provide necessary care, support and ongoing assessment for the duration of the transport.

[20] Co-Response TEMHS Clinical Practice Guideline, Version 1.0, 21 October 2020.

During transport restricted practices should be applied only for the management of safety. Each incident of restricted practice, chemical and physical, should be documented and only applied if appropriately qualified clinical staff have capacity to monitor the person throughout the transport.

The CVP is aware of Royal Flying Doctor Aviation (RFDA) protocol with the Department of Health of compulsory intubation on route for regional travel to an approved treatment facility of all mental health consumers. This policy does not rely on individual clinical assessment or respect consumer's current presentation and effectively means people with disabilities are being discriminated against. Similarly the CVP has received complaints about consumers being mechanically restrained in vehicles. Currently services do not consider this a restricted practice.

The amended legislation must provide that if a restrictive practice is required, details relating to the circumstance which necessitated the restriction and if medication was used without consent, the circumstance which necessitated the administration of medication, the drug/s that was administered, and the name of the authorising doctor. These provisions are contained in the Queensland Ambulance Service Clinical Practice Procedure as an example.[21]

Like restricted practices in other settings, mechanical restraint in a vehicle is traumatising, stigmatising and a breach of Human Right. For these reasons, the legislation needs to provide that this practice is subject to the person's presentation, clinical assessment, recorded, monitored and subject to oversight.

Change of practise that may not need legislative reform:

1. Adoption of the least restricted transport option to minimise stigma involved in transport to ATF. Police involvement should only occur as a last resort and be consistent with their role to ensure public safety.

[21] State of Queensland (Queensland Ambulance Service). (2020). Clinical Practice Procedures: Behavioural disturbances / Transport of person under the Mental Health Act 2016. https://www.ambulance.qld.gov.au/docs/clinical/cpp/CPP_Transport%20of%20persons%20under%20the%20MHA%202016.pdf.

2. In the case Police transport is necessary mental health staff or the multi-disciplinary team should be in attendance and available to provide necessary care, support and ongoing assessment for the duration of the transport.
3. The RFDA protocol with the Department of Health of compulsory intubation on route for regional travel to an ATF should cease. This practice should be in alignment with processes for other restricted practices and be subject to individual presentation, clinical assessment, monitoring, recording and oversight.
4. Accurate record keeping of the restrictive practice used, the circumstance, which necessitated the restriction and if medication was used without consent, the circumstance which necessitated the administration of medication, the drug/s that was administered, and the name of the authorising doctor.
5. Police working with mental health consumers receive mandated training.

Police Apprehension and Transport Recommendations:

1. Legislate that Police use in an apprehension or transport is as a last resort.
2. Legislative provisions that prescribe that the mode and manner of each transport incident should be based on clinical assessment and undertaken in the least restrictive manner possible in consultation with the person and their family, carers, supporters or nominated person.
3. Legislative provision that ensures mechanically restraint in vehicles comes into alignment with practices for other restricted practices. As with other restricted practices mechanical restraint in vehicles should be subject to individual presentation, clinical assessment, monitoring, recording and oversight.
4. Legislate for the use of multi-disciplinary mental health crisis assessment and treatment teams' work collaboratively with Police attending together when people are experiencing a mental health crisis.

PART FOUR: MONITORING

Respecting and responding to different needs, goals and preferences

4.1 The Chief Psychiatrist

How do you think the legislation can support the role of the Chief Psychiatrist?

The CVP commend the introduction of the Chief Psychiatrist to be embedded in the reformed Act. This would bring the NT in line with other States and Territories in establishing the essential functions to provide overall clinical and governance guidance and decisions. This would contribute to improving quality and safety in public mental health service delivery across the NT.

The CVP support the leadership and coordination role of the Chief Psychiatrist in determining policy based on standards and best practice, clinical assessment and treatment reviews, investigations, reporting and clinical governance responsibilities to stakeholders and the NT Community.

However, the CVP raise that oversight of mental health and treatment is not only vested in the Chief Psychiatrist role as shown in other States and Territories. The CVP, NTCAT, Approved Procedures and Quality and Safety Committee and accreditation structures and processes all inform and make up mechanisms, checks and protections that ensure quality and safety of public mental health services.

Role of Chief Psychiatrist

The CVP recommend the following functions of Chief Psychiatrist position be defined and embedded in the Act.

To:

- Provide clinical leadership and promotes continuous improvement in the quality and safety of mental health services.

- Promote the rights of people receiving mental health treatment in public mental health services and promotes their recovery.
- Provide clinical leadership through developing guidelines and undertaking clinical reviews, audits and investigations.
- Is responsible for monitoring restrictive practices, electroconvulsive therapy and reportable deaths.
- Provide advice and reports to the Minister about the provision of mental health services.

The key functions of the Chief Psychiatrist are to:

- develop and assist mental health service providers to comply with standards, guidelines and practice directions.
- develop and provide information, training and education to promote improved quality and safety.
- monitor the provision of mental health services in order to improve quality and safety.
- assist mental health service providers to comply with the Act, regulations and codes of practice.
- conduct clinical practice audits and clinical reviews.
- analyse data, undertake research and publish information about mental health services and treatment.
- publish an annual report.
- give direction to mental health service providers about providing mental health services.
- promote cooperation and coordination between mental health services and providers of other health, disability and community support services.

The CVP recommend that the Chief Psychiatrist has responsibility and oversight for the NT Mental Health Clinical Service plan. These types of plans are in place in other jurisdictions. This has been raised in previous CVP Annual Reports and the concept of

this plan though recommended as part of the McGrath Forensic review report[22] is on the current range of service, priorities, and emerging needs and include workforce capacity issues with measures proposed to address the challenges. The CVP consider that the Chief Psychiatrist has an important role in this area to identify and advocate strategies and investment that best meets the current and emerging issues of the NT public mental health services.

