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

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NORTHERN TERRITORY GOVERNMENT

Acknowledgments

We acknowledge all people who have personal experience of mental illness. The voice of people with lived experience is essential in the development of our work.
We acknowledge Aboriginal people as the first peoples and the traditional owners and custodians of the land and waters.
We acknowledge and respect Aboriginal Elders past and present, and support emerging leaders across the Northern Territory and Australia.
We thank and acknowledge the contribution that stakeholders, decision making bodies and Northern Territory Government agencies have made to develop this document for consultation.

Abbreviations

Full term	Abbreviation
Mental Health and Related Services Act 1998	*MHRS Act*
Northern Territory Civil and Administrative Tribunal	NTCAT
Chief Health Officer	CHO
Chief Executive Officer	CEO
Community Management Order	CMO
Forensic Mental Health Service	FMHS
Criminal Code Act 1983	The Criminal Code

Terminology

In this document, people receiving care and treatment under the *Mental Health and Related Services Act 1998* (the *MHRS Act*) are referred to as:

VOLUNTARY CONSUMERS **OR** INVOLUNTARY PATIENTS **OR** FORENSIC CLIENTS

The term Aboriginal is used throughout this document to refer to all people of Aboriginal and Torres Strait Islander descent who are living in the Northern Territory.

Issues Index

Minister's Foreword

The review of the *Mental Health and Related Services Act 1998* is a commitment under the *Northern Territory Mental Health Strategic Plan 2019-2025*. The review of the Act aims to ensure that the legislation continues to reflect best practice in mental health treatment and care.

The release of the Discussion Paper is an important first step to ensure that Territorians have the opportunity to submit ideas and contribute to the legislation that provides for the care, treatment and protection of people with mental illness.

The Northern Territory Government's vision is for an inclusive community that understands social and emotional health and wellbeing, mental health and mental illness and provides quality and safe treatment and care to Territorians. Strong and contemporary legislation informed by Territorians with lived experience, their carers and families and communities is an important foundation in achieving this vision.

I would like to encourage you to take this opportunity to be involved in the review of the *Mental Health and Related Services Act 1998* and to contribute your ideas to the improvement of this very important piece of legislation.

Hon Natasha Fyles MLA
Minister for Health

Introduction

The *Mental Health and Related Services Act 1998* aims to provide for the care, treatment and protection of people with mental illness, while at the same time protecting their civil rights. A strong legislative framework is key to underpin a mental health policy that is fit-for-purpose and aligns with contemporary values. This is why the Northern Territory Government is committed to modernising the *Mental Health and Related Services Act 1998*.

The *NT Mental Health Strategic Plan 2019-2025* sets out its mission to 'establish a better understanding of mental health and mental illness by increasing mental health literacy, reducing the stigma associated with mental illness and to ensure that the mental health service system is responsive, coordinated, provides timely and high quality, culturally safe and appropriate care at the right place at the right time'.

The review provides a basis for everyone to work together and contribute to improve the lives for people with a lived experience, their families and carers, advocates, clinicians and service providers.

We want to hear from you

This Discussion Paper raises a variety of topics about mental health legislation in the Northern Territory, and concepts that have been introduced in other Australian jurisdictions.

The next page contains suggested questions to generate discussion on general and specific matters for your consideration. They are not intended to limit what you may raise in your submission, rather to generate discussion. The Department of Health wants to hear your views about how mental health treatment and care is regulated in the Northern Territory.

You are welcome to write your submission that:

- answer all of the questions
- answer most or some of the questions, but not all of them
- answer 1 or 2 questions
- raises something about the mental health legislation that is not included in the Discussion Paper.

All submissions will be carefully considered to determine the best way forward. Please include reasons for your views and if available, any evidence that supports your views.

The *Mental Health and Related Service Act 1998* is available on the Northern Territory Legislation website:
https://legislation.nt.gov.au/en/Legislation/MENTAL-HEALTH-AND-RELATED-SERVICES-ACT-1998

Part Five of the Discussion Paper includes information about Part IIA of the *Criminal Code Act 1983* (NT). *The Criminal Code Act 1983* is available on the Northern Territory Legislation website:
https://legislation.nt.gov.au/en/Legislation/CRIMINAL-CODE-ACT-1983

Submissions must be received by 31 May 2021.

Please send your submission by either:

- Post: Mental Health Alcohol and Other Drugs Branch,
  Department of Health,
  PO Box 40596, Casuarina, NT 0811
- Email: MHActReview.DoH@nt.gov.au

If any of the content in the Discussion Paper raises issues that are distressing please contact:

Beyond Blue 1300 224 636 www.beyondblue.org.au

Lifeline 13 11 14 www.lifeline.org.au

Online information and support at www.ReachOut.com

Your GP can also help you access the services you need.

We want to hear from you

The following suggestions are not intended to limit but rather generate discussion on general and specific matters for consideration:

General Matters

- Do you think the current legislation is effective in regulating mental health treatment and care?
- Do you think the *MHRS Act* needs amendments, or does the Northern Territory need to make an entire new Act for mental health?
- Does another Australian jurisdiction have laws about mental health that you think the Northern Territory should look at?

Part One: Principles and Rights of the Patient

- How can we use the legislation to promote the rights of the voluntary consumer or involuntary patient when they are receiving care?
- 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?
- 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?
- What is your opinion about introducing the concept of investigating the 'will and preference' of someone to help make decisions about mental health treatment and care?
- What steps should be taken to find out someone's will and preference?

Part Two: Person-centred approach

- Should the Northern Territory introduce a 'nominated support person' into the mental health legislation?
- What kind of roles should the nominated support person have?
- How many nominated support persons should an involuntary patient have?
- What do you think about the current provisions relating to the use of interpreters?

- Should special provisions apply for children when determining capacity and making treatment decisions, or applying to be admitted as a voluntary patient?

Part Three: Admission and Treatment

- What do you think about the current process of assessment and examination for involuntary admission?
- What are your thoughts about the process to involuntarily admit somebody on the grounds of mental illness, or mental disturbance or complex cognitive impairment?
- Do you have any feedback on the current voluntary admission process?
- What do you think about the current power of Police to apprehend a person in order to take them to be assessed?
- What do you think about the current approach under the *MHRS Act* that grants leave to involuntary patients?
- What do you think about regulating the power to search someone and seize property under the *MHRS Act*?

Part Four: Monitoring

- What do you think of the current approach to regulating the use of restrictive practices under the *MHRS Act*?
- How do you think the legislation can further promote the elimination of restrictive practices?
- How do you think the legislation can support the role of the Chief Psychiatrist?
- What do you think about how the legislation regulates electroconvulsive therapy (ECT)? Can we make improvements?

Part Five: Forensic Provisions

- Is the current legislation effective in regulating forensic mental health? How can we make improvements?
- Do you think the legislation provides effective and appropriate clinical pathways for forensic clients? How can the Northern Territory improve this?

Part One:

Principles and Rights of the Patient

...To bring about the best therapeutic outcomes for patients, and, as far as possible, their recovery and participation in community life.

Part One: Principles and Rights of the Patient

Consider for your submission:

- How can we use the legislation to promote the rights of the voluntary consumer or involuntary patient when they are receiving care?
- 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?
- 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?
- What is your opinion about introducing the concept of investigating the 'will and preference' of someone to help make decisions about mental health treatment and care?
- What steps should be taken to find out someone's will and preference?

1.1 Recovery

Current approach

Section 9(c) of the *MHRS Act* prescribes that:

When providing treatment and care to a person who has a mental illness, mental disturbance or complex cognitive impairment…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.

Although this provision touches on some elements of recovery, compared to modern mental health legislation around Australia, recovery (and even the word 'recovery') is relatively absent from the legislation.

The *NT Mental Health Strategic Plan 2019-2025* provides the following to explain 'recovery':

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

A focus on recovery in mental health 'has largely been championed and driven by people with lived experience their families, friends and peers'.[1] Priority Area 2 of the *NT Mental Health Strategic Plan 2019-2025* is to provide culturally secure, safe and trauma informed care focussed on recovery, committing to develop, promote and implement strengths-based recovery-oriented models of care.

Discussion

Strengthening the incorporation of 'recovery' into the legislation aligns with a number of national standards and policies. Standard 10.1 of the *National Standards for Mental Health Services 2010 'Supporting Recovery'*, supports and promotes recovery-oriented values and principles in its policies and practices.

In 2013, the Australian Health Ministers' Advisory Council released *'A national framework for recovery-oriented mental health services'*, providing a 'vital' new policy direction to enhance and improve mental health service delivery in Australia.[2] The recovery approach aligns with the *Roadmap for National Mental Health Reform 2012-22* and *The Fifth National Mental Health and Suicide Prevention Plan.*

National policies and scholar articles note that there is no single, standard definition of 'recovery' and a standard definition is difficult due to its individualised nature.[3] Although legislation across Australia includes the concept of 'recovery', the term itself is not defined.

However, it may be argued that an absence of a definition leaves the term open to interpretation by decision makers, and leaves potential uncertainty for consumers, their families/carers and other supporters, and clinicians administering treatment and care for the purposes of 'recovery'.

