Approved procedure 61

Controlled Document

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| **Target Audience** | Approved Treatment Facilities under the Mental Health and Related Services Act |
| **Jurisdiction** | Northern Territory |
| **Document Owner** | Chair Mental Health and Related Services Act Approved Procedures and Quality Assurance Committee |
| **Approval Authority** | Chief Executive |
| **Author** | Approved Procedures and Quality Assurance Committee |

*\*Content of this document has been adapted from “Electronic communication and privacy in designated mental health services”, State of Victoria, Department of Health and Human Services (2018). Available from:* [*https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist/chief-psychiatrist-guidelines/electronic-communication-privacy-designated-mental-health-services*](https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist/chief-psychiatrist-guidelines/electronic-communication-privacy-designated-mental-health-services)

# Purpose

This document has been produced to assist approved treatment facilities develop their own policy suite relating to the use of electronic communication devices. The principles presented in this approved procedure are informed by, but not limited to, the following national and legislative frameworks:

* The Australian Charter of Healthcare Rights (the Charter)[[1]](#footnote-1)
* National Mental Health Statement of Rights and Responsibilities (the Statement)(Appendix 1)
* *Mental Health and Related Services Act 1998* (MHARS Act) (Appendix 2)
* *Information Act 2002* (Appendix 3)
* *Surveillance Devices Act 2007* (Appendix 4)

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| Key message  * All people have inherent dignity and worth and are entitled to the equal protection of their human rights and fundamental freedoms without discrimination of any kind (the Charter and the Statement). * All people have the right to the freedom of lawful communication including:   + communicating with other persons in the approved treatment facility;   + sending and receiving uncensored private communications;   + receiving visits from their counsel or representative in private, or visits from other people at all reasonable times; and   + access to postal and telephone services and newspapers, radio and television) of patients within approved treatment agencies is to be ensured (MHARS Act). * An authorised psychiatric practitioner (APP) may order that a right of a patient be restricted or denied if they reasonably believe that there is a serious likelihood of the person suffering serious physical or mental deterioration or the safety or well-being of others or the general community is at risk (MHARS Act). * The APP must notify the Tribunal and the patient’s appointed Guardian of a restriction of entitlement, and the person must be advised of their right to apply to Tribunal for a review (MHARS Act). * Any restriction on the liberty of a patient, and any interference with their rights, dignity, privacy and self respect is to be kept to the minimum necessary in the circumstances (MHARS Act). * Recording and disseminating of ‘health information’ using an electronic communication device is subject to the Privacy Principles (The Information Act and Surveillance Devices Act). |

# Terminology

For the purpose of this document, electronic communication devices include:

* mobile phones,
* tablet devices, and/or
* computers.

# Continuum of restrictions

Universal restrictions (removing all mobile communication devices – for example, on child and adolescent units or in mental health intensive care units) contravenes the Statement and the MHARS Act.

In accordance with the MHARS Act, restrictions on the right to communicate need to be patient-centred, recovery-focused and be the least restrictive approach possible to protect health, safety and wellbeing.

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| **Least restrictive through to most restrictive practices for using electronic communication devices**  No restriction  The person can use the electronic communication device at any time, unsupervised.  Least restrictive   * Electronic devices can be used unsupervised and/or in a private space. * Each patient keeps their own electronic devices in a personal locker. Access to the device is managed by the patient and documented within the care plan. * Charging points and wireless headphones are available if ligature concerns require removal of cabled items. * Telephones, computers or tablets with internet access are available for use by any patient within designated areas. Access will depend on local demand.   Restrictive   * Patients don’t have access to internet or telephones. * Patients can only use their devices in a particular supervised area or don’t have access to a private area to use devices. * Patients have to ask staff for access to shared telephones and/or restrictions are placed on the amount of calls that are being made or who the calls are being made to. * Each patient keeps their own electronic devices, but charging cords are confiscated and provision is not made for other means of charging. * Headphones are confiscated without a wireless alternative being provided.   Most restrictive   * Patients’ devices are confiscated. * Patients’ use of devices is directly supervised on a 1:1 basis (impinging privacy).   With regard to all the examples provided above, the MHARS Act provisions need to be met (see Appendix 2). |

# Guiding principles for electronic communication and privacy

Approved treatment facilities should establish clear directives for staff on the patient use of electronic communication devices to ensure staff are informed of the legal framework and the patients’ rights to communicate in a manner that respects the right of other staff and patients’ to privacy. Best practice is patient-centred and recovery-focused, with the least restrictive approach possible and where reasonable alternatives are offered and supported.