The CVP raise that the public reporting of the Chief Psychiatrist functions must be detailed in the legislation, as in other jurisdictions. This provides transparency and accountability to stakeholders and the NT community. Reporting on all complaint trends, quality and safety projects, progress against any open recommendations by an oversight body and the NT Coroner. Deaths in care, compliance with the legislation, strategies and progress against how consumers and carers are being involved in their care and treatment, activities relevant to the NT Mental Health Strategic Plan as some examples.

Complimentary Monitoring role CVP

The CVP has a clear monitoring role in regard to the adequacy of treatment and care that is broader than complaints resolution and advocacy functions.[23]

The CVP highlight that there is limited or no consumer/carer policy input mechanisms currently and inconsistent employment of peer positions as part of the service's multidisciplinary teams. To be a contemporary, recovery orientated mental health service means that consumers and carers are involved in the co-design of services, provision of those services and that they contribute on an ongoing basis through their feedback to the development of effective, quality services. There needs to be improved mechanisms that hear directly from the people who are in receipt of those service.

This must change for the NT public mental health service system. The CVP strongly advocates that as part of the review that introduction of co-design mechanisms and peer positions are developed, workforce and advisory mechanisms are embedded in the legislation.

[22] McGrath, D. (2019). Report on the *review* of *forensic mental health* and disability services within the Northern Territory. Recommendation 13, p. 14.
[23] *Mental Health Related Services Act 1998* (NT) s.3 (q) - with regard to the fundamental principles of the Act.

The CVP has heard, reviewed matters and observed examples of serious quality and safety concerns as shown in the CVP Annual Reports. Many consumers and carers have raised matters that relate to quality of service provision. Over the past 10 years significant CVP issues have been the failure of rights provision, cultural safety breaches, non-compliance with the Act that all relate to the quality and safety of services. Some examples of interactions and services responses that did not uphold people's human rights and consumers and carers not feeling as if they have been treated fairly, with dignity and respect.

The CVP supports the amendments suggested in the discussion paper as there is a clear transfer of the administrative responsibilities from the Chief Health Officer (CHO) to the Chief Psychiatrist. The benefit of having a Chief Psychiatrist role is both in the expertise in the area of mental health and that the position is focussed on mental health. The CVP support the suggested amendment where new provisions are drafted to monitor compliance with restrictive practices such as mechanical restraint and seclusion by the Chief Psychiatrist.

However the current CVP role is complimentary to suggested Chief Psychiatrist's role. The CVP has a broader monitoring function than complaints resolution that relates directly to quality and safety of services. The functions of Community Visitors and Community Visitor Panels are articulated in sections 104, 105, 111 and 112A of the current Act. Broadly speaking, Community Visitors have inquiry, complaint, monitoring, and reporting and advocacy functions.

Under section 104 of the current Act, a Community Visitor may inquire into and make recommendations relating to matters such as the adequacy of services for assessment and treatment, the adequacy of information regarding individual rights, the accessibility and effectiveness of complaints procedures required under Part 13 of the Act and any other matter having regard to the principles (Part 2) and objects (s3) of the Act or as directed to the Principal Community Visitor by the Minister.

Section 107 provides broad powers of inspection allowing a Community Visitor to inspect any part of a facility or premises, visit persons receiving treatment or care at the Approved treatment facility (ATF) or Approved Treatment Agency (ATA), inspect documents or

medical records relating to the person's care and treatment and inspect any records or registers required to be kept under the Act.

The panel function of section 111 refers to the duties of Community Visitor Panels, which must visit an ATF at least once every six months in order to enquire into standards of facilities and treatment, adequacy of information about complaints procedures and other rights and any other matter that might be referred to the Panel by the Principal Community Visitor. This function is unique to the CVP compared to other states and territory official visiting programs and promotes community confidence in the process. The panels offer a multi-disciplinary team approach of medical, lawyer and community member expertise.

The CVP currently inspects both the seclusion and mechanical restraint register pursuant to sections 61(14) and 62(14) and reports publicly about the findings. These functions should remain.

They are complementary quality and safety functions that the CVP consider has contributed to the reduction in seclusions and have shown the impact and incidences of these interventions from a consumer and carer perspective. The CVP raises that the inspection functions should be strengthened and not divested in one role. The CVP recommend that the functions of inspection are expanded for the Chief Psychiatrist and remain for the CVP.

Monitoring including Chief Psychiatrist Recommendations:

6. That the functions of Chief Psychiatrist position be defined and embedded in the Act.[24] Including the functions that involve public reporting.
7. The Chief Psychiatrist has appointments and delegation for the credentialing and authority to appoint Authorised Psychiatric Practitioners, Designated Mental Health Practitioners and Psychiatric Case Manager/Coordinator roles.
8. The Chief Psychiatrist chairs the APQAC and the membership is expanded to include consumers and carers and other appropriate members.

[24] Victoria State Government. Health Victoria. Chief Psychiatrist. https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist.

9. The Chief Psychiatrist has oversight and publicly reports on the NT Mental Health Clinical Service plan.
10. That the CVP monitoring functions remain and provides the complementary strengthening of oversight that is required to improve quality and safety and public confidence.

4.2 Regulating restrictive practices

What do you think of the current approach to regulating the use of restrictive practices under the MHRS Act?

The review of the Act allows the Northern Territory an opportunity to build on the existing human and legal rights safeguards, regulatory oversight and independent monitoring for restrictive practices in the Northern Territory. It also provides an opportunity for the Northern Territory to demonstrate a commitment to the National priority of the reduction and elimination of restrictive practices.

Currently Part 9 of the Act authorises the Community Visitor to conduct inspections of the records required to be kept by the Approved Treatment facility for the use of the following restrictive practices only; mechanical restraint and seclusion.