It has been suggested that including the concept of 'recovery' will provide a strong legislative framework upholding best practice policies and principles, and promoting the person-focussed approach to care.

Other jurisdictions

South Australia

In South Australia, the *Mental Health Act 2009* (SA) sets out the concept of 'recovery' at section 6(a)(i):

...to ensure that persons with severe mental illness (i) receive a comprehensive range of services of the highest standard for their treatment, care and rehabilitation with the goal of bringing about their recovery as far as possible

The section is further supported by section 7(1)(a) of the *Mental Health Act 2009* (SA) where the Minister, Tribunal, Chief Psychiatrist, health professionals and other bodies involved in the administration of the Act are to be guided in the performance of their functions:

...to bring about the best therapeutic outcomes for patients, and, as far as possible, their recovery and participation in community life

The South Australian legislation incorporates the concept of 'recovery' as a core principle that guides the standard of care and imposes it as a goal to be obtained, influencing all decision making under the Act.

Queensland

The *Mental Health Act 2016* (QLD) also includes 'recovery' in the main objects of the Act at section 3(2)(c):

The main objects are to be achieved in a way that...promotes the recovery of a person who has a mental illness, and the person's ability to live in the community, without the need for involuntary treatment and care...

The QLD legislation also stipulates that 'the importance of recovery-oriented services and reduction of stigma associated with mental illness must be recognised and taken into account' at section 5(k). This is particularly important as this guides how decisions are made and implemented under the legislation.

Western Australia

Schedule 1 of the *Mental Health Act 2014* (WA) is a Charter of Mental Health Care Principles. The purpose of the Charter is to 'influence the interconnected factors that facilitate recovery from mental illness.'[4] Principle 3.2 of the Charter prescribes:

A mental health service must promote positive and encouraging recovery focused attitudes towards mental illness, including that people can and do recover, lead full and productive lives and make meaningful contribution to the community.

Under Principle 4 of the Charter, the delivery of treatment, care and support is to be of high quality based on contemporary best practice to promote recovery in the least restrictive manner that is so consistent with their needs.[5]

Australian Capital Territory

The first object of the *Mental Health Act 2015* (ACT) is to promote the recovery of people with a mental disorder or mental illness.[6] A person with a mental disorder or mental illness has a right under the legislation, to determine their own recovery.[7]

1.2 Capacity and informed consent

Current approach

Informed consent

Section 7 of the *MHRS* Act, sets out what it means to give informed consent. Under section 7(2), a person can give informed consent:

(a). when the person's consent is freely and voluntarily given without inducement being offered and

(b). the person is capable of understanding the effects of giving consent and

(c). the person communicates his or her consent on the approved form.

Under section 7(3), a person can give informed consent only when they have been given:

(a). a clear explanation of the assessment and possible diagnoses, the nature of proposed treatment, including sufficient information about the type of treatment, its purpose and likely duration to permit the person to make a balanced judgement regarding undertaking it and

(b). an adequate description, without concealment, exaggeration or distortion, of the benefits, discomforts and risks associated with the treatment; and

(c). an adequate description of any appropriate alternative form of treatment that is reasonably available; and

(d). a clear answer to all relevant questions asked by the person (and the answer has been understood by the person); and

(e). advice that the treatment may be refused or consent may be withdrawn at any time while the treatment is being undertaken; and

(f). advice that independent legal or medical advice may be obtained in relation to the treatment before giving consent (and reasonable assistance is provided to obtain that advice, if requested); and

(g). advice of all rights of review and appeal under this Act; and

(h). advice of any relevant financial advantage that may be gained by a medical practitioner proposing the treatment and by the approved treatment facility or approved treatment agency where the treatment is to be undertaken; and

(j). advice of any relevant research relationship between a medical practitioner proposing the treatment and the approved treatment facility or approved treatment agency where the treatment is to be undertaken; and

(k). explanations, descriptions and advice in a manner or form that the person is used to communicating in (and due regard is to be given to age, culture, disability, impairment and any other factors that may influence the person understanding the explanation).

Section 7 also prescribes that a person must be given adequate time to consider the information before being asked to consent,[8] that the person may request that another person be present while the informed consent is obtained,[9] and that they may be assisted by an interpreter if they are unable to communicate adequately in English.[10]

A person cannot give informed consent under the Act unless all the elements set out in section 7 are complied with,[11] and the person-in-charge of the approved treatment facility or approved treatment agency is responsible for ensuring that section is being complied with.[12]

Involuntary admission

When a person lacks capacity to consent to treatment, it may be necessary for that person to be admitted as an involuntary patient. The criteria for involuntary admission and treatment is set out in Part 3 of the *MHRS Act* and sets out the criteria for involuntary admission on the grounds of mental illness[13], mental disturbance[14] and complex cognitive impairment.[15] In relation to informed consent, Part 3 sets out the following as criteria for involuntary admission:

Involuntary admission on the grounds of **Mental illness**	Involuntary admission on the grounds of **Mental disturbance**	Involuntary admission on the grounds of **Complex cognitive impairment**
Section 14(b)(iii)	Section 15(d)	Section 15A(e)
The person is not capable of giving informed consent to the treatment or has unreasonably refused to consent to the treatment...	The person is not capable of giving informed consent to the treatment and care or has unreasonably refused to consent to the treatment...	The person is not capable of giving informed consent to the treatment and care...

Discussion

It is the consent of the patient that makes the medical intervention lawful when it would otherwise be unlawful.[16] Actively involving patients in decisions about their treatment and care recognises the importance of autonomy and independence, including the freedom to make one's own choices,[17] and this includes acknowledging that a person's capacity to give informed consent may fluctuate in response to variations in their health and circumstances.[18]

For individuals whose psychotic illness substantially impairs their decision-making, mandatory treatment may offer the best hope of becoming well enough to actively participate in their recovery.[19] Where a person lacks capacity,[20] their refusal to treatment may be overridden as it will not be taken to reflect a genuine free choice, but the practitioner must treat the patient in accordance with their clinical judgement of what is in the patient's best interests.

Modernised mental health legislation aims to strike a balance between clinical concerns that promote individual wellbeing, the safety of the public and legal fairness.[21] A balance needs to be made between preserving the fundamental human rights of the person and recognising that to not treating severe mental illness may have devastating individual and societal consequences.[22]

International law

Critically for mental health reform, the rights protected under international law include the right to freedom from discrimination,[23] protection from cruel, inhuman or degrading treatment,[24] freedom of movement,[25] and right of everyone to the enjoyment of the highest attainable standard of physical and mental health.[26] In July 2008, the Australian Government ratified the United Nations Convention on the Rights of Persons with Disabilities (the Convention). Importantly, the Convention specifies at Article 12:

(1). *State Parties reaffirm that person with disabilities have the right to recognition everywhere as persons before the law.*

(2). *States Parties shall recognise that persons with disabilities enjoy legal capacity on an equal basis with other in all aspects of life.*

From an international law perspective, a mentally ill person who has capacity to make informed consent should be permitted to refuse treatment in the same way as another capable patient.[27]

Case law

Case law provides a number of authorities that help to explain when someone can make informed consent, and in what circumstances where someone's refusal to treatment can be overridden.

In the case of *Hunter and New England Area Health Service v A*,[28] the court found that a person is entitled to make autonomous decisions about medical treatment, provided they have the capacity to do so. A person will have the capacity to refuse medical treatment if they are able to comprehend and retain information which is material to the decision and use and weigh the information as part of the process of making the decision.[29]

In 2014, the Victorian Supreme Court in the case of *PBU & NJE v Mental Health Tribunal*[30] confirmed that the legislative test to determine capacity must be interpreted and applied in a way that is compatible with the patient's human rights. This decision was significant as it indicated that a person who lacks insight *may* (not *must*) be lacking in capacity.[31]

Other jurisdictions

Victoria

A person has the capacity to give informed consent under the *Mental Health Act 2014* (Vic) if the person:

(a). understands the information he or she is given that is relevant to the decision, and

(b). is able to remember the information that is relevant to the decisions, and

(c). is able to use or weigh the information that it relevant to the decision, and

(d). is able to communicate the decision he or she makes by speech, gestures or any other means.[32]

To provide guidance to any person who is required to determine whether someone has capacity to give informed consent, section 68(2) instils further principles including: a person's capacity to give informed consent is specific to the decision the person is to make;[33] that a person's capacity to give informed consent may change over time;[34] and a determination that a person does not have capacity should not be made only because the person made an 'unwise' decision.[35]

South Australia

In South Australia, the *Mental Health Act 2009* (SA) contains the presumption a person has full decision-making capacity in respect of decision about their health care, residential and accommodation arrangements and personal affairs.[36] However, under subsection 5A(2)(a) the presumption will be rebutted if the person is not capable of:

(i). understanding any information that may be relevant to the decision (including information relating to the consequences of making a particular decision); or

(ii). retaining such information; or

(iii). using such information in the course of making the decision; or

(iv). communicating his or her decision in any manner...[37]

For each of these four elements, the legislation provides further guidance:

- *a person will not be taken to be incapable of understanding information merely because the person is not able to understand matters of a technical or trivial nature;*[38]