Policy documents for electronic communication should include the following at a minimum:

* the purpose of the documents in the context of patient-centred, recovery-focused care
* a patient’s right to communicate privately and lawfully with any person
* the benefits and risks to a person’s mental health through the use of electronic communication devices
* conditions that need to be met when restricting communication, including providing alternative options to enable safe and timely communications for patients/consumers in a manner that minimises interference with their rights, dignity, privacy and self-respect
* assignment of responsibilities associated with the monitoring process, documentation requirements such as risk assessments and escalation points, as well as patient requests for decision reviews
* ceasing restrictions on communication immediately when no longer necessary
* required minimum standards for documentation of the use of devices and restrictions placed on their use
* the required review frequency of restrictions on entitlements
* secure storage and registration of personal electronic communication devices
* maintaining the privacy of others
* prohibition on publishing private conversations and activity
* expressed and implied consent to recording private activity and conversations
* inclusions and exceptions to the above
* criteria for consultation, including with patients and their families/nominated representatives
* roles and responsibilities of staff in supporting patients’ rights regarding communication and privacy.

Policies and guidelines need to align with this approved procedure and relevant legislation that applies to communication and privacy.

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| **Note**  NT Health policies and guidelines on the management and use of communication devices are also required to align with the NT Health Seclusion and Restraint Policy, which is located on the staff intranet (PGC). |

Approved treatment facilities directives for respectful use of mobile phones in the units should include the following:

* devices must be kept on vibrate
* devices must be turned off or switched to silent mode for group sessions, medical reviews etc.
* patients are to go to their rooms or a quieter area to take or make calls
* patients must take responsibility for their own devices and each must have a name tag
* headphones may be used for self-soothing e.g. for sleep disturbance or anxiety, etc.
* patients do not have to keep their devices if they don’t wish too (they can be placed in a locker for safekeeping).
* access to devices can not be used as punishment.

# Electronic communication and recovery

From the perspective of the individual being treated for mental illness, the use of electronic communication devices can promote recovery, as defined within the National Standards for Mental Health Services (2010). In this context recovery means gaining and retaining hope, meaning and purpose in life, understanding one’s abilities and disabilities, engaging in an active life, personal autonomy, social identity and maintaining a positive sense of self.

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| **Examples of ways that electronic communication devices can promote recovery**   * To stay connected to friends, family and other members of a personal support network, including other patients and patient support networks. * To use features of the device for therapeutic benefit and/or recreation (for example, listening to music, playing games, using self-help apps and watching videos). * To access legal rights such as legal representation, advocacy, making a complaint, seeking a second opinion, contacting a nominated person or other rights under the MHARS Act. * To find out more about mental health problems/diagnoses, recovery, treatments, coping skills, rights information and service standards. * To seek out support services and options following discharge. * To address day-to-day needs (paying bills, reading correspondence and communicating with Centrelink or employers). * To maintain a sense of normalcy/routine (using social media is part of many people’s routine) and dignity (almost everyone uses these devices). |

Patient-centred, recovery-focused decisions about electronic communication devices should be documented in the care plan.

# Patients’ rights

A patient’s right to communicate is protected under the MHARS Act (see Appendix 2).

The patient, their adult guardian, decision maker and representative, where appropriate are be provided with information regarding the patient’s rights within 24 hours of admission. This information is to include, but is not limited to, patients having the right to:

* contact and be contacted by letter and phone (as per sections 95 and 96 of the Act); and
* have people visit and see them in reasonable privacy (as per section 97 of the Act).

## Restrictions to the right to communicate

Decisions about communication need to encompass the MHARS Act principles, especially with regard to promoting a person’s recovery, providing treatment in the least restrictive way possible, recognising people’s individual needs and the role of parents, guardians, families and carers.

Removing a person’s electronic device can have an adverse impact on wellbeing, recovery, connection with family and friends and their engagement with treatment. Therefore, in the presence of restrictions, due consideration needs to be given to meeting the patient’s communication requirements by offering alternative options. There are particular considerations for ensuring the safety and wellbeing of children and young people using electronic communication. More information on e-safety can be found at the end of this document.

Under section 98, an APP may order that a right of a person under section 95, 96 or 97 be restricted or denied, if they reasonably believe that there is a serious likelihood of the person suffering serious physical or mental deterioration or that the safety or well-being of any other person or the general community is at risk (see Appendix 2).

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| **Note**  Details used by the clinician to inform their decision to restrict or deny a person’s entitlement are to be documented in the patient’s file including the details of least restrictive measures that may have been considered and/or trialled and any reasons why the measure/s may not have been trialled or implemented. |

When restricting or denying a right under section 98, the APP must review the order at least once a day or the order lapses at the end of the day on which it is not reviewed. They may also vary or revoke the order.

The APP must also record the details of the order and the order’s associated reviews in the clinical record of the person.

The patient and the following people should be notified of the restriction and the reasons for it:

* the nominated person/guardian/carer;
* a parent (if the patient is under the age of 16 years).

However, under the MHARS Act, if the person is an involuntary patient, the APP must, at a minimum, notify the following of the order:

* the Tribunal;
* the person's adult guardian;
* if the person has a decision maker – the decision maker.