The Community Visitor inspects the register containing the records and conducts examination of the clinical documentation of instances that raise concern. Significant analysis of the data obtained during an inspection of restrictive practices occurs and reports are prepared by the CVP.

CVP reports highlight areas of concern, non- compliance with legislation and peoples' rights, emerging trends and raise recommendations on serious areas of concern. Along with feedback from people who use the mental health services, inspections, observations and data analysis inform the advocacy work of the CVP who provides a mechanism for people's views to be heard.

Current legislation requires that records must be kept and made available for inspection however evidence suggests that this is not always occurring and the CVP continue to

advocate for the rights of people subjected to restrictive practices to be upheld by the mental health services.

Since January 2016 Community Visitors in the Northern Territory have inspected the records of 1070 seclusions and since July 2018, 93 Mechanical restraints. It is important to note that 18 instances of mechanical restraint were not recorded and the CVP became aware of them while conducting clinical file reviews. This is unacceptable and an example of why external, independent monitoring by the CVP is essential to protect the legal and human rights of people using the mental health services.

Restrictive practices can present serious human rights infringements and regulation and monitoring of restricted practices is an essential component of protecting the rights of vulnerable people. Current mental health legislation in the Northern Territory only refers to mechanical restraint and seclusion. The legislation must extend the definition of restrictive practices to physical, chemical and environmental restraint. The extended definition is in line with other relevant Commonwealth and State legislation including mental health legislation.

Currently physical restraint is not regulated by the Act in the Northern Territory and as such concern exists that physical restraint is not viewed as causing the same level of harm, to the person to which it is applied, as mechanical restraint or seclusion. Research demonstrates that this is not the case and that evidence suggests physical restraint can lead to serious harm.

Queensland took the opportunity to introduce into legislation the regulation of physical restraint when the legislation was reviewed in 2016. An evaluation of the implementation of the updated Act found that, ‘Available data and information indicates that the Act is supporting less restrictive ways and patient rights focused treatment and care’, and that

'The regulation of physical restraint ensures it is only used when necessary, and if required, done in an appropriate way that is safe, managed and monitored'.[25]

Currently in the NT the *National Disability Insurance Scheme (Authorisation) Act 2019* defines and regulates restrictive practices including seclusion, chemical restraint, mechanical restraint, physical restraint and environmental restraint and including the prohibition of the seclusion of children with a disability as part of the NDIS regime. There must be clarity within mental health legislation in regard to these restrictive practices as well as the use of restrictive practices on a person with a behaviour support plan registered with the NDIS Quality & Safety Commission in the mental health setting.

Having different definitions of restrictive practices and varying notification, recording and monitoring regulations across intersecting legislation weakens the protections afforded to people who may be subject to restrictive practices.

The CVP has highlighted concerns related to compliance with the legislated requirements for several years. It is imperative that the Act makes it clear that that operational pressures are not a factor that justifies the use of restrictive practices or justifies non-compliance with preconditions to their use or contemporaneous reporting of their use.

In reports to the mental health services the CVP have identified that the lack of clarity surrounding the regulation of restrictive practices on prisoners is not acceptable. Inadequate recording and the uncertain authorisation of the use of restrictive practices by APP's to satisfy the requirements of Darwin Correctional Centre is a direct contradiction of the current Act.

This lack of clarity impacts on the regulation and monitoring of restrictive practices on prisoners and the ability of the CVP to carry out the inspection functions authorised in the Act, undermining the rights of prisoners as people receiving care and treatment on mental health wards. The legislation should set out that the overriding principle is the care, treatment and recovery of the prisoner from their mental illness or distress.

[25] Queensland Health. Clinical Excellence Queensland. Evaluation of the Mental Health Act 2016 implementation. Evaluation Report: April 2019.

Children and young people in the Northern Territory have the highest rates of mental illness out of any age group in the Territory.[26] Mental health legislation must recognise the particular vulnerability of children and protect them from the trauma caused by isolation or, as referred to in the mental health legislation, 'seclusion' and mechanical restraint.

The focus of admission must be recovery oriented, trauma informed care and treatment in a specialist youth environment. Restrictive practices have no therapeutic value and must never be used as a behaviour management or punitive intervention for children and young people, many of whom have experienced significant trauma.

It is well accepted that exposure to trauma in childhood may lead to ongoing problems in learning, behaviour, and physical and mental health throughout adulthood. Children and young people have the right to be protected from exposure to trauma and mental health services have an obligation to prevent exposure and provide children with the therapeutic support required for recovery. (See further submission in the youth section, eliminating use of restrictive practices).

Legislative changes must be made to protect vulnerable children's rights and mental health services must ensure that all policies, directives and written instructions to staff accord with the legislation and that staff are trained adequately on the legal and policy requirements.

A further issue is the use of the term 'reasonable force' throughout the Act without a definition of what constitutes 'reasonable force' in section 4. Aside from the use of reasonable force by a police officer the Act must provide guidance and make it clear for all health professionals, consumers, carers, nominated person be clear in what constitutes 'reasonable force' when used by any other specified person for any authorised purpose under the Act.

Currently the Palmerston Regional Hospital is not an Approved Treatment Facility and there have been occasions where the use of mechanical restraints during transport from

[26] Northern Territory Government. Department of Health (2015) Mental Health Service Strategic Plan 2015–2021. p. 9. Those aged 15–24 years old comprised only 15% of the Northern Territory population yet accounted for 25% of community-based clients and 24.6% of admissions to mental health inpatient facilities in 2014.

Palmerston to Darwin has been justified by the term ‘use of reasonable force’. Not only does this raise the issue of whether mechanical restraint is ‘reasonable force’ in that situation, it negates independent oversight of the use of mechanical restraint and, as it is not under the Act and therefore the preconditions to its use and recording of the use in the register as restrictive practice does not occur and is unable to be monitored.