- *a person will not be taken to be incapable of retaining information merely because the person can only retain the information for a limited* time;[39]
- *a person may fluctuate between having impaired decision-making capacity and full decision-making capacity;*[40]
- *a person's decision-making capacity will not be taken to be impaired merely because a decision made by the person results, or may result, in an adverse outcome for the person.*[41]

Australian Capital Territory

The *Mental Health Act 2015* (ACT) prescribes that someone has 'decision-making capacity' if that person can, with assistance if needed:[42]

(a). understand when a decision about treatment care or support for the person needs to be made; and

(b). understands the facts that relate to the decision; and

(c). understand the main choice available to the person in relation to the decision; and

(d). weigh up the consequence of the main choices; and

(e). understand how the consequences affect the person; and

(f). on the basis of paragraph (a) to (e), make the decision; and

(g). communicate the decision in whatever way the person can.[43]

Further guidance is provided under section 8 that sets out the principles of decision-making capacity. Such principles include the presumption that someone has decision-making capacity unless the contrary is established;[44] capacity is particular to the decision the person is about to make;[45] a person must not be treated as not having capacity only because the person makes an unwise decision[46] or if the person has impaired decision-capacity under another Act, in relation to another decision.[47]

Queensland

In Queensland, the *Mental Health Act 2016* (QLD) sets out the treatment criteria as per the following:

> *(a). the person has a mental illness;*
>
> *(b). the person does not have capacity to consent to be treated for the illness;*
>
> *(c). because of the person's illness, the absence of involuntary treatment, or the absence of continued involuntary treatment, is likely the result of*
>
> *(i). imminent serious harm to the person or others; or*
>
> *(ii). the person suffering serious mental or physical deterioration.*[48]

All the elements must apply to that person in order for the criteria to be satisfied. The meaning of capacity is regulated under section 14 of the *Mental Health Act 2016 (QLD)*:

> *(1). A person has capacity to consent to be treated if the person –*
>
> *(a). is capable of understanding, in general terms –*
>
> *(i). that a person has an illness, or symptoms of an illness, that affects the person's mental health and wellbeing; and*
>
> *(ii). the nature and purpose of the treatment for the illness; and*
>
> *(iii). the benefits and risks of the treatment, and alternative to the treatment; and*
>
> *(iv). the consequences of not receiving the treatment; and*
>
> *(b). is capable of making a decision about the treatment and communicating the decision in some way.*[49]

The person may be supported by another person in understanding the matters in section 14(1)(a) and making a decision about the treatment,[50] and the person may have capacity to consent to be treated even though the person decides not to receive treatment.[51]

Part Two:

Person Centred Approach

...To support the consumer along their care and treatment journey to recovery.

Part Two: Person centred approach

Consider for your submission:

- Should the Northern Territory introduce a 'nominated support person' into the mental health legislation?
- What kind of roles should the nominated support person have?
- How many nominated support persons should an involuntary patient have?
- What do you think about the current provisions relating to the use of interpreters?
- Should special provisions apply for children when determining capacity and making treatment decisions, or applying to be admitted as a voluntary patient?

2.1 Wills and preference

Current approach

Section 8(d) of the *MHRS Act* sets out how the Act is to be interpreted. Amongst other principles, a power or function conferred or imposed by the Act is to be exercised or performed so that:

*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…*

There are numerous sections within the *MHRS Act* that gives discretion to practitioners, persons-in-charge or decision makers (such as NTCAT) to disclose or withhold information from a person's primary carer, parent or guardian, dependent of whether the disclosure would be in the person's best interests. Those scenarios include:

- A practitioner may decide not to notify the person's primary carer when a community management order is revoked – section 50A(2)
- A practitioner may decide not to allow the giving of information to the person's representative or primary carer when the practitioner has information regarding the treatment of a person (including medication) admitted to an approved treatment facility, or under a community management order – section 88(3)

- A practitioner may decide not to allow consultation with, or the giving of information to, the person's representative or primary carer when the practitioner needs to consult on proposed arrangements in a discharge plan for a person being discharged from an approved treatment facility – section 89(5)
- The person-in-charge of an approved treatment facility, after consulting with an authorised psychiatric practitioner, may decide not to notify the person's primary carer when a financial protection order is made for a person – section 168A(2).
- A practitioner may decide not to notify a parent or guardian of the person under 18 when they are admitted to an approved treatment facility as a voluntary patient – section 26(3)
- A practitioner may decide not to notify the person's primary carer when a person is detained at an approved treatment facility on the grounds of mental illness for up to 24 hours, or for a further period of 14 days – section 41(2)
- A practitioner may decide not to notify the person's primary carer when a person is detained at an approved treatment facility on the grounds of mental disturbance for up to 72 hours, or for a further period of 7 days – section 43(2)
- A practitioner may decide not to notify the person's primary carer when an application has been made to NTCAT to admit the person on the grounds of complex cognitive impairment – section 44D(2)
- A practitioner may decide not to notify the person's primary carer when an interim community management order has been made for a person – section 47(2)

In these circumstances, the practitioner or person-in-charge must give NTCAT a written report of the decision, including reasons.

Discussion

International law

Article 12 of the United Nations Convention on the Rights of Persons with Disabilities (the Convention) recognises that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life. The Convention calls on parties to take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity.

In 2014, the United Nations Committee on the Rights of Persons with Disabilities released a General comment that interpreted Article 12. The General Statement advised that *'support in the exercise of legal capacity must respect the rights, will and preferences of persons with disabilities...'*[52]

Recognising the will and preference of a person promotes consumer engagement in their care and treatment and is an important step in facilitating mental health recovery. In 2018, the New Zealand Medical Journal published an article that found *'when the principles of procedural justice are followed, consumers feels affirmed and are more likely to trust the process even if ultimately the decision are not those they prefer.'*[53] Recent reform to mental health legislation in Australia has incorporated the concept of will and preference (or 'wishes') of an involuntary patient when practitioners make decisions about their patient's treatment and care.

Although the Convention did not create rights that were not already existing in international law, it specified 'how the principles of human dignity, equality, non-discrimination, autonomy and full social participation and inclusion apply'.[54] Incorporating a consideration for people to participate in communication with their treating team about their care promotes 'the central premise...that consumers and carers are both major stakeholders in the planning and delivery of healthcare'.[55]

Other jurisdictions

Western Australia

The Western Australian legislation recognises the 'best interests' and 'wishes' of a person as two separate and defined concepts. The matters relevant to ascertaining a person's wishes are defined under section 8 of the *Mental Health Act 2014 (WA)*:

(1). This section applies whenever a person or body is required under this Act to ascertain the wishes of a person in relation to a matter.

(2). For the purposes of ascertaining those wishes, the person or body must have regard to the following —

(a). any treatment decision in an advance health directive made by the person that is relevant to the matter;

(b). any term of an enduring power of guardianship made by the person that is relevant to the matter;

(c). any anything that the person says or does that is relevant to the matter if it is said or done at a time that is reasonably contemporaneous with when those wishes are required to be ascertained;

(d). any other things that the person or body considers relevant to ascertaining those wishes.

Section 7 of the *Mental Health Act 2014 (WA)* defines the matter relevant to decision about person's best interests, which includes having regards to the person's wishes:

(1). This section applies whenever a person or body is required under this Act to decide what is or is not in the best interests of a person.

(2). The person or body making the decision must have regard to these things — the person's wishes, to the extent that it is practicable to ascertain those wishes…

Under section 179, a patient's psychiatrist must have regard to the patient's wishes in relation to the provision of treatment to the extent that it is practicable to ascertain those wishes. There is also an obligation under section 179 for a psychiatrist to make a record that details:

(a). the patient's wishes, to the extent they were able to be ascertained by the medical practitioner; and

(b). the things to which the medical practitioner had regard in ascertaining the patient's wishes; and

(c). if the decision made by the medical practitioner is inconsistent with a treatment division in an advance health directive, made by the patient — the reasons the decision was made.

Tasmania

In Tasmania, the *Mental Health Act 2013* (Tas) still incorporates the 'best interest' threshold. Under section 55, an involuntary patient may be given treatment without informed consent or tribunal authorisation if an approved medical practitioner authorises the treatment as being urgently needed in the patient's best interests. An approved medical practitioner may authorise treatment as being 'urgently needed' in the patient's best interests if it is of the opinion of that practitioner that achieving the necessary treatment outcome would be compromised by waiting for tribunal authorisation (section 55(2)). This also applies to forensic patients under section 87.

Division 3 of the *Mental Health Act 2013* (Tas) does require that each involuntary patient has a treatment plan. In preparing a treatment plan, a medical practitioner is to consult the patient and any other person as the practitioner thinks fit in the circumstances. The legislation does not go into detail about what the practitioner must consider or how much weight they put onto the patient's wishes when constructing the treatment plan, only that it is to be in the 'approved form' under section 52(1).

Queensland

Section 5 of the *Mental Health Act 2016* (QLD) sets out the principles that apply to the administration of this Act. When making decisions, section 5(b) outlines the following:

- *to the greatest extent practicable, a person is to be encouraged to take part in making decisions affecting the person's life, especially decisions about treatment and care*
- *to the greatest extent practicable, in making a decision about a person, the person's views, wishes and preferences are to be taken into account*
- *a person is presumed to have capacity to make decision about the person's treatment and care and other matters under this Act.*

This principle is supported but the use of 'advance health directives' (AHDS) that come into effect if a person loses capacity.