They must also inform the person of their right to apply to the Tribunal for a review of the order.

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| **Note**  Where a patient has been subject to a restriction or denial of entitlement, the APP must notify the Tribunal via Form 49 Restriction or Denial of Entitlement Notification as soon as practicable and no later than 24 hours after the order has been made. The tribunal is to be separately notified following each occasion of restriction or denial. |

The restriction of entitlement order can not apply to a letter or other postal article from or to the following:

* the Minister;
* the Chief Executive Officer of NT Health;
* a member of Parliament;
* the principal community visitor or a community visitor;
* the person-in-charge of the approved treatment facility;
* an APP;
* the Registrar of the Tribunal;
* a representative of the person;
* the person's adult guardian;
* if the person has a decision maker – the decision maker;
* the Anti-Discrimination Commissioner; and
* the Commissioner for Health and Community Services Complaints

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| **Examples of applying the MHARS Act principles in practice**   * Patients are appropriately informed of their rights and responsibilities in relation to communication and use of electronic devices as part of their orientation to the ward and a risk assessment is undertaken regarding their treatment and care upon admission. * If directives have been breached, causing potential harm, a dialogue needs to occur with the patient to explore the circumstances. Agreement should be sought on how the requirements of the policy or legislation can be met. * A discussion about restricting the use of electronic devices may be appropriate if the policy or legislation is repeatedly breached in a manner that causes harm, despite agreement on appropriate use. * Restrictions to communication may occur when there are potential or actual breaches to privacy of both patients and staff and the legislative requirements in MHARS Act (section 98) are met. ‘Health information’ is protected by the Information Privacy Principles within the Information Act (see Appendix 3). * A communication device can only be taken away from an inpatient without their agreement where the requirements of the MHARS are met. * Clinicians must record and provide rationale to substantiate decisions made to restrict entitlements to enable review by the Tribunal, as appropriate. |

# Electronic devices and privacy

Recording a private activity or conversation – for example, about health information – using a ‘surveillance device’ may contravene the Surveillance Devices Act. Contemporary electronic communication devices typically have the capacity to record audio and visual information and, as such, these devices can be considered ‘surveillance devices’ under the Act (see Appendix 4).

## Unreasonable restrictions

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| Examples when it would generally not be reasonable to restrict use of electronic communication devices:   * A first time breach of communication policies – especially if there was no prior explanation of policies and expectations, or no first warning/advice given.   NB This does not include action is unlawful, in which case, refer to next section, “Reasonable restrictions”.   * Taking photos of the facility if other patients and staff are not in the photo (it is reasonable to take photographs of a mental health facility; these are public services and other patients in the hospital can do this). * Making online purchases (unless there were risks such as accruing significant debt). * Concern that a patient may use the device for unlawful or harmful reasons but has not actually done so (pre-emptive management of risk). * Because a patient is making complaints, seeking legal advice, seeking advocacy or expressing anger at the service. * Because a patient is writing about their experience of being unwell, or of being in hospital, on social media (unless this contravenes the Surveillance Devices Act or Health Records Act). This is an increasingly common and often helpful strategy for people to connect with their community, and to activate their support networks. * Because a patient is writing about unusual beliefs/delusions on social media (unless this contravenes the Surveillance Devices Act, Health Records Act or otherwise poses a high risk of harm to the person or others). * Because a patient is researching their treatment, diagnosis, the service or any other issue related to their admission. * Because of the patient’s age, physical or intellectual disability   • For any punitive reason. |

## Reasonable restrictions

Restrictions to communication may be considered in the following circumstances.

Note: These examples are not exhaustive and every situation needs to be tailored to individual circumstances and preferences.

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| **Examples when it may be reasonable to restrict use of electronic communication devices**   * Inappropriate use of a device (for example attempting to damage or throwing the device). * Unlawful use of a device (for example, stalking and harassment). * Breach of another person’s privacy, for example:   + Photographing or audio or video recording of another person (patient, visitor or staff member) without their knowledge, permission or approval   + audio or video recording staff, including conversations between a patient and their mental health clinician about their care plan without the express or implied consent of the patient and the clinician and when this conversation is taking place in a private area where it would be reasonable to expect not to be overheard (this contravenes the Surveillance Devices Act)   + audio or video recording a patient and posting the recording on social media such as YouTube without the express or implied consent of all parties captured in the recording (this also contravenes the Surveillance Devices Act). * Patient request for restriction in an advance statement (the patient may have personal reasons for not wanting their phone). * Patient agreement following a discussion about risk of harm, such as past instances of accruing large debts while unwell (this kind of restriction should have patient discussion and consent, be part of a treatment plan, may involve carers/family, and should always be based on current risks not past history). * Extreme disinhibited behaviour that may have serious long-term repercussions for the person (for example, posting naked photographs online or making extremely large online purchases). |

From time to time mental health services may receive requests from people external to the unit to restrict a patient’s mobile phone use because the individual is feeling threatened, harassed or otherwise unsafe. For example, the person might be making frequent calls to family members, carers or the police. Strategies are suggested below.