The CVP recommend that if the use of reasonable force is maintained in the Act then the Act must specify a relationship between the use of any restrictive practice and the relevant requirements as set out in the Act. Also relevant are earlier comments in regard to transport.

How do you think the legislation can further promote the elimination of restrictive practices?

To further promote the elimination of restrictive practices in mental health settings effective and evidence-based alternatives must be specified in legislation, implemented into trauma informed practice, embedded into organisation culture and the training and development of staff and; subject to regulation and independent monitoring.

Recovery Principles and Trauma Informed Care Principles should inform the legislation and underpin service delivery. A strong focus on person centred care and meaningful individual care plans, developed in collaboration with the person, and recognising a person’s right to least restrictive care and treatment in a safe environment are essential to eliminating the use of restrictive practices.

Legislation must be clear that a restrictive practice cannot be applied for reasons of the operational processes or the policy of another agency. That restrictive practices are only ever used where there is no other less restrictive method of ensuring the safety of the person or another. It must clearly outline the authorising persons responsibilities and obligations and the consequences of not complying with the requirements.

Limiting further the staff, and having only specialist staff able to authorise restrictive practices would also assist in reduction and elimination. Removing the right of senior nurses to approve restrictive practices and only Authorised Psychiatric Practitioners

(APP) and Designated Mental health Practitioners (DMHP) who have specialist qualifications and training can authorise restrictive practices.

Evidence demonstrates that strategies aligned with a person centred, individualised approach rather than a ‘one size fits all’ is more effective in reducing the use of restrictive practices. Consistent with this approach, the requirement in the legislation for a ‘reduction and elimination plan’ to be initiated when a restrictive practice is authorised, would serve to underpin the development of evidence based organisational practices.

Clear concise legislation is one piece of the jigsaw will ensure restrictive practices are authorised only as a last resort and to ensure that safe and therapeutic care is delivered to people who have complex needs, as well as providing the safest possible work environment for staff.

The legislation would also need to be accompanied by a change of culture in regard to restrictive practise, with a clear implementation plan for any changes, induction, training and education for all staff, consumers, their families, carers and nominated person.

Data collection is recognised as an essential component in the reduction of the use of restrictive practices. Currently in the Northern Territory there is no one centralised data recording system in place to maintain the restrictive practices data required by the Act.

Changes to legislation in relation to recording data could be used to underpin organisational improvements in data entry for restrictive practices to improve data quality. These improvements would enhance oversight of restrictive practices and legislative compliance, improve understanding of trends and inform practice improvement activities for the mental health services.

Data collected about restrictive practices can be used by mental health services to identify baselines and trends, set goals for reduction and elimination, monitor the effectiveness of reduction strategies and importantly, to inform practice.

Monitoring programs such as the CVP should have access to any centralised restrictive practices recording platform to conduct the role and functions authorised by the Act.

Restrictive Practices Recommendations:

1. Regulation of restrictive practices extended to include seclusion, chemical restraint, mechanical restraint, physical restraint and environmental restraint.
2. The restrictive practices monitoring role of the Principal Community Visitor is maintained and further broadened to include the monitoring of seclusion, chemical restraint, mechanical restraint, physical restraint and environmental restraint.
3. The relationship of the Act with other relevant legislation is articulated with primacy clearly established for the care, treatment and recovery for mental illness and underlying disabilities.

Implementation changes for Restrictive Practices that may not require legislation:

1. Specialist training in recognising the symptoms of trauma, intergenerational trauma, and the provision of trauma informed de-escalation, is mandatory for all staff involved in the authorisation and application of restrictive practices.
2. That the National Principles to Support the Goal of Eliminating Mechanical and Physical restraint in Mental health Services are used to inform legislation.
3. Mental health services staff must comply with, and understand, the sections of the Act concerning the use of force, mechanical restraint, seclusion and search and seizure (if introduced).

4.3 Electroconvulsive therapy (ECT)

What do you think about how the legislation regulated electroconvulsive therapy (ECT)? Can we make improvements?

This commentary on the discussion on ECT is also informed by CVP submission on role of the Chief Psychiatrist, informed consent, cultural safety and the ascertaining of and recording of wills and preference.

The CVP acknowledges that ECT is an important evidence-based therapy and should be accessible to all persons accessing care and treatment if required. The current legislation regulates ECT separately from other treatments and our experience suggests that this should continue. The legislation should be clearer by including in the definition the number of episodes for a treatment.

Informed consent must be regularly reviewed in the context of treatment. The Act must ensure that a person is able to request completion of, or agree to, ongoing ECT treatment if they become able to give consent during the treatment period.

The role of Chief Psychiatrist in monitoring ECT, the credentialing of staff performing ECT and ensuring skills are maintained is supported. To ensure patient rights are upheld, external independent monitoring of ECT is required.

The discussion paper references the 2019 Royal Australian and New Zealand College of Psychiatrists (RANZCP) position statement on ECT and the NT's Health and Community Services Complaints Commission investigative report. Consequently the need for change in the discussion paper focuses on removing "legislative barriers" to ECT rather than a focus on protecting rights and ensuring patient safety, although it does conclude "when determining the best way forward and removing ambiguity a balance needs to be achieved between protecting the rights of patients with adequate oversight, without compromising clinical care".

Only one example is given from other jurisdictions in relation to the role of the oversight body for emergency ECT, namely ACT *Mental Health Act 2015*, despite the fact that the RANZCP contains a comparison table of all jurisdictions that include provision for emergency ECT. The New Zealand and Tasmania Acts have little regulation of ECT as a separate treatment with New Zealand legislation deferring to RANZCP guidelines and codes of conduct.