Although the AHDs are established under the *Powers of Attorney Act 1998* (QLD), the *Mental Health Act 2016* (QLD) actively promotes their use. For example, when an authorised doctor makes an assessment to determine whether a person requires treatment, the practitioner must take reasonable steps under section 43(4) to find out whether there is a less restrictive way for the person to receive treatment and care, including searching the person's health records to find out whether the person has made an AHD.

The incorporation of AHDs to capture a patient's wishes gave individuals greater control over their healthcare. In April 2019, the Queensland Government released an *Evaluation report on the Implementation of the Mental Health Act 2016* (QLD). When reporting on the uptake of involuntary patients using AHDs, the Evaluation Report commented that:

Advocates, legal representatives and other service providers who responded to the survey provided feedback that AHDs are a valuable tool for managing decision making and allowing increased patient input when unwell. However, staff indicated that while clinicians wanted to be more proactive in suggesting patients make an AHD, usually by the time the treating team is involved there are concerns that the patient no longer has capacity to make an AHD.[56]

The Report advised that aims to increase AHD uptake would be achieved by 'looking for opportunities to discuss the making of an AHD with patients, for example, when a patient gains capacity'.[57]

2.2 Nominated support person

Current approach

When a decision has been made regarding an involuntary patient's admission, treatment or care, the *MHRS Act* contains a requirement in a number of sections for a practitioner to notify the following people:

(a). the person
(b). the person's adult guardian
(c). if the person has a decision maker – the decision maker
(d). a legal practitioner acting or prepared to act for the patient
(e). the person's primary carer
(f). the principal community visitor
(g). NTCAT.

Examples of when the practitioner must do this include:

- When a person has been detained at an approved treatment facility for involuntary admission on the grounds of mental illness – section 41
- When a person has been detained at an approved treatment facility for involuntary admission on the grounds of mental disturbance – section 43
- When an application has been made to NTCAT to make an order for the person to be involuntarily admitted on the grounds of complex cognitive impairment – section 44D

- When an interim community management order has been made for a person – section 47
- When a community management order has been revoked – section 50A

In these circumstances, a practitioner may decide that notifying the person's primary carer would not be in the best interests of that person, and so can withhold notification.

More recent reform to mental health legislation has introduced the concept of a 'nominated support person'. The purpose of the role is to receive more than notifications, but to assist the person by making sure their rights are being upheld and their interests and wishes are taken into account while they are admitted as an involuntary patient or under a community management order.

Discussion

International comparison – Scotland

The *Mental Health (Care and Treatment) (Scotland) Act 2003* introduced the role of the 'Named Person' to represent a person's interests once they became subject to involuntary treatment. Under the legislation, a person receiving care and treatment under the Act can nominate a family member or a friend to represent their interests as their 'named person'. The effect of the nomination was that the named person now had rights to notification, access to information, consultation, attendance and representation at tribunal hearings, and rights of appeal.[58] The named person replaced the former 'Nearest Relative' role. Under the former 1984 Mental Health (Scotland) Act, the 'Nearest Relative' of a patient was allowed to receive information about that person's care. A person receiving treatment under the former legislation was not able to choose who their 'Nearest Relative' was, and this was found to be contrary with human rights legislation.[59]

When the legislation was first introduced, section 251 created a default appointment in the event the patient did not make select a nominated person. There was no ability to 'opt out'. This provision was viewed as 'problematic'[60] as the default Named Person may be appointed against the patient's wishes. Although the patient had the ability to object to the appointment via application to the Tribunal, issues arose in circumstances where the default Named Person may have already received information about that patient before they had the opportunity to object.

To fix this, the *Mental Health (Scotland) Act 2015* repealed sections 251 and 253 so *'that a carer or relative does not become a named person by virtue of those sections if the patient does not nominate a named person. Therefore a patient aged 16 or over will only have a named person if they choose one'.*[61]

Introducing the concept of a 'nominated person' represented a 'significant [advancement]'[62] in the role and rights of carers contributing to a person's journey to recovery and has since been implemented in contemporary Australian mental health legislation.

Other jurisdictions

Queensland

Nominated support persons are recognised in the *Mental Health Act 2016* (QLD) and are intrinsically linked to the person-centred planning and human rights approach. Section 25 of the Act provides that is the right of the patient to nominate one or two support persons in the event they become an involuntary patient.

The purpose of the nominated support person is to support the consumer in their care and treatment if they are, or become, an involuntary patient. Nominated support persons are afforded a number of important rights under the legislation, including:

- receiving all notices required to be given to the patient under the legislation
- discussing confidential information with the treating team
- providing support or represent the patient at Tribunal hearings

The legislative provisions are supported by a 'Guide and form for appointing a nominated support person'[63] that provides information about appointing a nominated person under the *Mental Health Act 2016* (QLD).

In April 2019, the Queensland Government released the *Evaluation of the Mental Health Act 2016 implementation report*. The Evaluation Report recorded that as of 30 June 2018, 13% of involuntary patients had one or more nominated persons appointed. This was a 2% decrease from the rate of involuntary patients with the former 'allied person' recorded in 2017. However, the Evaluation Report acknowledged that the new nominated support person process left a gap for patients with long term loss of capacity:

Additionally, the introduction of the need for a patient to have capacity to appoint a [nominated support person] (a reform aimed at strengthening patient rights) contrasts with the previous requirement under the [Mental Health Act] 2000 for an administrator to appoint an allied person if one was not already appointed, and the administrator is satisfied a patient did not, at the time, have capacity to appoint one…Stakeholders indicated that the requirement for capacity was a barrier to a [nominated support person] being appointed for patients. [64]

The report noted that uptake would continue to be monitored by the Chief Psychiatrist and that numbers were expected to grow as patients gain capacity to appoint a nominated support person and as awareness grew about the role.

South Australia

The *Mental Health Act 2009* (SA) recognises the importance of carers, relatives and friends as participants in the treatment, care and recovery of people with a mental health problem and sets an expectation that a guardian, medical agent, carer, relative or friend will be involved in treatment and care planning when someone is subject to an involuntary order.

A nominated person in South Australia:

- receives a copy of all involuntary orders that are made, varied or revoked by psychiatrists or authorised medical practitioners
- receives a copy of the statement of the patient's rights
- is allowed to lodge applications for community treatment orders, review of orders and appeal against decision
- acknowledges the right to seek contact with a community visitor who visits the treatment centre.

The South Australian legislation allows for the sharing of personal information between mental health professionals and carers provided that this is in the best interests of the patient. If the patient is under an order, information that is reasonably required for the care, treatment or rehabilitation of the patient can be shared without the patient's consent.

Victoria

Victoria establishes the process of being a nominated person under sections 24-27 of the *Mental Health Act 2014* (Vic). Under the legislation, a consumer can nominate a person to receive information and provide them with support in the event they become unwell and require involuntary treatment.

Any person can be nominated provided they are willing to do so and are able to fulfil the functions and responsibilities of the role. There is no age restriction on who may nominate or who may be nominated. For example, a consumer may nominate their teenage child who normally provides care or support. The nomination is accepted, as long as they are willing, available and able to fulfil the role.

A nominated person will be informed 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 patient's right to communicate is restricted
- a restrictive intervention is used on a person
- a patient is absent without leave from a designated mental health service
- the authorised psychiatrist grants, varies or revokes a patient a 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 patient'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
- the Mental Health Tribunal lists a matter for hearing
- the Mental Health Tribunal grants or refuses to grant an application for the performance of electroconvulsive treatment

The obligation to notify the nominated person is to the extent that is reasonable in the circumstances.

Western Australia

The role of a nominated person is established in the *Mental Health Act 2014* (WA) under section 263:

The role of a nominated person is to assist the person who made the nomination by ensuring that, in performing a function under this Act in relation to that person, a person or body —

(a). observes that person's rights under this Act; and

(b). takes that person's interests and wishes into account.

A nominated person is entitled to receive information about a person's treatment and care and be involved in matters relating to their care. To avoid doubt, section 266(3) makes clear that the nomination does not authorise a nominated person to apply on the patient's behalf for admission or discharge or make a treatment decision about the provision of treatment (unless authorised to do so in another capacity, for example, as their guardian).

The nominated person is afforded the same rights as the person's carer or close family members. There is no age limit on consumers to nominate a nominated person, however only adults are eligible to be a nominated person. A person cannot have more than one nominated person. The nomination can be revoked, or a nominated person may resign from their role.

A patient's psychiatrist must ensure that the nominated person is provided with the relevant information, however, if the psychiatrist reasonably believes the disclosure of information to the nominated person is not in their patient's interest, they may not provide that information. A record of the decision, including reasons, must be filed and a copy must be provided to the patient and the Chief Mental Health Advocate.

2.3 Cultural security

Current approach

The *MHRS Act* contains provisions that require practitioners to have regard to preserving the cultural security of a consumer or patient that identifies as Aboriginal. The Act is to be interpreted and a power or function conferred or imposed by the Act is to be exercised or performed so that:

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.[65]

When providing treatment and care to an Aboriginal person, the following principles apply:

(a). as far as possible, the person's treatment and care is 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.