1. Establish safe methods for talking to the patient about the concern and accessing their device – this might require input or support from family members and/or advocates and prior considerations as to what options can provided to the patient, who should be present and in what setting.
2. Following the discussions with the patient, the person affected, other relevant family members/carers and/or police, determine whether the calls are unlawful (for example, stalking, harassment, threats of violence) or lawful but upsetting.
3. In accordance with the MHARS Act, the APP is the only person who can direct staff to restrict communication. The conditions that need to be met when restricting communication are provided in the MHARS Act. The APP may consider information and evidence provided by others when arriving at the decision to restrict communication and whether further action is needed in the event that the circumstances leading up to the restriction were unlawful.

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| **Frequent calls to a family member or carer resulting in the person requesting a restriction in communication**  In the event that there was no unlawful act leading to the request for restriction, explore the needs and circumstances driving the unwelcome behaviour from the perspectives of both parties. Learning how to express needs and meet those needs in a manner that doesn’t negatively impact on relationships with family and carers can be an important component of the recovery process. Family or carers may also benefit from support in their relationship and communication with the patient. Supporting the patient to make and participate in decisions about helpful and effective communication and managing personal discomfort when communication needs are not met immediately can be an important part of the recovery process and aligns with the principles of the MHARS Act and the Charter. |

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| **Frequent calls to the police resulting in a request from the police to restrict communication**  Explore the nature of the calls to police. Is the patient seeking to report an unlawful act? Does the person have a complaint about their rights being violated? Does the person feel unsafe?  Supporting the patient’s right to make and participate in decisions about the most appropriate course of action aligns with the MHARS Act and the Charter and is part of the recovery process. Depending on the nature of the calls, the patient may be supported in communicating with the agency that is best positioned to address their concerns. This may be the police, Health and Community Services Complaints Commissioner, Independent Mental Health Advocacy or other agency. |

# Electronic devices and security

Mental health facilities ensure the safe keeping of patients’ personal belongings when they are admitted, especially with regard to valuables (including electronic devices), medications, sharp objects and any other object considered to be potentially dangerous, offensive or inappropriate.

## Procedure for the care of patients’ electronic devices

1. Once a decision has been made (either by the clinical team or the patient) for an electronic device to be held by staff for safe-keeping, it is to be recorded in the Patient Property List.
2. When a device is placed into safe-keeping, a staff member in the presence of the patient (or a second staff member acting on the patient’s behalf) is to check over the device and record the details of the device on the form.
3. The form is to be signed by two staff members and the patient.
4. The form is to be filed in the patient record and a copy provided to the patient.
5. The device is then placed in the patient property storage area.
6. Prior to providing the device back to the patient, staff are to check over it in the presence of the patient.
7. The checklist is then to be completed with both the staff member and the patient signing the form.
8. The electronic device is then returned to the patient.

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| **Damage to electronic devices**  Where a personal item, held by staff for safekeeping, has been lost or damaged, patients, or their representative may make a claim for compensation for the repair/replacement of the item.  The facility is not responsible for any loss or damage to an item that is in the possession of the patient at the time of loss and/or damage. |

# E-safety

The online world is part of everyday life for many children and young people. It is a forum where they can play, learn and socialise. Electronic communication also exposes young people to potential risks to their mental health and wellbeing. The Office of the eSafety Commissioner has produced advice for parents (<https://esafety.gov.au/education-resources/iparent>) on how to minimise the risks associated with using mobile phones, tablet devices and computers, which includes information on social media, screen time, protecting personal information, exposure to inappropriate content, cyberbullying and contact with strangers. This information might also be of helpful to mental health service providers.

# Other relevant and regulatory requirements

The requirements and protections of the *Mental Health and Related Services Act 1998* apply to all patients including prisoner patients and those in police custody. However, provisions of the other legislation may at times override the requirements for the restriction or denial of entitlements under the Act i.e. people being held in custody under provisions of the following legislation may be denied access to electronic devices under that legislation*:*

* *Correctional Services Act 2014*;
* *Youth Justice Act 2005*; and
* *Police Administration Act 1978.*

# Summary

Patients have the right to communicate. Communication can promote recovery. There may be circumstances when restricting communication may be necessary to protect health, safety, wellbeing and privacy.

Information about using communication devices, must be conveyed in a manner in which the individual, according to their specific circumstances, can best understand. Where an individual is represented by a guardian or is a child, information must be provided to the guardian of the individual or the parent or the guardian of the child where the individual or child does not fully understand the information conveyed.