The Community Visitor Panel of the Top End has been reviewing the facilities for ECT and the ECT register and ECT reports to the Chief Executive Officer required under the current Act since the mid-2000s.

A CVP recommendation that an electronic register be created to enable data use for quality improvement was implemented but those performing ECT still use the old paper based register which administration staff transfer to the electronic register. There is no evidence that the data is used, except maybe for preparing reports to the Chief Executive Officer as required under the Act.

ECT is an important treatment option for some people and legislation should not prevent the use of ECT. Legislation must afford a person the protection that legislation can provide and continue to authorise the use of ECT only when it is the least restrictive option, is an appropriate evidence based treatment or when other treatments have failed.

Consequently, ECT needs to be regulated to ensure that it is delivered safely and with informed consent.

To ensure cultural safety in the NT context legislation should require mental health services to work with people to build their knowledge of ECT and support family, carers and nominated support persons. A persons rights in regards to their cultural needs, as outlined in other relevant sections of this submission, must be upheld and embed in legislation pertaining to ECT.

When a person is too mentally unwell to give informed consent ECT should be used in accordance with relevant evidence and with consideration given to their wills and preference if previously expressed.

The criteria for approval of involuntary treatment with ECT is perhaps best articulated in Queensland legislation 2016 with approval by Mental Health Tribunal and if people wish legal or other support. While Emergency ECT should require the additional criteria of threat to life or serious and imminent harm with the approval of psychiatrist plus chief psychiatrist. A report to the NTCAT that emergency ECT has been commenced should be accompanied with an application for ongoing ECT if informed consent cannot be given.

There is no current mention in the Act of the number of individual ECT treatments that can be approved in an emergency or if involuntary in a certain period of time.

While the RANZCP is critical of limits to the number of treatments and requirements for NTCAT approval. This is an important safety net people where ECT is administered in an emergency or after an application to NTCAT. Providing a definition of ECT that includes number of treatments is necessary to provide clarity for people in the NT and would help confidence in promoting advance care directives in relation to ECT and cannot be seen to compromise clinical care. Other jurisdictions; ACT has a maximum of 9 (3 in emergency) treatments and a Psychiatric Treatment Order in the definition, NSW; max 12 times in 6 months, SA; 12 treatments over 3 months, VIC; maximum 12 within 6 months, WA; 12 prescribed at a single time and a treatment plan.

The language of treatment varies in different jurisdictions with some referring to ECT episode as one episode of ECT and treatment as a prescribed course. The language should be clear in a definition.

Current legislation includes monthly reporting of episodes of ECT and adverse events to the CEO Health. It is possible for an individual client's treatments to stretch over several months and not be apparent in data. Without indication for treatment, standardised definition of side effects or apparent inclusion of dose titrating ECT, current reports do not provide any useful information.

The oversight role should change to Chief Psychiatrist with reporting aligned to the RANZCP recommendations, that ECT units should participate in network for standardised recording of treatment (indications and) outcomes and side effects and regular review of these outcomes by clinical services.

While ECT treatment for some people, including children and young people is controversial, evidence-based treatment should be allowed if recommended by an authorised psychiatric practitioner, Chief Psychiatrist and approved by NTCAT. The wills and preferences of the person, if expressed, and involving family, carers and nominated person.

Informed consent includes the ability to decline ECT in favour of other less restrictive treatment even if this is considered an unwise decision. The external monitoring and advocacy role of CVP is critical to ensure confidence in, and safety of, ECT as is the

approval role of NTCAT and strengthening the clinical governance role of the Chief psychiatrist.

It is important that legislation requires processes to continually review informed consent, support people to have an active role in decision making and ascertain wills and preferences when an application for ECT is made.

The new legislation must strengthen the role of the NTCAT and Community Visitor Program in protecting the rights, promoting procedural justice and supporting the wishes of people, especially people who do not have the capacity to give informed consent.

While the discussion paper refers to the key points in the recommendations of the RANZCP Position Statement 74, the recommendations are in fact broader and can be summarised as:

1. Equitable access to safe ECT should be available to people in the NT for whom it is clinically indicated.
2. Oversight by NTCAT should be consistent across jurisdictions.
3. ECT units should participate in network for standardised recording of treatment outcomes and side effects and regular review of these outcomes by clinical services.
4. All psychiatrists prescribing and administering ECT should have appropriate training and expertise, with ongoing training and credentialing of Psychiatrists who provide ECT. Potential development of RANZCP advanced certification in ECT and neurostimulation.
5. Psychiatrists should continue to challenge the stigma and discrimination associated with ECT and accurate depiction of ECT within the media should be promoted.

ECT Recommendations:

8. That ECT continues to be regulated.

9. That the Act is clearer in relation to ECT by the addition of a definition that included number of episodes for a treatment.

10. The role of Chief Psychiatrist in monitoring restrictive practices including ECT is established in legislation including credentialing of staff performing ECT.

11. That a centralised register of records for the use of electro convulsive therapy is required to be kept by the ATF,

12. The PCV ensure that a register of records kept for the purposes of ECT is inspected at regular intervals.

13. That the legislation promote a therapeutic alliance with patients, promoting the principles that people can make decision about their own health even if it is considered an unwise.

14. To establish that information about ECT must be provided to carers, significant family members and nominated support person.

ECT implementation which potentially do not need legislation.

15. That informed consent provisions to ECT should be used in accordance and recorded with evidence (including evidence for treatment of children) previous treatments and response to treatment for the patient, is in accordance with their wills and preferences if previously expressed, is the least restrictive option, and is an appropriate treatment or other treatments have failed. Also the recording of co-morbidities.

PART FIVE: FORENSIC PROVISIONS

Is the current legislation effective in regulating forensic mental health?
Can we make improvements to the legislation?