(b). if the person is an Aboriginal or Torres Strait Islander person, the involuntary treatment is, where possible, to be provided in collaboration with an Aboriginal and Torres Strait Islander health practitioner.[66]

A relationship that arises through 'Aboriginal customary law or tradition' is recognised when determining who is considered a 'relative' of a person (for the purposes of defining someone's primary carer).[67]

The legislation provides a number of sections that references the use of an interpreter if a person is unable to communicate adequately in English but who can communicate adequately in another language:

- A person who is unable to communicate adequately in English but who is able to communicate adequately in another language is to be assisted, as far as is practicable, by a competent interpreter when obtaining informed consent – section 7(5)
- The *MHRS Act* is to be interpreted and a power or function conferred or imposed by the Act is to be exercised or performed so that a person who has a mental illness who needs language, interpreter, advocacy, legal or other services to assist them in communicating, has access to those services – section 8(f)
- In the circumstances where a person is admitted to an approved treatment facility or if a community management order is made for the person, information in relation to the admission or order 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 – section 87(2)
- NTCAT must permit a person who is the subject of a review or involuntary detention application to have access to an interpreter to assist the person to prepare for the hearing and to assist the person at the hearing where the person does not speak English to a level that will enable the person to under the proceedings – section 134(2)

Discussion

Cultural security is a commitment to the principle that the construct and provision of services offered by the 'health system will not compromise the legitimate cultural rights, values and expectations of Aboriginal people'.[68] *Cultural security refers to the embedded structures, policies, workforce attributes and other elements required to enable health consumers to experience cultural security.* ***Northern Territory Health Aboriginal Cultural Security Framework 2016 - 2026.***

A commitment to cultural security means building a system where Aboriginal people feel safe, secure and able to participate as staff and consumers of NT Health, including mental health services, without fear of judgement or discrimination.[69]

The barriers to Aboriginal people accessing mental health services include:

- diagnostic standards reflect Western culture context[70]
- 'ethnocentric' and 'monocultural' nature service delivery[71]

- shame and stigma associated with mental ill-health[72]
- mental health services provided in isolation not connected to 'holistic' Aboriginal approach of social and emotional wellbeing[73]
- reluctance to seek help, particular by Aboriginal youth[74]
- past experiences of racism, discrimination or lack of respect and understanding of culture within mainstream health[75]
- 'general cultural insensitivity, including a lack of awareness that many Aboriginal families fear their children will be taken from them, which can make them wary and reluctant to seek help for a mental health problem.'[76]

Barriers in relation to culturally secure provision of mental health services to Aboriginal people include:

- limited co-ordination and collaboration between services or with the mental health service and the community and families[77]
- lack of Aboriginal Mental Health Workers[78]
- lack of accessibility to mental health services in remote regions[79]
- lack of accessibility and use of interpreters[80]
- limited or no recognition of unique trauma experienced by Aboriginal communities[81]

The National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023 reaffirmed the following nine principles:

(1). Aboriginal and Torres Strait Islander health is viewed in a holistic context that encompasses mental health and physical cultural and spiritual health. Land is central to wellbeing. Crucially, it must be understood that when the harmony of those interrelations is disrupted, Aboriginal and Torres Strait Islander ill health will persist.

(2). Self-determination is central to the provision of Aboriginal and Torres Strait Island health services.

(3). Culturally valid understandings must shape the provision of services and must guide assessment, care and management of Aboriginal Torres Strait Islander people's health problems generally, and mental health problems, in particular.

(4). It must be recognised that the experiences of trauma and loss are a direct outcome of the disruption to cultural wellbeing. Trauma and loss of this magnitude continues to have inter-generational effects.

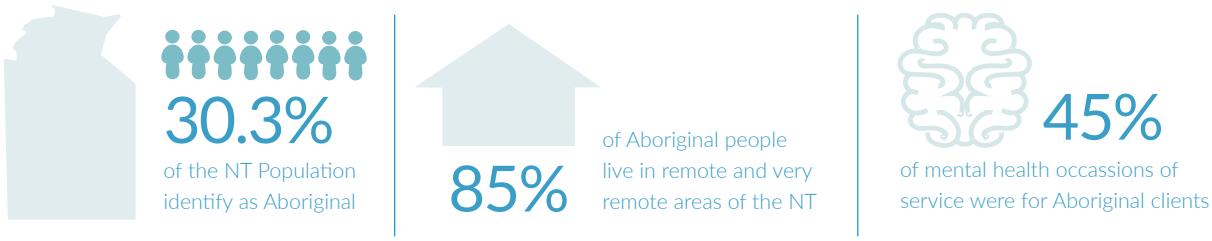
(5). The human rights of Aboriginal and Torres Strait Islander people must be recognised and respected. Failure to respect these human rights constitutes continuous disruption to mental health. Human rights relevant to mental illness must be specifically addressed.

(6). Racism, stigma, environmental adversity and social disadvantage constitute ongoing stressors and have negative impacts on Aboriginal and Torres Strait Islander peoples' mental health and wellbeing.

(7). *The centrality of Aboriginal and Torres Strait Islander family and kinship must be recognised as well as the broader concepts of family and the bonds of reciprocal affection, responsibility and sharing.*

(8). *There is no single Aboriginal or Torres Strait Islander culture or group, but numerous groupings, languages, kinships and tribes, as well as ways of living. Furthermore, Aboriginal and Torres Strait Islander people may currently live in urban, rural or remote settings, in traditional or other lifestyles, and frequently move between these ways of living.*

(9). *It must be recognised that Aboriginal and Torres Strait Islander people have great strengths, creativity and endurance and a deep understanding of the relationship between human beings and their environment.*



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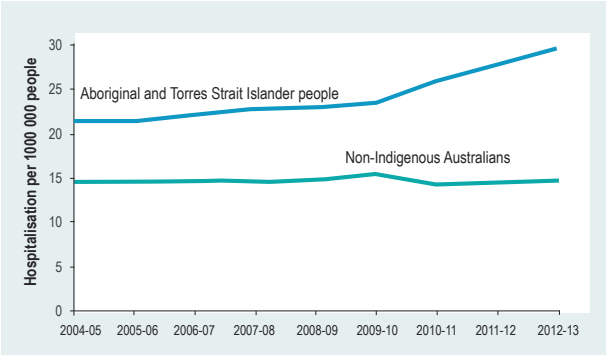

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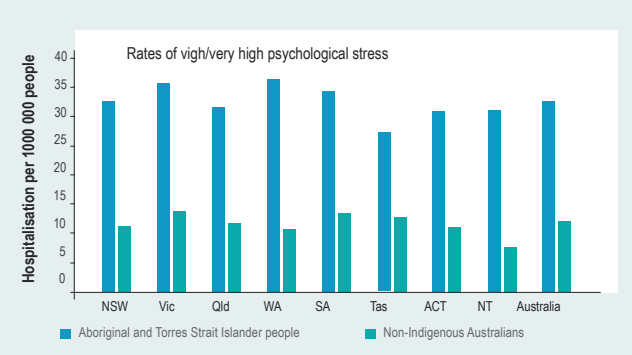
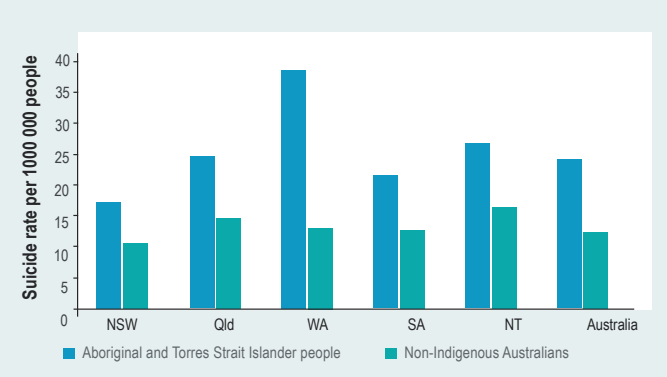


The NT has the highest per capita population of Aboriginal people in Australia, accounting for 30.3% of the NT population.[84] The majority of Aboriginal people, 85%, live in remote and very remote areas.[85] In 2018/19, NT Health provided mental health occasions of services to a total 7,914 clients. Of those occasions, 3,603 (45%) were for clients who identified as Aboriginal.[86]

Aboriginal people are overrepresented within the mental health system and in particular, overrepresented in acute mental health services.[87] The two graphs above illustrate the rate of hospitalisation and psychological distress experiences by Aboriginal people, compared to non-Aboriginal people.

The NT has the highest per capita rates of suicide for Aboriginal people in the country. National data shows that suicide rates of Aboriginal people are more than double that of non-Aboriginal population, with young males and those in regional communities particularly at risk.[88]

(89)



The *Northern Territory Suicide Prevention Strategic Framework 2018-2023* contains the strategy to reduce the Territory's suicide rate by half over the next ten years. It outlines the three priority areas for focus:

(1). Building stronger communities that have increased capacity to respond to and prevent suicidal behaviour through raising awareness and reducing stigma

(2). Informed, inclusive services that provide timely, integrated, compassionate and culturally safe responses that meet the diverse needs of people across the Territory

(3). Focused and evidence-informed support for the most vulnerable groups of people.