Restrictions to communication need to be patient-centred and recovery-focused and discussed with the patient in a way that supports their right to participate in or make decisions. Restrictions need to be the least restrictive possible to protect health, safety, wellbeing and privacy and include a discussion about alternative options that support communication while protecting the patient and others.

Restrictions need to be monitored and ceased as soon as the reason for the restriction no longer applies. Options for securely storing and registering personal property are recommended, together with access to ‘charging stations’ (with due consideration to safety of ligatures). Health services are required to adhere to relevant legislation regarding communication and privacy.

# Key measures

The following measures may be helpful to mental health services to audit their compliance with local policy:

1. Approved treatment facilities have a policy suite that supports electronic communication in a manner that accords with the principles in this approved procedure.
2. Staff are aware of the following national and legislative frameworks and how they apply to electronic communication and privacy:
   * National Mental Health Statement of Rights and Responsibilities (see Appendix 1)
   * *Mental Health and Related Services Act 1998* (see Appendix 2)
   * *Information Act 2002* (see Appendix 3)
   * *Surveillance Devices Act 2007* (see Appendix 4).
3. NT Health staff are aware of the Seclusion and Restraint Policy and how it applies in relation to restricting inpatient access to electronic communication devices.
4. Reduced inpatient and consumer complaints about electronic communication access and privacy in approved treatment facilities services.

# Further information

In developing, implementing and evaluating policy for mental health services, NT Health supports recovery-oriented, patient-centred, interdisciplinary collaboration. As such, consultation with patients and others affected by the suite of policy documents is a critical step in the process, in alignment with the *Mental Health and Related Services Act 1998*.

# Document Quality Assurance

|  | **Method** | **Responsibility** |
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| **Implementation** | Document will be accessible via the MHARS Act internet and intranet pages and the PGC. | Senior Compliance and Clinical Policy Co-ordinator MHAOD Branch |
| **Review** | Document will be reviewed within a period of 4 years. | Approved Procedures Quality Assurance Committee |
| **Evaluation** | Document will be informally evaluated at time of review. | Approved Procedures Quality Assurance Committee |

# Key Associated Documents

All related material produced by the Northern Territory Department of Health is available from: **https://health.nt.gov.au/professionals/mental-health-information-for-health-professional**

Mental Health and Related Services (MHARS) Act 1998 – available from: **https://legislation.nt.gov.au/en/LegislationPortal/Acts/By-Title#**

# Definitions and Search Terms

| **Preferred Term** | **Description** |
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| **APP** | Authorised psychiatric practitioner |
| **MHARS Act** | *Mental Health and Related Services Act 1998* |

#### Alternative Search Terms

# Appendix 1 – Relevant sections of the National Mental Health Statement of Rights and Responsibilities

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| Statement | Provisions |
| **1** | All people have inherent dignity and worth and are entitled to the equal protection of their human rights and fundamental freedoms without discrimination of any kind. |
| **3** | Non-discrimination and social inclusion are fundamental to the mental health of the whole community. There is a recognised correlation between severe mental illness, low socio-economic status and social exclusion. |
| **4** | Mental health consumers have the right to social inclusion and participation in social life on an equal basis with others without discrimination of any kind. |