The CVP has advocated for improved mental health services to prisoners over numerous years. The CVP draws stronger focus onto the needs of all prisoners to receive an equitable, recovery-oriented and therapeutic service.

The CVP highlights that forensic consumers are the most marginalised and powerless individuals in our society.[27] Part 11 of the current Act set out the mental health treatment and care for prisoners. The CVP has 9 open recommendations regarding the treatment and care of prisoners.

The CVP inspections of both forensic mental health services identified high referrals from prisoners for support, and difficulties in meeting the need for services (including psychological support). As a result, the mental health teams have to prioritise service for the most acute prisoners, being those who are critically unwell or at imminent risk of self-harm.

For forensic consumers released (or needing to be released) from prison on non-custodial supervision orders, there have been substantial difficulties identifying and supporting community placements. In some instances, individuals who are not considered 'fit to plead' as a result of their mental impairment or cognitive impairments have been held in unnecessarily restrictive environments. This has affected them receiving timely support to transition to the community as a basic human right.

The CVP raise that prisoners have the right to receive mental health services appropriate to their needs. Adult prisoners need mental health acute services provided by specialist staff. All prisoners need improved psychological support within detention facilities, avoiding the escalation of mental health crises in order to receive support.

[27] McGrath David Consulting, Report on the Review of Forensic Mental Health and Disability Services within the Northern Territory 2019, p 18.

The CVP consider the care that can be provided to prisoners with mental illness or suffering a mental disturbance needs to be substantially improved and their rights as a consumer respected.

5.1 Procedure for summary criminal offences (Local Court)

The CVP support the Approval Process in the Local Court should be transferred from Chief Health Officer (CHO) to the Chief Psychiatrist.

There should also be tightening of the requirement of who can provide advice to the Chief Psychiatrist under section 77. Elevating the approval process from Designated Mental Health Practitioner (DMHP) to Authorised Psychiatric Practitioner (APP). Whilst DMHP are qualified and experienced clinicians, their expertise in the area of forensic mental health is not likely to be at the expert level of an APP, or sufficient to determine if a person was suffering from a mental illness or mental disturbance in the context of a criminal culpability.

Further similar to the NT Law Reform Committee recommendations[28], the CVP supports amendments to section 77 to include discretion for a clinical pathway, such as a therapeutic supervision order, similar to the current community management orders referred to in Part 7 Division 2 of the Act to be prescribed.

The lack of reference to treatment and care in section 77 raises concern. It would be appropriate for a clinical pathway to be addressed in this context. Currently a person may have charges dismissed under section 77 but there is no requirement for the subsequent provision of therapeutic treatment and care to them. The inclusion of ongoing supervision, and commitment to treatment plan for a defined period would be appropriate.

[28] Northern Territory Law Reform Committee. (May 2016). Report on the Interaction between people with mental health issues and the criminal justice system. Report No. 42, Recommendations 17 to 19.

5.2 Procedure for indictable criminal offences (Supreme Court)

Part IIA of the Criminal Code and Mental Health Related Services Act

The area of gravest concern is the indefinite nature of Part IIA of the *Criminal Code* supervision orders, which are inconsistent with episodic nature of mental illness and recovery model. Many other reports have commented on concerns and the breach of human rights in regard to this.

Suggestions for reform are beyond the scope of the CVP role. The type of concerns raised with the CVP by people who are incarcerated are about mental health services provided into the prison, the lack of availability, or preventive capability and as set out below decision making responsibility and primacy of mental health care when people are brought onto the ward.

Various reports have been conducted into forensic service in the last three years, and legislative reform to flow from them is difficult until a plan is prepared for the provision of mental health service in NT more broadly and where Forensic services will sit.

The CVP supports forensic patients being managed in mental health facilities rather than Correctional or Youth Justice Facilities.

Importantly any reforms to the Act must mesh and work well with provisions in the Criminal Code.

Should forensic provisions be contained in its own piece of legislation?

Regardless of whether a person is ordinarily in the care of Corrections, Youth Justice, all persons receiving treatment and care under the Act, should be offered the same level of care and treatment and the same rights and legal protections as all other consumers.

Therefore the CVP view is that separate legislation is not required if the legislation is clear on how the Act and Criminal Code are applied and interact with each other.

Do you think the legislation provides effective and appropriate clinical Pathways for forensic clients? How can the Northern Territory improve this?

Prisoners or Youth detainees in Approved Treatment Facilities *(ATF's)*

The current legislation lacks clarity about the overarching priority of treatment in a therapeutic environment for persons transferred to an Approved Treatment Facility while under the control of Corrections or Youth Justice.

The legislation must be clear in respect to the use of restrictive practices on persons ordinarily under the control of Corrections or Youth Justice. This area of legislation needs to clearly articulate the role and function of Corrections or Youth Justice when a person is receiving care and treatment in an ATF.

The CVP have identified and reported on the confusion that exists around the use of restrictive practices on persons in an ATF who are ordinarily under the control of Corrections. Specific concerns relate to:

- the authorisation and application of restrictive practices.
- the monitoring of a person to whom a restrictive practice has been applied.
- the recording and documentation of the use of the restrictive practice.

The expectation that an operational arrangement between the two organisations is sufficient to address these concerns is not acceptable. This has been the case previously and the evidence suggests that an operational agreement has not provided the clarity sought by clinicians, the transparency required by law or the protections set out in section 61 and 62 of the Act.

APP's have reported that they are being asked to authorise restrictive practices based on the operational requirements of Corrections. In particular with the use of mechanical restraint. The CVP advocates for reduction in the use of restrictive practices however acknowledges that there are times where it may be deemed the appropriate and the least restrictive option in the circumstances.

When a restrictive practice is used on a person receiving care and treatment in an ATF, whether they are ordinarily under the control of Corrections or not, it must be authorised, recorded and applied in line with the Act.