On 16 November 2020, the Productivity Commission publicly released the final report for the inquiry into Mental Health. The report found a disproportionate prevalence of mental ill-health in Aboriginal people. Findings included that Aboriginal people:

- have a higher rate of mental ill-health compared to other Australians[90]
- are twice as likely to be hospitalised for mental illness[91]
- are twice as likely as non-Indigenous people to die by suicide[92]

The Productivity Commission's report emphasises the unique risk factors experienced by Aboriginal people that can increase their likelihood of mental ill health, including: intergenerational trauma; racism and discrimination; and disadvantage and social exclusion.[93] The Productivity Commission also reports that Aboriginal people who are experiencing mental ill-health find it more difficult to access culturally sensitive and appropriate health services.[94]

NT Health supports increased access to services and equity of outcomes for Aboriginal people. Providing a culturally secure, safe and trauma informed care focused on recovery is a priority under the *NT Mental Health Strategic Plan 2019-2025*. The *NT Health Aboriginal Cultural Security Policy* acknowledges the important role the NT has to play in setting appropriate standards for cultural security in health care and the demonstrated benefits to be gained through the delivery of culturally secure services.[95] All NT public health system staff must adhere to the *Northern Territory Health Aboriginal Cultural Security Policy* and the *Northern Territory Health Aboriginal Cultural Security Framework 2016 – 2026* (The Framework) that focuses on the centrality of culture in optimising health care, by enabling effective communication, and supporting consumer engagement, and supporting consumer empowerment and self-management.[96] The Framework aims to guide NT Health staff in better understanding the concept of cultural security and provides guidance across the six domains, or priorities, of cultural security that includes:

- Workforce
- Communication
- Whole of organisation approach
- Leadership
- Consumer and community participation
- Quality improvement, planning, research and evaluation.

International law

In 2007 the United Nations released the *United Nations Declaration on the Rights of Indigenous Peoples* which outlines at Article 7: 'Indigenous individuals have the rights to life, physical and mental integrity, liberty and security of the person'. Culture and cultural identity are recognised by the UN Declaration as being critical to social and emotional wellbeing, and is therefore critically important in the delivery of health services.[97]

Other jurisdictions

South Australia

There are numerous Aboriginal communities across South Australia, with the Aboriginal population concentrated in metropolitan Adelaide (approximately 51%) and the remaining living in regional South Australia.[98] Under section 7(ca)(iv) of the *Mental Health Act 2009* (SA), when providing care or treatment to an Aboriginal person, mental health services should take into account *'the persons' traditional beliefs and practices and, when practicable and appropriate, involve collaboration with health workers and traditional healers from their communities'.*

In the South Australian Aboriginal Health Survey, 68.1% of respondents reported speaking some words of an Aboriginal language at home.[99] Section 45(1) of the *Mental Health Act 2009* (SA) stipulates that an interpreter 'must' be arranged by a medical practitioner or authorised mental health professional if they intend to examine a person who is unable to communicate adequately in English, but could communicate adequately with the assistance of an interpreter. The exception to this rule at section 45(2):

(2) Subsection (1) does not apply—

(a). to an examination following which a level 1 community treatment order or level 1 inpatient treatment order may be made unless the assistance of an interpreter can be readily arranged by the medical practitioner or authorised mental health professional in the circumstances; or

(b). if the medical practitioner or authorised mental health professional and the person can communicate adequately in a language other than English.

Queensland

Aboriginal people make up 4.3% of the Queensland population, with most living in regional centres (51.4%) and major cities (31.8%). 16.9% of the Queensland Aboriginal population live in remote and very remote areas. Mental illness is the highest contributor to Aboriginal burden of disease in Queensland.[100]

The *Mental Health Act 2016* (QLD) recognises under section 5(g) the following considerations as guiding principles for the interpretation of the Act:

- *the unique cultural, communication and other needs of Aboriginal people and Torres Strait Islanders must be recognised and taken into account*
- *Aboriginal people and Torres Strait Islanders should be provided with treatment, care and support in a way that recognises and is consistent with Aboriginal*

tradition or Island custom, mental health and social and emotional wellbeing, and is culturally appropriate and respectful

- *to the extent practicable and appropriate in the circumstances, communication with Aboriginal people and Torres Strait Islanders is to be assisted by an interpreter.*

Western Australia

Aboriginal Health, a state-wide office within the Western Australian Government's Department of Health Western Australian Government, report on their website that Aboriginal people make up 3.8% of the Western Australian population, and yet have the greatest health needs of any group in the State.[101]

The *Mental Health Act 2014* (WA) defines a 'traditional healer' under section 4:

...in relation to an Aboriginal or Torres Strait Islander community, means a person of Aboriginal or Torres Strait Islander descent who:

(a). uses traditional (including spiritual) methods of healing; and

(b). is recognised by the community as a traditional healer.

Schedule 1 of the Mental Health Act 2014 (WA) — Charter of Mental Health Care Principles includes under Principle 7: People of Aboriginal or Torres Strait Islander descent:

'A mental health service must provide treatment and care to people of Aboriginal or Torres Strait Islander descent that is appropriate to, and consistent with, their cultural and spiritual beliefs and practices and having regard to the views of their families and, to the extent that it is practicable and appropriate to do so, the views of significant members of their communities, including elders and traditional healers, and Aboriginal or Torres Strait Islander mental health workers.'

Sections 50, 81 and 189 relate to the assessment, examination and provision of treatment to patient of Aboriginal or Torres Strait Islander descent that requires:

'To the extent that it is practicable and appropriate to do so, the assessment of a person who is of Aboriginal or Torres Strait Islander descent must be conducted in collaboration with —

(a). Aboriginal or Torres Strait Islander mental health workers; and

(b). significant members of the person's community, including elders and traditional healers.

Further, section 9 provides that communication with a person under the Act, must be in a language, form of communication and terms that the person is likely to understand using any means of communication that is practicable and using an interpreter if necessary and practicable.

Part Three:

Admission and Treatment

...the person is to be provided with timely and high quality treatment and care in accordance with professionally accepted standards.

Part Three: Admission and Treatment

Consider for your submission:

- What do you think about the current process of assessment and examination for involuntary admission?
- What are your thoughts about the process to involuntarily admit somebody on the grounds of mental illness, or mental disturbance or complex cognitive impairment?
- Do you have any feedback on the current voluntary admission process?
- What do you think about the current power of Police to apprehend a person in order to take them to be assessed?
- What do you think about the current approach under the *MHRS Act* that grants leave to involuntary patients?
- What do you think about regulating the power to search someone and seize property under the *MHRS Act*?

Introduction

The *MHRS Act* covers the admission of voluntary consumers and involuntary patients under a number of sections in the legislation.

From the outset, section 9 sets out the principles relating to provision of treatment and care:

(a). the person is to be provided with timely and high quality treatment and care in accordance with professionally accepted standards

(b). where possible, the person is to be treated in the community

(c). 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

(d). the person is to be provided with appropriate and comprehensive information about

(i) the person's mental illness, mental disturbance or complex cognitive impairment, and

(ii) proposed and alternative treatment and services available to meet the person's needs

(e). where possible, the person is to be treated near where he or she ordinarily resides or where relatives or friends of the person reside

(f). 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

(g). as far as possible, the person is to be involved in the development of any ongoing treatment plan or any discharge planning

(h). the person is to be given medication only for therapeutic or diagnostic purposes and not as a punishment or for the convenience of others

(j). except as provided by this Act, the person is not to be given treatment without his or her consent

(k). the person's treatment is to be carried out, wherever practicable, within a multi-disciplinary framework

(m). 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

(n). 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

(p). 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.

3.1 Involuntary admission

Section 10 of the *MHRS Act* lists the principles relating to involuntary admission and treatment. When admitting and treating a person as an involuntary patient the following principles apply:

- the person should only be admitted after every effort to avoid the person being admitted as an involuntary patient has been taken;[102]
- where the person needs to be taken to an approved treatment facility or into custody for assessment, the assistance of a police officer is to be sought only as a last resort and there is no other means of taking the person to the approved treatment facility or into custody;[103]
- involuntary treatment is to be for a brief period, reviewed regularly and is to cease as soon as the person no longer meets the criteria for involuntary admission on the grounds of mental illness, mental disturbance or complex cognitive impairment;[104]
- where the person is from a non-English speaking background, involuntary treatment is, where possible, to be provided by health service providers who are from the same non-English speaking background.[105]

A person can be admitted to an approved treatment facility or an approved treatment agency on an involuntary basis under three different grounds – mental illness, mental disturbance or complex cognitive impairment. Each criteria for the different grounds is outlined in Part 3 of the Act.

The legislative process for examination is illustrated below but can be summarised as:

(1). The person is brought before a medical practitioner, an authorised psychiatric practitioner or a designated mental health practitioner for an **assessment**

(2). The practitioner will assess the person and may recommend that they require an **examination**

(3). The person is **examined** and an authorised psychiatric practitioner (one who did not make the assessment) will make a recommendation on what to do next.