# Appendix 2 – Relevant sections of the *Mental Health and Related Services Act 1998*

| Section | Provisions |
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| **3** | The objects of this Act are as follows:   1. to provide for the care, treatment and protection of people with mental illness while at the same time protecting their civil rights; 2. to establish provisions for the care, treatment and protection of people with mental illness that are consistent with the United Nations' Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, the Australian Health Ministers' Mental Health Statement of Rights and Responsibilities and the National Mental Health Plan; 3. to establish provisions for the review of the voluntary and involuntary admission of people into approved treatment facilities and the treatment provided to people in approved treatment facilities; 4. to establish provisions for obtaining informed consent and the authorisation of treatment; 5. to establish provisions for emergency detention and treatment; 6. to provide regulation of specific forms of treatment; 7. to establish provisions for the administration of involuntary treatment in the community; 8. to mainstream and integrate, as far as possible, provision for the administration and review of admission, hospitalisation and treatment of prisoners; 9. to establish the right of people receiving or seeking psychiatric treatment or care to be given oral and written explanations of their legal rights and entitlements under this Act in a form and language that they understand; 10. to establish the right for people who are subject to this Act, their relatives, friends and representatives, and any other people with a genuine interest in particular people who are subject to this Act, to make a complaint; 11. to provide for approved treatment facilities and approved treatment agencies to establish accessible internal complaints procedures; 12. to affirm the right of people who are subject to this Act to complain to independent complaint bodies established by or under other legislation; 13. to provide for a principal community visitor, community visitors and community visitor panels with inquiry, complaints, investigation, visiting, inspection, advocacy and reporting powers and functions; 14. to provide for the registration of mental health orders made outside the Territory; 15. to provide a procedure for approved treatment facilities and approved treatment agencies to be approved; 16. to recognise the continuing appropriate care provided by relatives and friends and other non-professional care givers in the community, and to ensure that therapeutic alliances involving appropriate non-professionals are recognised. |
| **8** | This Act is to be interpreted and a power or function conferred or imposed by this Act is to be exercised or performed so that:   1. a person who has a mental illness receives the best possible care and treatment in the least restrictive and least intrusive environment enabling the care and treatment to be effectively given; and 2. in providing for the care and treatment of a person who has a mental illness and the protection of members of the public, any restriction on the liberty of the person and any other person who has a mental illness, and any interference with their rights, dignity, privacy and self respect is kept to the minimum necessary in the circumstances; and 3. the objective of treatment is directed towards the purpose of preserving and enhancing personal autonomy; and 4. the administration of medication to a person serves the best interests and health needs of the person and is administered only for therapeutic or diagnostic purposes and not as punishment or for the convenience of others; and 5. medication to be administered to a person is prescribed only by persons who are authorised by law to do so; and 6. a person who has a mental illness who needs language, interpreter, advocacy, legal or other services to assist him or her in communicating has access to those services; and 7. the assessment, care, treatment and protection of an Aboriginal person or a person from a non-English speaking background who has a mental illness is appropriate to, and consistent with, the person's cultural beliefs, practices and mores. |
| **9** | When providing treatment and care to a person who has a mental illness, mental disturbance or complex cognitive impairment the following principles apply:   1. the person is to be provided with timely and high quality treatment and care in accordance with professionally accepted standards; 2. where possible, the person is to be treated in the community; 3. as far as possible, the person's treatment and care is to be designed to assist the person to live, work and participate in the community and to promote and assist self-reliance; 4. the person is to be provided with appropriate and comprehensive information about:    1. the person's mental illness, mental disturbance or complex cognitive impairment; and    2. proposed and alternative treatment and services available to meet the person's needs; 5. where possible, the person is to be treated near where he or she ordinarily resides or where relatives or friends of the person reside; 6. as far as possible, the person's treatment and any service to be developed for the person is appropriate having regard to the age and gender of the person; 7. as far as possible, the person is to be involved in the development of any ongoing treatment plan or any discharge planning; 8. the person is to be given medication only for therapeutic or diagnostic purposes and not as a punishment or for the convenience of others; 9. except as provided by this Act, the person is not to be given treatment without his or her consent; 10. the person's treatment is to be carried out, wherever practicable, within a multi-disciplinary framework; 11. the person's treatment and care is to be based on an individually developed plan that is discussed with the person, reviewed regularly and revised, as necessary, and is provided by qualified professional persons; 12. the person's treatment and care is, as far as possible, to be appropriate to and consistent with the person's cultural beliefs, practices and mores, taking into account the views of the person's family and community; 13. any assessment of the person to determine whether he or she needs to be admitted to an approved treatment facility is to be conducted in the least restrictive manner and environment possible. |
