



MHACA

Mental Health Association of Central Australia

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Review of the NT Mental Health and Related Services Act

Submission by the Mental Health Association of Central Australia

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“Talk to lived experience not learned experience.”

The Mental Health Association of Central Australia (MHACA) welcomes the opportunity to provide information to support the review of the NT Mental Health and Related Services Act.

MHACA is a community managed organisation that provides individual and group based psychosocial support services, NDIS support coordination, tenancy support and homelessness assistance, suicide prevention and mental health promotion programs in Central Australia. We are the only specialist mental health NGO in the Northern Territory (NT) outside of Darwin.

We welcome the review of the NT Mental Health and Related Services Act as an opportunity to modernise the act to reflect best practice for the care, treatment and protection of people with mental illness.

MHACA is a member of the peak body for community managed mental health services across the Northern Territory, the Northern Territory Mental Health Coalition, and has contributed to the community consultation process led by the NTMHC on the review of the Act. MHACA would like to provide support for the points and recommendations made in the submission by the NTMHC.

MHACA strongly supports including principles of recovery into the Act, and for the Act to reflect a human rights perspective and an emphasis on person-centred and culturally and trauma informed care. Our own submission is directly informed by the experience of our participants, many of whom have a lived experience of the application of the current Act as part of their clinical mental health care.

The strongest message from our participants is highlighting the often poor, and sometimes traumatising experiences they have encountered through their attempts to seek assistance, admission and treatment in mental health wards and experiences with community based clinical mental health care. Many of these issues relate to the quality of their interactions with health professionals which may not be directly influenced by the Act.

Nevertheless, we believe that the Act has an important role in reinforcing key principles in the way supports are delivered, and in particular the emphasis on forming a respectful relationship where the informed consent of the patient is at the forefront of all treatment conversations.

Whilst developing an updated or new NT Mental Health and Related Services Act is very welcome, unless it is supported by an implementation process which is well resourced, participants question whether their experiences will change.

MHACA would also like to reference the recommendations made by the recent Royal Commission into Victoria’s Mental Health System <https://finalreport.rcvmhs.vic.gov.au/recommendations/> for consideration in the context of the review.

Mental Health Matters

Part One: Principles & Rights of the Patient

1.1 Recovery

“The concept of recovery is rooted in the simple yet profound realisation that people who have been diagnosed with mental illness are human beings ... we can speak for ourselves. We have a voice and can learn to use it. We have the right to be heard and listened to. We can become self-determining. We can take a stand toward what is distressing to us and need not be passive victims of an illness. We can become experts in our own journey of recovery.” Patrician Deegan, Mental Health Advocate

MHACA values the wisdom of people with a lived experience of mental illness and distressing life episodes. Recovery is a fundamental principle underlying all of MHACA’s services and programs and we strongly support the inclusion of recovery principles into the Act. People need to be partners in their own recovery.

MHACA also strongly supports that trauma-informed care and practice (TICP) be embedded within object of the act.

“More training is required for trauma-based patients. The staff don’t have an understanding of trauma. They offer things like positive thinking and self-care and self-talk, and yeah it does help but when you’ve got a background in trauma and when you’re in certain situations you can’t control if those thoughts are going to come up and you can’t control any triggers that are coming up.” MHACA Participant

1.2 Capacity and Informed Consent

Some MHACA participants expressed that they often felt left out of important discussions relating to their treatment.

A participant spoke of not being able to feel heard when she had an issue that needed resolving whilst in the mental health ward, however when she engaged the Community Visitor Program to advocate for her the issue was able to get resolved quickly.

Participants:

- expressed the need for more chances to ask questions and express their opinions in discussions about their treatment.
- didn’t always know all the information for the medications, what they were for and if there are any alternatives available.
- expressed the desire for open and respectful negotiation of treatment where they are a “partner in care”.

In terms of refusal of treatment, it was felt that:

- the way this is enforced needs scrutiny, as participants reported coercive or negative responses if they expressed misgivings about treatment recommendations.
- more treatment options need to be provided.
- the right to refuse treatment should be promoted and respected
- principles need to be developed to inform the legislation.

MHACA supports including criteria to strengthen the understanding of capacity and informed consent.