As set out above the Local Court process requires the development of appropriate clinical pathways for those whose matters are being considered under section 77.

Forensic Recommendations:

1. Approval Process transferred from Chief Health Officer (CHO) to the Chief Psychiatrist in regard to Local Court process.
2. Tightening the requirement on who can provide advice to the Chief Psychiatrist under section 77.
3. Amendments to Local Court process to include supervision and treatment plan not just dismissal of charges
4. Consistency in the definition of ‘mental illness’, ‘mental impairment’ and ‘cognitive impairment’ across the Act and Criminal Code.
5. Review of the indefinite nature of Part IIA of the Criminal Code supervision orders.
6. Legislative clarity for therapeutic decision making including the use of restrictive practises for prisoners and youth detainees on acute wards.

Annexure 1

Northern Territory Context

There are unique challenges in the delivery of disability services in the NT. The CVP draws attention to the disproportionate impact of mental health[29] and disability[30] for Aboriginal[31] people that affect services in the NT. The NT has the highest rate of public guardianship in the country per population. Delivery of services is affected by the vast geographic land mass, the small population, and the level of disadvantage and trauma experienced by a large number of Aboriginal Territorians.

While there are numerous examples of innovative and professional care programs and services, dedicated staff working in high pressured and with outdated infrastructure is acknowledged. There is significant capacity issues and a need for reviewing and redefining care models that incorporate a focus on engaging with the person with a lived experience and their carers and service approaches targeted to prevention, early intervention.

There is a high workforce turnover and limited development opportunities, combined with cultural values that affect the ways in which matters can be raised in a culturally safe manner. This leads to a lack of understanding of and safeguards against human rights abuses. Workforce capacity issue and outdated community models of care, changing and fragmented, silo governance processes, resource capacity issues that impact on services, a focus on crisis and not community care etc. An under investment in stigma reduction.

[29]Department of Health (2016) *Primary Health Networks Mental Health and Suicide Prevention Needs Assessment* Northern Territory PHN, accessible at http://www.ntmhc.org.au/wp-content/uploads/2016/09/2016-NT-PHN-Needs-Assessment-Mental-Health-and-Suicide-Prevention.pdf

[30]Australian Institute of Health and Welfare (2019) *Disability Support for Indigenous Australians*, accessible at: https://www.aihw.gov.au/reports/australias-welfare/disability-support-for-indigenous-australians. This noted that Indigenous Australians were 1.8 times as likely to have a disability, and 2 times as likely to use disability support services.

[31]Aboriginal is the term used by the CVP for 'First Nations' people in line with the NT Govt style guide and is used throughout the CVP public reporting

Background to the NT CVP

The NT Community Visitor Program was created and operates under two pieces of legislation, the *Mental Health and Related Services Act 1998* and the *Disability Services Act 1993.*

The CVP in the NT was established in 2001 in the mental health field and has operated continuously since this time. In 2013, the role extended to specialist disability facilities (Secure Care) and places operated by the NT Government.

The CVP is one of the legislative mechanism in the NT which protects the legal and human rights of people receiving public mental health treatment and forensic disability services in the Northern Territory.

The CVP is a professional service,[32] operating according to established values, procedures and protocols between the services being monitored. The CVP ensures that its service is provided by skilled professionals, who are culturally safe and focused on the needs of clients.

More information regarding the program and how it is provided is at www.cvp.nt.gov.au

[32] **CVP Community Visitors and Panels, Qualifications, skills, experience statement**

- 3. 75 staff including Principal Community Visitor
- 7 panel members
- 10 current sessional Community Visitors **Total: 21 members**

Expertise & Knowledge, Skill set – Diversity audit

- 3 Aboriginal people
- 6 lived experience (2x consumers & 4 Carers)

Professional Background & Qualifications with high level retention rate of CV's

4 x social worker / 2 x nurses / 5 x lawyers / 2 x social science degrees / 2 x community development expertise
1 x Master Management / 1 x Master of Government Law / 2 x NDIS Behaviour Clinician / 1 x Master of Counselling
2 x Doctor / Associate Professor / 5 x accredited mediators /

Value of CVP for Safeguarding

The CVP performs a vital specialist role that works to safeguard the rights, interests and quality of services of people with disabilities as a statutory complaint resolution and advocacy service.

The CVP model provides both informal and formal safeguarding mechanisms across the range of developmental[33], preventative and corrective measures.[34]

There will always be the need for feedback from people living with disability who receive services and oversight from an independent body like the CVP. This helps ensure that services work well for people living with a disability and their stakeholders. The work of the CVP gives the community confidence that people are being supported and their rights respected. The relationship with rights protection and complaints management directly relates to safeguarding people living with a disability.

The importance of this role was acknowledged in the Council of Australian Governments' decision to complete a national review of the schemes as these relate to disability safeguarding. The 'National Community Visitor Schemes Review' (December 2018) report for the Disability Reform Council found that statutory visiting programs such as the CVP provide local, independent support to people living with disability by:

- Upholding an individual's human rights and ensuring service provision is appropriate in order to prevent violence, abuse and exploitation.
- Supporting appropriate decision making that reflect the wishes of the individual.
- Facilitating local capacity building to achieve resolution of issues in the services at the earliest and lowest possible resolution.

[33] Developmental, preventative, corrective definitions,

[34]Australian Senate Community Affairs Reference Committee, Violence, abuse and neglect against people with disability in institutional and residential settings, including the gender and age related dimensions, and the particular situation of Aboriginal and Torres Islander people with disability, and culturally and linguistically diverse people with disability, November 2015, https://www.aph.gov/Parliamentary_Business/Committees/Senate/Community_Affairs/Violence_abuse_neglect/Report

- Adding to regulatory intelligence on services and systemic issues to the state and territories and other appropriate services.[35]

More information about the CVP legislative functions and safeguarding achievements, including what consumers and carers have said about their support over the years is found at below.