Flow chart 1. **Legislative process for examination**

How does a person get an assessment?

An assessment may be requested

Who can request an assessment?

- You can
- Someone with a real concern for your health or welfare

Apprehension by Police

A police officer may apprehend you and take you to be assessed if they believe on reasonable grounds that:

- you may require treatment or care because of how you appear or how you are behaving
- you are likely to cause serious harm to yourself or to someone else
- they cannot to seek assistance from someone who can undertake an assessment

Who can undertake the assessment?

- A medical practitioner
- Authorised psychiatric practitioner
- Designated mental health practitioner

However, they may decline to assess you if they think you don't need treatment.

If the practitioner does agree to make the assessment:

They must assess and determine whether you need treatment under the Act as soon as possible.

The practitioner makes an assessment

What happens now?

If the practitioner is satisfied you fulfil the criteria for involuntary admission, the practitioner will make a recommendation for a psychiatric examination.

What does that mean?

The recommendation authorises the practitioner or a paramedic to bring you to an approved treatment facility to undergo a **psychiatric examination.**

- If you don't want to go, they are allowed to assert some control over you to take you there
- If you can't be taken to the approved treatment facility immediately, you may have to stay at another hospital until they have room
- Someone at the hospital may administer treatment, without the approval of NTCAT but only if
  - they believe you might hurt yourself or someone else
  - that your behaviour is putting yourself or another person in danger
  - to prevent you getting very sick

You may have to stay at the treatment facility for up to 24 hours and you may not be allowed to leave

The psychiatric examination

Once you are taken to an approved treatment facility, you must be examined by an authorised psychiatric practitioner. The authorised psychiatric practitioner will decide if you need treatment and what to do next.

After an examination, an authorised psychiatric practitioner has four choices

You fulfil the criteria for involuntary admission on the grounds of **mental illness**	You fulfil the criteria for involuntary admission on the grounds of **mental disturbance**	You fulfil the criteria for involuntary treatment **in the community**	**You don't fulfil criteria for involuntary admission**
You must be admitted to the facility as an involuntary patient.	You must be admitted to the facility as an involuntary patient.	The practitioner will make an order for compulsory treatment outside of the facility until NTCAT looks at your case. You do not have to be admitted.	The practitioner must let you leave the facility.

Involuntary admission on the grounds of mental illness

Criteria

Under section 14, the criteria for the involuntary admission of a person the grounds of mental illness are that:

(a). The person has a mental illness and,

(b). as a result of the mental illness;

(i) the person requires treatment that is available at an approved treatment facility; and

(ii) without that treatment, the person is likely to either:

A. Cause serious harm to themselves or to someone else, or

B. Suffer serious mental or physical deterioration; and

(iii). The person is not capable of giving informed consent to the treatment or has unreasonably refused to consent to the treatment; and

(c). There is no less restrictive means of ensuring that the person receives the treatment.

Admission

After being examined to be admitted on these grounds, the person may be detained at an approved treatment facility under section 39 for either:

- up to 24 hours, and they must be examined by an authorised psychiatric practitioner in that time
- for up to 14 days after a recommendation for psychiatric examination.

In the instance a person is being held for 24 hours before their examination, the practitioner must inform the Principal Community Visitor and NTCAT that the person is being detained under section 39(1)(b) or 39(3)(a).

After the psychiatric examination, if the authorised psychiatric practitioner believes that the person fulfils the criteria for involuntary admission, the practitioner may detain the person at the approved treatment facility for up to 14 days after the examination.

If the authorised psychiatric practitioner believes the person does not fulfil the criteria for involuntary admission, the authorised psychiatric practitioner must discharge the person as an involuntary patient.

Review

A person admitted as an involuntary patient must be examined by an authorised psychiatric practitioner every 72 hours. If they no longer meet the criteria for involuntary admission, the person must be discharged.

Notification

After someone is detained at an approved treatment facility, a practitioner must notify the following people under section 41:

(i). the person;

(ii). the person's adult guardian;

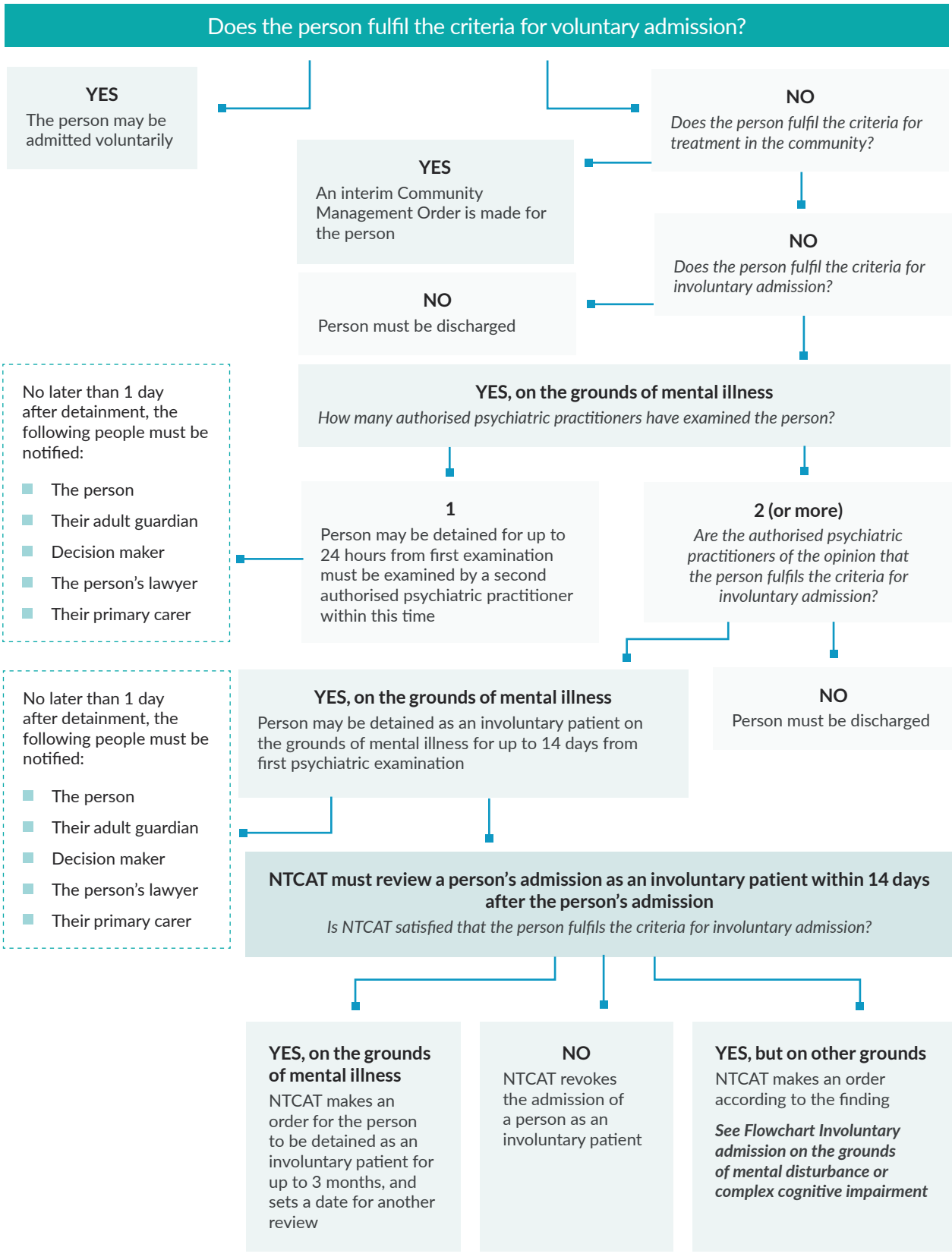
(iii). if the person has a decision maker – the decision maker;

(iv). a legal practitioner acting or prepared to act for the person;

(v). the person's primary carer.

The practitioner may decide not to notify the patient's primary carer if it is not in the patient's best interests. If this is the case, the practitioner must provide a written report to NTCAT explaining their decision and reasons why.

Flow chart 2. Involuntary admission on the grounds of mental illness



Involuntary admission on the grounds of mental disturbance

Criteria

Section 15 sets out the criteria for the involuntary admission of a person on the grounds of mental disturbance as follows:

(a). the person does not fulfil the criteria for involuntary admission on the grounds of mental illness or complex cognitive impairment; and

(b). the person's behaviour is, or within the immediately preceding 48 hours has been, so irrational as to lead to the conclusion that:

(i) the person is experiencing or exhibiting a severe impairment of or deviation from his or her customary or everyday ability to reason and function in a socially acceptable and culturally appropriate manner; and

(i) the person is behaving in an abnormally aggressive manner or is engaging in seriously irresponsible conduct that justify a determination that the person requires psychiatric assessment, treatment and care that is available at an approved treatment facility; and

(c). unless the person receives treatment and care at an approved treatment facility, he or she:

(i) is likely to cause serious harm to himself or herself or to someone else; or

(ii) will represent a substantial danger to the general community; or

(iii) is likely to suffer serious mental or physical deterioration; and

(d). the person is not capable of giving informed consent to the treatment and care or has unreasonably refused to consent to the treatment and care; and

(e). there is no less restrictive means of ensuring that the person receives the treatment and care.

