Northern Territory Branch

12 June 2024

Att: Senior Policy Officer
Mental Health, Alcohol and Other Drugs Branch

Re: Exposure Draft of the Mental Health Bill 2024 – (*Mental Health and Related Services Act 1998* Review)

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) Northern Territory (NT) Branch appreciates the opportunity to provide a response to the Exposure Draft of the Mental Health Bill 2024 ("Exposure Draft Bill").

The NT Branch welcomes the significant reforms of the Exposure Draft Bill to place people and lived experience at the focus of mental health legislation. We highlight some of the notable improvements below in recognition of their importance.

The Branch provides further comment on concerns that pertain to the role of those in the mental health workforce in ensuring the best possible outcomes for people cared for under the new mental health legislation.

We are committed to advocating for improvements which will benefit the mental health of the NT community and look forward to continuing to work collaboratively to progress solutions for better mental healthcare.

To discuss further please contact our NT Policy & Advocacy Advisor, Monique Hodson-Smith via Monique.Hodson-Smith@ranzcp.org

Yours sincerely

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Mental Health Context in the NT

AIHW data demonstrates that the NT consistently records the highest rates of involuntary treatment compared to all other Australian jurisdictions. The unique challenges facing Northern Territorians, and particularly Aboriginal and Torres Strait Islander people, include geographic vastness, cultural and linguistic diversity, disproportionately higher rates of substance abuse, trauma, grief, and domestic violence.

A significant proportion of the Territory population lives in rural and remote locations where access to mental health services is significantly limited. This increases the risk of mental health crises, potentially escalating to the need for involuntary treatment.

The mental health workforce is the foundation of the mental healthcare system and will be an essential component to realise the implementation of the proposed Act. Unfortunately, the NT continues to face a critical and chronic shortage of key mental health workers, including psychiatrists. Of notable importance is the need to ensure availability of the Aboriginal and Torres Strait Islander mental health workforce (see Part 8, Division 3).

The NT Branch welcomes the fact that the Exposure Draft Bill clarifies the aims under Clause 3, including that:

1. the highest standard of treatment and care be given to persons with a mental illness or mental disorder, and
2. treatment and care be given in a way that is least restrictive of the person's rights and liberties and that promotes the person's recovery and full participation in the community.

Part 1 Preliminary matters

Part 1 of the Exposure Draft Bill sets out preliminary matters that provide a foundation to how the proposed legislation is to be interpreted and applied.

Treating people with a mental illness or mental disorder with respect and dignity is integral to the safe and ethical delivery of mental healthcare. The NT Branch agrees that the rights-based framework and guiding principles affirm the capacity of the legislation to uniformly prioritise person-centred and culturally appropriate care.

The NT Branch agrees with the clarifications and modernised provisions that detail person-centred reforms under Division 4. For example, the use of 'person' instead of 'patient' is a significant and important improvement that upholds commitment to Article 3 of the UN Convention on the Rights of Persons with Disabilities (CRPD).

The modernised inclusions under Division 4 ('interpretation and important concepts)' also offer leadership and clarity. The NT Branch supports the updated criteria for the legislation to only be applied to people with a mental illness (Clause 18 and 19) or a mental disorder (Clause 17), rather than those presenting with mental disturbance or diagnosed complex cognitive impairment.

Under Section 18, Meaning of Mental Illness, the NT Branch recommends that the symptom list under 18(1) to also include (vi) very severe anxiety.

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The Royal Australian & New Zealand College of Psychiatrists

Part 2 Decision making capacity and informed consent

Part 2 sets out the fundamental concept that an adult has full decision-making capacity, unless the contrary is proved, and provides a clear definition of capacity to provide informed consent. It also addresses the capacity of children to consent to treatment.

The RANZCP supports the consideration of trauma in providing treatment and care outlined under the diversity principle (9)(2)(a). People with a mental illness or mental disorder experience higher rates of trauma in life, and these experiences are likely to be higher prior to contact with mental health services. The RANZCP recommends explicit wording that the term 'disability' be interpreted to include mental as well as physical health conditions.

The impact of trauma may impair decision-making capacity (Section 29) and informed consent (Section 30). The NT Branch recommends providing a specific reference to the need for trauma-informed care. Making this explicit in the Exposure Draft Bill would address concerns that a significant proportion of individuals with experiences of trauma also have adverse experiences and outcomes when engaging with mental health services.

Part 3 Protection of rights

Part 3 is about the rights of persons who come within the ambit of the proposed legislation. Putting these provisions near the beginning of the Exposure Draft Bill emphasises their importance.

For consistency in the interpretation of the Exposure Draft Bill, the NT Branch calls for an explicit statement in Section 3(b) about the inclusion of the person with lived experience in their treatment and management.

Part 10 Restrictive interventions

Part 10 sets out how practices of restraint and seclusion (restrictive interventions) are to be regulated.

As detailed in its Position Statement 61, the RANZCP is committed to achieving the aim of reducing, and where possible, eliminating, restrictive interventions in a way that supports good clinical practice and provides safe and improved care for the person. The NT Branch agrees the introduction of the principle of 'least restriction' is essential to uphold protections of human rights.

Minimising and eliminating restrictive interventions require the provision of resources, including sufficient funding; education, training, and support for cultural change; as well as rigorous oversight and formal records.

In circumstances where adverse events or patient outcomes may in whole or in part be attributable to inadequate resourcing, the current provisions (*see for example 86 (1): "in the least restrictive environment practicable" and 107 (2) "care cannot reasonably be given to the person in the community…" and Sections 236 & 249*) do not enable those determining or managing resource allocation to be held accountable. This exposes clinicians to inequitable actions in, for example, Coronial hearings.

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We note that, from a safety and quality perspective, individual clinicians and staff are rarely responsible alone for adverse events. Adverse events more often occur due to a combination of culture and service leadership failings, including at a board, executive or government level.

We recommend more clarity regarding the accountability of services for the delivery of treatment, care, and support within the system. System accountability includes ensuring all resourcing required is available to the workforce to enable treatment, care, and support to be delivered safely and effectively.

Where restrictive interventions have been reduced, clinicians are invested in and supported by building on and developing their existing skills and capacities. This has not been achieved by means of externally set targets but rather by clinical leadership, together with learning from lived experience and empowerment of staff.

Part 13 Administration

Part 13 deals with how the proposed legislation is to be administered.

The NT Branch supports the integral role of psychiatry leadership to be embedded within governance and oversight structures for the successful implementation of the legislation. The introduction of the statutory authority of a Chief Psychiatrist 13(2)(2) embeds that psychiatry leadership. It recognises the importance of placing medical and mental health expertise to achieve the first objective of the Exposure Draft Bill under Clause 3, that *“the highest standard of treatment and care be given to persons with a mental illness or mental disorder”.*

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