Part Two: Person-centred Approach

2.1 Will and Preferences

As part of consultation processes, MHACA participants strongly supported the development of care plans whilst the person is well, which would then better support and inform their care when they have a relapse or admission to the Hospital and may have less capacity to express their wishes. Most participants had not heard of Advanced Care Directives as a current option to support their mental health care.

One MHACA participant had found a psychologist who had helped develop a care plan which could then support her when she had relapses and was admitted to the mental health ward. She now feels a lot better prepared and more confident in knowing that her needs can be expressed to any clinical services staff when required.

For patients who have recurring mental health challenges that require admission, MHACA strongly supports the development of a care plan or Advanced Care Directive developed in conjunction with their clinical care team whilst the person is well, that enables the person to express clear views about their own treatment needs and wishes.

2.2 Nominated support person

The role and function of the nominated support person is not well understood by participants or carers. Participants expressed the importance of being able to identify who their preferred NSP should be. Carers reported that even if they were the nominated support person, it was not unusual for the in-patient facility to not consult with them or share important information including discharge plans with them. Carers reported being informed that a family member was about to be, or had already been, discharged without any consultation about whether there was an appropriate and supportive environment available to the patient, or in a way that let family prepare.

2.3 Cultural Security

Trauma informed care and culturally responsive care is particularly important when supporting Aboriginal community members who are overrepresented in the clinical mental health care system. MHACA supports the inclusion of traditional healing practices, including Ngangkari services, into clinical mental health care.

The importance of access to interpreters at all stage of the access and treatment process cannot be emphasized enough. In particular it is important that interpreters or ALOs are involved in assisting with defusing critical incidents and where seclusion or restraint is being considered as an option. Participants reported feeling extremely confused and alienated from what was happening to them and reported that simple misunderstandings had resulted in what they saw as punitive or frightening responses in the in-patient setting.

A MHACA participant reiterated the importance of incorporating traditional Aboriginal healing practices alongside clinical mental health treatments and stated as part of a consultation process that when he received a Ngangkari healing as part of his treatment it made his recovery much quicker.

Part Three: Admission & Treatment

3.1 Involuntary admission and 3.2 Voluntary Admission

Some MHACA participants spoke about the challenges of being admitted to the mental health ward as a voluntary patient, and not being admitted when they really felt they needed help. In the public consultations, caregivers, family and friends also spoke about the challenges in seeking to get people who they felt were very mentally unwell to be admitted into the mental health ward.

One participant said she was not believed that she was unwell when seeking admission and her behaviour was labelled as attention seeking. This made the participant feel further distressed and suicidal. She then compared the distress of not being voluntarily admitted when she was seeking help versus the distress of being involuntarily admitted and the resulting confusion about the two processes.

Some participants also spoke about the distress involved in being involuntarily admitted.

3.4 Apprehension by the Police

Where possible MHACA would recommend transport by ambulance instead of police to clinical care. Participants expressed the shame associated with being apprehended by police, and the reluctance they felt to engage in treatment following an episode of this nature. Family members also spoke of a reluctance to involve police at times of distress due to a perception that things may not end well in the event that the family members was in a heightened state. In the event that police are involved there is a suggestion that they should be accompanied by a person with mental health expertise and training in de-escalation techniques and/or if at all possible and appropriate that an Elder or Aboriginal Health Worker be involved.

3.5 Leave

Carers expressed the view that they should be involved in decisions about leave, that their views should be respected and that all risks should be clearly explored with them prior to decisions being made.

Part Four: Monitoring

Some MHACA participants had found the Community Visitors Program to be a great support in advocating for their needs, and MHACA believes this program needs greater promotion to patients. There needs to be access to active advocacy for people who are dissatisfied. MHACA participants felt that if people complain they are seen as 'resistant'.

MHACA believes that principles are required to inform complaints assessment processes and that all patients should receive information about their rights and the complaints and advocacy options available to them. MHACA has assisted participants to make complaints in serious matters and it has been our experience that we have often needed to be very insistent about the patients' rights in order to get a good hearing and to find a resolution.