| **13** | When a person who has a mental illness, mental disturbance or complex cognitive impairment is being treated in an approved treatment facility the following principles apply:   1. the person's legal rights and his or her right to privacy and to religious freedom are to be respected; 2. the confidentiality of information relating to the person is to be respected; 3. subject to this Act, the person's freedom of lawful communication (which includes the freedom to communicate with other persons in the approved treatment facility, to send and receive uncensored private communications, to receive visits from his or her counsel or representative in private, to receive visits from other people at all reasonable times and to have access to postal and telephone services and to newspapers, radio and television) is to be ensured; 4. the person's living conditions are to be as close as practicable to those usually experienced by people of a similar age living in the general community; 5. subject to section 92, the person is to have access to his or her personal records; 6. the person's right to make a complaint under an Act in respect of his or her treatment under this Act is not affected. |
| **87** | Information to be given to patients   1. This section applies if:    1. a person is admitted to an approved treatment facility; or    2. a community management order is made for a person.   (1A) No later than one day after the person is admitted or the order is made, an authorised psychiatric practitioner must give the information specified in subsection (1B) to:   * + 1. the person; and     2. the person's adult guardian; and   (ba) if the person has a decision maker – the decision maker; and   * 1. the person's representative.   (1B) For subsection (1A), the following information is specified:   * + 1. the person's rights and entitlements under this Act;     2. how those rights and entitlements may be exercised;     3. the advocacy and legal services that are available to the person;     4. any other information relating to the person's admission and treatment as the CEO considers relevant.  1. As far as possible, information given under subsection (1):    1. must be given both orally and in writing, in a language and form in which the person to whom it is given is used to communicating in and in a culturally appropriate manner including, where necessary, through the use of interpreters; or    2. where the person is used to communicating in a form other than orally or in writing, a version that is as close as possible to the content of the written information must be given in the form in which the person is used to communicating. 2. In giving information to a person under this section, regard must be had to the age, culture, disability, impairment and any other factor of the person that may influence the person understanding the information. 3. Where information is provided to a person through the use of an interpreter, that fact must be included in information provided to the Tribunal when it conducts a review in relation to the person. |
| **95** | The person-in-charge of an approved treatment facility must ensure:   1. that a person at the approved treatment facility is permitted to correspond, by post or otherwise, with persons outside the facility without interference or restriction; or 2. that a letter or other postal article that a person at the approved treatment facility wants posted is posted without being opened; or 3. that a letter or other postal article addressed to a person at the approved treatment facility is delivered to the person without being opened and is delivered as soon as reasonably practicable after it is received. |
| **96** | The person-in-charge of an approved treatment facility must ensure that a person at the approved treatment facility is able, in reasonable privacy, to make and receive telephone calls so far as is reasonably practicable and, at the discretion of the person-in-charge, subject to the person paying the cost of making those calls. |
| **97** | The person-in-charge of an approved treatment facility must ensure that a person at the approved treatment facility is able to receive visitors in reasonable privacy at the times that are determined. |
| **98** | 1. An authorised psychiatric practitioner (APP) may order that a right of a person under section 95, 96 or 97 be restricted or denied if the APP reasonably believes that unless the right of the person is restricted or denied there is a serious likelihood of the person suffering serious physical or mental deterioration or that the safety or well-being of other persons, another person or the general community is at risk. 2. An APP must review an order made under this section at least once a day and may vary or revoke the order. 3. An order under this section lapses at the end of the day on which it is not reviewed. 4. An APP must make a record in the clinical record of the person when an order under this section is made and when the order is reviewed. 5. If a person in respect of whom an order under this section is made is an involuntary patient, the APP must:    1. notify the following of the order being made:       1. the Tribunal;       2. the person's adult guardian;       3. if the person has a decision maker – the decision maker; and    2. inform the person of the person's right to apply to the Tribunal for a review of the order. |
| **99** | 1. Section 98 does not apply to a letter or other postal article:    1. addressed to a person at an approved treatment facility from a person referred to in subsection (2); or    2. addressed to a person referred to in subsection (2) from a person at an approved treatment facility. 2. The persons referred to are the following:    1. the Minister;    2. the Chief Executive Officer of NT Health;    3. a member of Parliament;    4. the principal community visitor or a community visitor;    5. the person-in-charge of the approved treatment facility;    6. an APP;    7. the Registrar of the Tribunal;    8. a representative of the person;   (ha) the person's adult guardian;  (hb) if the person has a decision maker – the decision maker;   1. the Anti-Discrimination Commissioner; 2. the Commissioner for Health and Community Services Complaints. |