CVP Key Safeguarding Achievements

Individual Complaints, Enquiries, Support and Advocacy

55% issues resolved

The CVP is a specialist service with 20 years' experience (refer appendix 2 & 3 for more information).
Over this time the CVP has dealt with over 3380 matters in both mental health and specialist disability with an approximate 55% resolution rate.

PWD raise their matters directly with the CVP 75% of the time. This demonstrates that the visiting function provides PWD an accessible service that is tailored one-to-one support to the PWD. The process facilitates improved knowledge and skills for the PWD about their rights and how to exercise those rights.

The CVP has observed that sometimes a PWD believes that their issues of significance are not receiving adequate attention from the service provider. Worrying about issues or concerns with service providers may have considerable impact on health, quality of life, care and overall satisfaction with service delivery particularly within a facility or residential facilities.

The CVP visiting function enables CV to build a relationship of trust with people living with a disability. Approaches that support people living with a disability are own self-efficacy are explored and actions taken are made in consultation with the person living with a

[35]The Community Visitor Schemes Review, December 2018 Report for Department of Social Services for the Disability Reform Council, Council of Australian Governments, WestWood Spice, Page 11.

disability. CVs encourage the person living with a disability to develop independence, confidence and establish their own self-advocacy skills.

The CVP has shown the effectiveness and type of specialist individual advocacy service provided to people when they are in high distress situations. The CVP contends that this approach of 'low level resolution' with the service provider is both protective and preventative. The CVP views these statutory independent functions as extremely important in facilitating the person living with a disability's wills and preferences.

Over the past 10 years, rights, quality of service provision and advocacy were the priority areas identified by people living with a disability.

One of the key aims of the CV is to resolve issues in a manner which supports the development of a therapeutic relationship between the person living with a disability and service. This in turn supports the overall aim of providing the best possible person-centred, and therapeutic service.

The CVP has a statutory obligation to provide an accessible service that ensures contact with the person raising a matter on the next working day. The CVP has achieved this measure approximately 90% of the time for the past 10 years.

The CVP values and practices are embedded within the principles of person-centred care and empowerment.[36] The CVP has expertise and skills in proactively engaging with people living with a disability through visits and personal engagement with people. In this way the CVP is able to build relationships and better understand issues raised by the person living with a disability and other stakeholders.

In line with a human rights approach, empowering people with a disability to know what their human and legal rights are and how to facilitate those rights is fundamental.

[36] **CVP Values:** 1. Respect: We value the voice and opinion of our client group, staff and service providers by respecting knowledge and expertise, …being inclusive and ensuring cultural safety.
2. Empowerment: We walk alongside our clients, seeing the situation from their perspective, appreciating that all points of view are valid, striving to understand their journey and maintaining hope at all times.

Actively involving people living with a disability, carers and key stakeholders in their care and treatment requires improvements and ongoing focus. Like all services, at the core of all good work is the building of strong relationships between people living with a disability and staff. This means taking time to hear, listen deeply, and act in a way that shows no person is more powerful than the other. This shows respect for the person living with a disability and that humans rights are being observed.

The CVP considers that this is one of the most effective informal individual strategies to safeguard against violence, abuse, neglect and exploitation and has been shown to offer good practice.[37]

Systemic Advocacy

The CVP role within the mental health field is well established and effective. The CVP considers that the Panel functions made up of multi-disciplinary teams[38] (similar to OPCAT functions) enhances the preventative and corrective action roles.

This function is unique to the NT CVP and not present in other community visitor program in Australia.

The CVP annual reports evidence systemic issues in the NT over the past 20 years. Over the past 10 years, the CVP's focus has been for those people living with a disability subject to involuntary orders, in 'closed like environments.' To remove someone's right to live freely in the community, and require the person living with a disability to remain somewhere for their own health or the safety of others, is a very serious infringement on their human rights.

Systemic issues for people living with a disability in public mental health and disability services area are reviewed by CV's and CVP expert panels through their inspection roles. These visits and associated complaints and enquiries analyse inform public advocacy that provides a voice for people living with a disability.

Analysis of open recommendations in both Mental Health and Forensic Disability demonstrate the most significant issues handled by the CVP since 2013 have been

[37] The Community Visitors Schemes Review, December 2018 Report for Department of Social Services for the Disability Reform Council, Council of Australian Governments, WestWood Spice

[38] CVP Multidisciplinary: team: Doctor, Lawyer, Community Representative

quality of service provision, cultural safety, rights and advocacy needs. Interestingly similar needs are found in both individual and systemic matters.

It should be noted that many issues handled by the CVP require ongoing monitoring or are revisited after successful resolution.

The CVP independence and transparency to people living with a disability and the NT community has achieved significant outcomes. Some achievements for the CVP have been driven through formal open recommendations;

- Reporting compliance with Rights of people living with a disability.
- NT wide restrictive practices strategy in mental health in place.
- Quality and Safety Framework for Forensic Disability Services.
- Children and young person's mental health ward and model (2015).
- NT New infrastructure of Darwin mental health ward to address safety concerns of HDU (2020)
- A focus on cultural safety, interpreter use.

The CVP has identified gaps in community based services that impact on people living with a disability and the capacity for services to be provided in the 'least restrictive environment'. In many cases a lack of services results in an absence for the NT of important prevention and early intervention services. This is evident as shown in the gaps for Child and Youth services in remote regions, specialist services for youth in detention and significant gaps in Forensic mental health and disability services across the NT.[39] Due to the absence of services many people living with a disability and with complex needs invariably end up in crisis, either in the inpatient setting or criminal justice system.

[39] McGrath, D. (2019). Report on the review of forensic mental health and disability services within the Northern Territory.