4.1 The Chief Psychiatrist

MHACA fully supports the strengthening of the role of the Chief Psychiatrist and believes it needs to be a dedicated role. The current arrangement does not result in the leadership required to ensure the delivery of quality and safe services for people in the NT. In the period where there was a dedicated role we were fortunate to have appointees with a clear understanding of contemporary policy and practice and a dedication to improving service delivery. Without that knowledge and expertise it slumps back to a basic and tokenistic approach.

4.2 Regulating Restrictive Practices

NT is out of step with the rest of Australia and internationally in its use of restrictive practices and seclusion, and particularly in the overrepresentation of Indigenous patients being subjected to these practices.

MHACA would like to see a goal of zero use of seclusion, as is the case for some interstate clinical counterparts.

We believe the Act needs to strengthen the regulations associated with seclusion so that it is considered a last resort, and there is evidence of alternative methods being employed including use of interpreters and cultural advisors or ALO involvement.

"They left me there for days... It's not healthy... I was fretting... I didn't get informed what was happening... Every 4 hours felt like 24 hours... It was traumatic." MHACA participant

Part Five: Forensic Provisions

5.3 Clinical Pathway for Forensic Clients

MHACA is concerned that Forensic patients in Central Australia do not have access to the expertise and care required to meet their needs, particularly for those with complex presentations including those with brain injury and FASD. It is our experience that it is difficult to obtain clear care plans and that there is poor liaison between various elements of the care system and a lack of advance planning or communication systems so that people may be released through actions in the legal system without any arrangements at all in place to support them in the community.

Other Matters

MHACA would also like to make comment on how the Act sets out responsibilities for mental health care when the person has substance abuse issues. In a recent experience MHACA assisted a client who had expressed a high level of suicidality and expressed an intention to harm their child to make contact with the CATT team. In the screening by the hospital ED Department the client was asked if they had used any illegal substances in the previous 24 hours. When they disclosed this was the case the assumption was made that the person was intoxicated and they were told to return in 24 hours. There was no safety plan developed with the person, and no attempt to ensure that their child was not at risk.

Unfortunately turning people with AOD away at the point they are seeking assistance is this is not an unusual experience. We believe that the Act should ensure that people are not discriminated against in this manner and that at a minimum a safety and a follow-up plan is developed with the person if they are not considered sufficiently unwell or at risk to warrant an inpatient admission.

MHACA would like to take this opportunity to share further our participant's feedback about their experiences with clinical mental health services:

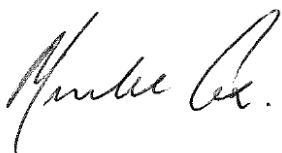
- being able to communicate, having access to your phone (instead of it being confiscated) whilst admitted to the ward was important for one of MHACA's participants.
- staff identification needs to be clear for patients (it can be confusing for participants if they don't know who people are)
- patient leave – the importance of having contact with the outside world
- active treatment processes are desirable
- provide adequate stimulation for patients whilst on the ward – participants reported feeling bored, having nothing to do
- participants also felt they had experienced discrimination by clinical staff
- past experiences can influence things like taking medication
- new psychiatrists – can focus on participant history of drug abuse and not current issue
- privacy and dignity needs protection
- a better understanding of neurodiversity needs to be incorporated into mental health clinical practice – a participant spoke of having Autism and displaying behaviours associated with this condition that were not understood whilst in the hospital which led to further distress. She said she was locked out of her room so she would socialise – however all she wanted was to be away from overstimulation and be in a quiet space.
- a participant spoke of not feeling safe in the ward and being touched inappropriately by another patient.
- a participant spoke of inappropriate comments from clinical mental health care staff

"I had quite a lot of people in the ward not knowing what dissociating is. There was one day when I dissociated and they just thought I was having a tantrum. I didn't know where I was and I was pretty scared, I didn't know who people were around me. Then one of the nurses said to the other nurse "she's dissociating" and the other nurse said "what's that?"..... I realise it's not that common but I think mental health nurses should at least know what it is."

MHACA reiterates our strong support for a NT Mental Health & Related Services Act that reflects best practice for the care, treatment and protection of people with mental illness. The Act should be recovery oriented, culturally competent, trauma informed and place the rights and interests of the person receiving the mental health care at the centre of the Act.

MHACA welcomes the opportunity to provide further comment on any of the issues outlined in our submission.

Yours Sincerely,



Merrilee Cox
CEO