# Appendix 3 – Relevant sections of the *Information Act 2002*

Recording of ‘health information’ using an electronic communication device is subject to the *Information Act 2002.*

| Section | Provisions |
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| **4 Definitions** | **Health information** means:   1. personal information about:    1. the physical or mental health of a person; or    2. a person's disability; or    3. the provision of a health service to a person, including the person's expressed wishes about that provision; or 2. personal information connected with the provision of a health service; or 3. personal information connected with the donation or intended donation by a person of his or her body parts, organs or bodily substances; or 4. personal information that is genetic information about a person in a form that is, or could be, predictive about the person's health at any time   **Sensitive information** means:   1. personal information about:    1. racial or ethnic origin; or    2. political opinions; or    3. membership of a political association; or    4. religious beliefs or affiliations; or    5. philosophical beliefs; or    6. membership of a professional or trade association; or    7. membership of a trade union; or    8. sexual preferences or practices; or    9. a criminal record; or 2. health information. |
| **Schedule 2 Information Privacy Principles** | IPP 2 Use and disclosure   * 1. A public sector organisation must not use or disclose personal information about an individual for a purpose (the secondary purpose) other than the primary purpose for collecting it unless one or more of the following apply:  1. if the information is sensitive information:    1. the secondary purpose is directly related to the primary purpose; and    2. the individual would reasonably expect the organisation to use or disclose the information for the secondary purpose; 2. if the information is not sensitive information:    1. the secondary purpose is related to the primary purpose; and    2. the individual would reasonably expect the organisation to use or disclose the information for the secondary purpose; 3. the individual consents to the use or disclosure of the information;   (ca) the use or disclosure is necessary for research, or the compilation or analysis of statistics, in the public interest and the following apply:   * 1. the research, compilation or analysis will not be published in a form that identifies the individual;   2. it is impracticable for the organisation to seek the individual's consent before the use or disclosure;   3. in the case of disclosure – the organisation reasonably believes the recipient of the information will not disclose the information;   4. if the information is health information – the use or disclosure is in accordance with guidelines issued by the Commissioner under section 86(1)(a)(iv) for this paragraph;  1. the organisation reasonably believes that the use or disclosure is necessary to lessen or prevent:    1. a serious or imminent threat to the individual's or another individual's life, health or safety; or    2. a serious or imminent threat of harm to, or exploitation of, a child; or    3. a serious threat to public health or public safety; 2. the organisation has reason to suspect that unlawful activity has been, is being or may be engaged in and uses or discloses the information as a necessary part of its investigation of the matter or in reporting its concerns to relevant persons or authorities; 3. the use or disclosure is required or authorised by law; 4. the organisation reasonably believes that the use or disclosure is reasonably necessary for one or more of the following by or on behalf of a law enforcement agency:    1. preventing, detecting, investigating, prosecuting or punishing an offence or a breach of a prescribed law;    2. enforcing a law relating to the confiscation of proceeds of crime;    3. protecting public revenue;    4. preventing, detecting, investigating or remedying seriously improper conduct or prescribed conduct;    5. preparing for or conducting proceedings before a court or tribunal or implementing the orders of a court or tribunal; 5. the Australian Security Intelligence Organisation (ASIO) has requested the organisation to disclose the information, the disclosure is made to an officer or employee of ASIO authorised by the Director-General of ASIO to receive the information and an officer or employee of ASIO authorised by the Director-General of ASIO to do so has certified in writing that the information is required in connection with the performance of the functions of ASIO; 6. the Australian Secret Intelligence Service (ASIS) has requested the organisation to disclose the information, the disclosure is made to an officer or employee of ASIS authorised by the Director-General of ASIS to receive the information and an officer or employee of ASIS authorised by the Director-General of ASIS to do so has certified in writing that the information is required in connection with the performance of the functions of ASIS.   Note 1: It is not intended to deter public sector organisations from lawfully co operating with law enforcement agencies in the performance of their functions.  Note 2: IPP 2.1 does not override any existing legal obligations not to disclose personal information. IPP 2.1 does not require a public sector organisation to disclose personal information – a public sector organisation is always entitled not to disclose personal information in the absence of a legal obligation to disclose it.  Note 3: A public sector organisation is also liable to the requirements of IPP 9 if it transfers personal information to a person outside the Territory. |

# Appendix 4 – Relevant sections of the *Surveillance Devices Act 2007*

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| Section | Provisions |
| **Section 4 Definitions** | **Listening device** means a device capable of being used to listen to, monitor or record a conversation or words spoken to or by a person in a conversation, but does not include a hearing aid or similar device used by a person with impaired hearing to overcome the impairment and permit the person to hear only sounds ordinarily audible to the human ear.  **Optical surveillance device** means a device capable of being used to monitor, record visually or observe an activity, but does not include spectacles, contact lenses or a similar device used by a person with impaired sight to overcome the impairment and permit the person to see only sights ordinarily visible to the human eye.  **Party** means:   1. for a private conversation – a person by or to whom words are spoken in the course of the conversation; or 2. for a private activity – a person who takes part in the activity   **Private activity** means an activity carried on in circumstances that may reasonably be taken to indicate the parties to the activity desire it to be observed only by themselves, but does not include an activity carried on in circumstances in which the parties to the activity ought reasonably to expect the activity may be observed by someone else.  **Private conversation** means a conversation carried on in circumstances that may reasonably be taken to indicate the parties to the conversation desire it to be listened to only by themselves, but does not include a conversation carried on in circumstances in which the parties to the conversation ought reasonably to expect the conversation may be overheard by someone else. |
| **Section 11**  **Installation, use and maintenance of listening devices** | 1. A person is guilty of an offence if the person: 2. installs, uses or maintains a listening device to listen to, monitor or record a private conversation to which the person is not a party; and 3. knows the device is installed, used or maintained without the express or implied consent of each party to the conversation.   Maximum penalty: 250 penalty units or imprisonment for 2 years. |
| **Section 12**  **Installation, use and maintenance of optical surveillance devices** | 1. A person is guilty of an offence if the person: 2. installs, uses or maintains an optical surveillance device to monitor, record visually or observe a private activity to which the person is not a party; and 3. knows the device is installed, used or maintained without the express or implied consent of each party to the activity.   Maximum penalty: 250 penalty units or imprisonment for 2 years. |
| **Section 15**  **Communication and publication of private conversations and activities** | 1. A person is guilty of an offence if the person: 2. communicates or publishes a record or report of a private conversation or private activity; and 3. knows the record or report has been made as a direct or indirect result of the use of a listening device, optical surveillance device or tracking device.   Maximum penalty: 250 penalty units or imprisonment for 2 years. |

1. Australian Commission on Safety and Quality in Health Care. Australian Charter of Healthcare Rights. Available from <https://www.safetyandquality.gov.au/consumers/working-your-healthcare-provider/australian-charter-healthcare-rights> [↑](#footnote-ref-1)