Admission

The admission process for a person admitted as an involuntary patient on the grounds of mental disturbance is outlined in section 42. The person admitted on these grounds may be detained for up to 72 hours at the approved treatment facility.

The person may be detained for a further period of up to 7 days if 2 authorised psychiatric practitioners are satisfied that if the person:

(1). is not capable of giving informed consent to treatment or care, or has unreasonably refused to give consent under section 42(2)(a)(b), and

(2). there is no less restrictive way of ensuring the person receives the treatment or care, and

(3). if released and did not receive treatment under the Act, the practitioners are satisfied that the person will either:

- cause serious harm to themselves or others or
- represent a substantial danger to the community or
- they are likely to suffer serious physical or mental deterioration

Review

If a person has been detained for 72 hours under section 42(1), an authorised psychiatric practitioner must examine the person not less than once every 24 hours.

If the person is being detained for a further 7 days under section 42(2), an authorised psychiatric practitioner must examine the person no less than every 72 hours.

After the examinations, under section 44(2), (2A) and (2B) the practitioner has the following options:

- if the person continues to fulfil the criteria for involuntary admission on the grounds of mental disturbance, the practitioner must continue to detain the person
- if the person fulfils the criteria for involuntary admission on the grounds of mental illness, they must admit them on those grounds
- if the person fulfils the criteria for involuntary admission on the grounds of complex cognitive impairment, they must:
  - continue to detain the person under section 42(1); and
  - notify an authorised officer within one day after the examination
- if the person fulfils the criteria for involuntary treatment in the community, the practitioner must make an interim community management order for the person;

After the examination, the practitioner may continue to detain the person if satisfied that the person;

(1). is not capable of giving informed consent to treatment or care, or has unreasonably refused to give consent, and

(2). there is no less restrictive way of ensuring the person receives the treatment or care, and

(3). if released and did not receive treatment under the Act, the practitioners are satisfied that the person will either:

- cause serious harm to themselves or others or
- represent a substantial danger to the community or
- they likely to suffer serious physical or mental deterioration

If the person does not fulfil the criteria for involuntary admission or treatment, the practitioner must release the person. If an authorised psychiatric practitioner considers that person upon release may cause serious harm to someone else on release, the practitioner must, at least 12 hours before the person's release, notify the Police Commissioner and (if practicable) the person who may be in danger.

Notification

A practitioner must notify the following people no later than one day after the involuntary patient has been admitted on the grounds of mental disturbance:

(i) the person;

(ii) the person's adult guardian;

(iii) if the person has a decision maker – the decision maker;

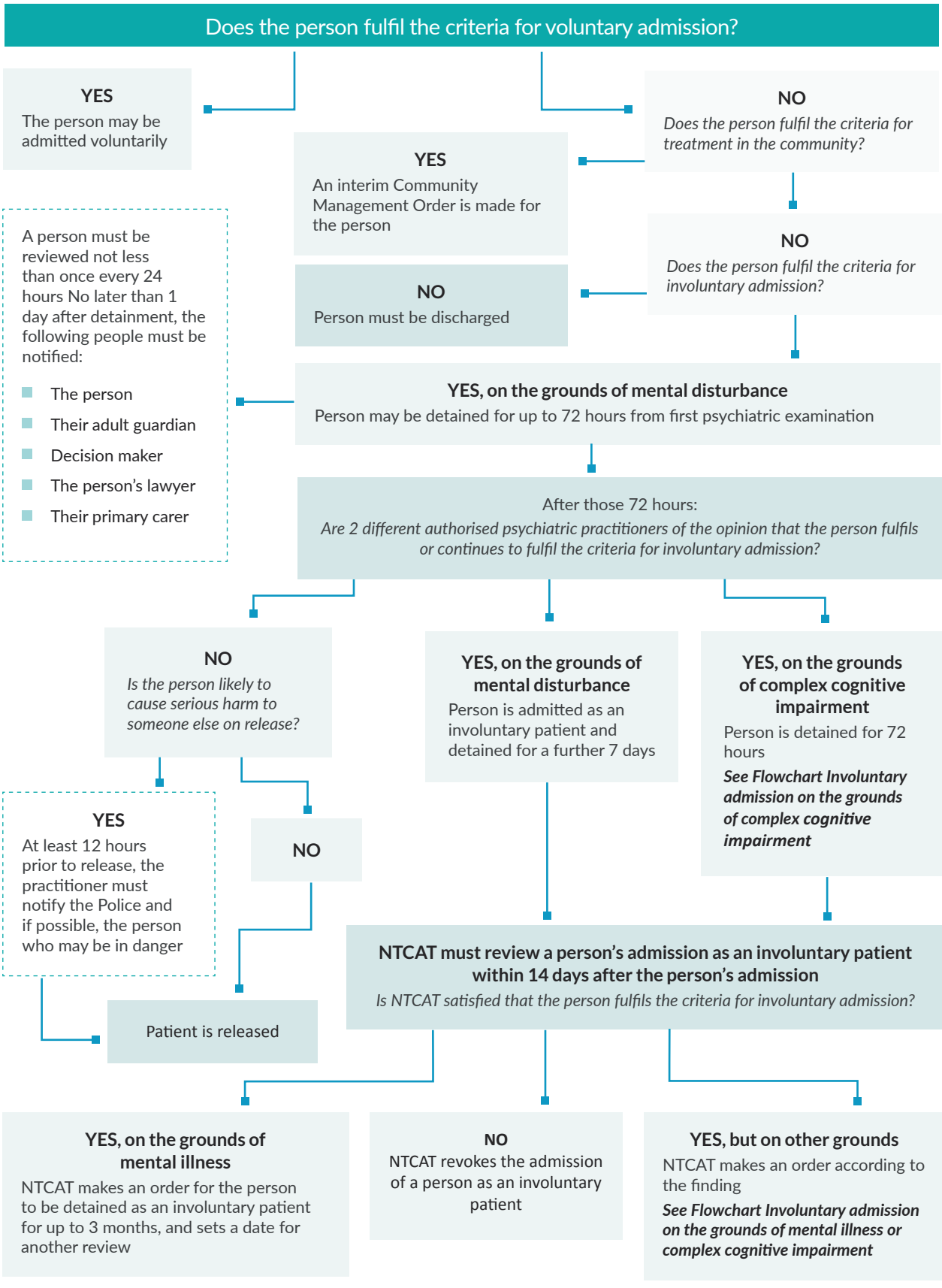
(iv) a legal practitioner acting or prepared to act for the person;

(v) the person's primary carer;

The practitioner may decide not to notify the person's primary carer if they believe it would not be in the patient's best interests to do so. If this is the case, they must provide a written report to NTCAT explaining their decision and reasons why.

In the event the person has been detained for a further 7 days, the practitioner must then notify the principal community visitor and NTCAT.

Flow chart 3. Involuntary admission on the grounds of mental disturbance



Involuntary admission on the grounds of complex cognitive impairment

Criteria

The criteria for the involuntary admission of a person on the grounds of complex cognitive impairment are:

(a). the person is an adult who does not fulfil the criteria for involuntary admission on the grounds of mental illness or mental disturbance; and

(b) the person has significant cognitive impairment; and

(c) unless the person receives treatment and care at an approved treatment facility, the person:

(i) is likely to cause serious harm to himself or herself or to someone else; or

(ii) will represent a substantial danger to the general community; or

(iii) is likely to suffer serious mental or physical deterioration; and

(d) the person is likely to benefit from the treatment and care; and

(e) the person is not capable of giving informed consent to the treatment and care; and

(f) there is no less restrictive way of ensuring the person receives the treatment and care.

Admission

If an authorised psychiatric practitioner and authorised officer form the opinion that a person fulfils the criteria for involuntary admission on the grounds of complex cognitive impairment, as soon as practicable after forming the opinion, the practitioner and officer must apply to NTCAT for an order for the person's involuntary admission on those grounds.

Under section 44C, when a person is an existing involuntary patient (i.e. they have been admitted on the grounds of mental disturbance), the practitioner and officer must apply to NTCAT before the date required to review the patient's admission on those grounds they were originally admitted. This date is called the 'review date'. The applicants must prepare and lodge with NTCAT a treatment management plan for the person and NTCAT must hear the application before the review date.

If the NTCAT decides the person fulfils the criteria for involuntary admission on the grounds of complex cognitive impairment, NTCAT must order:

- the person to be admitted and detained in an approved treatment facility as an involuntary patient on those grounds and
- that the treatment management plan (either as presented or modified by NTCAT) be implemented.

Otherwise, under section 44E(2), NTCAT must dismiss the application.

If:

- the person is an existing involuntary patient and
- NTCAT dismisses the application and
- NTCAT does not make any further order for the person to be detained as an involuntary patient on the original grounds

the person in charge of the approved treatment facility must release the person no later than 48 hours after the order was made.

Notification

Within one day of making the application to NTCAT, the applicant must give written notice to the following:

(i) the person;

(ii) the person's adult guardian;

(iii) if the person has a decision maker – the decision maker;

(iv) a legal practitioner acting or prepared to act for the person;

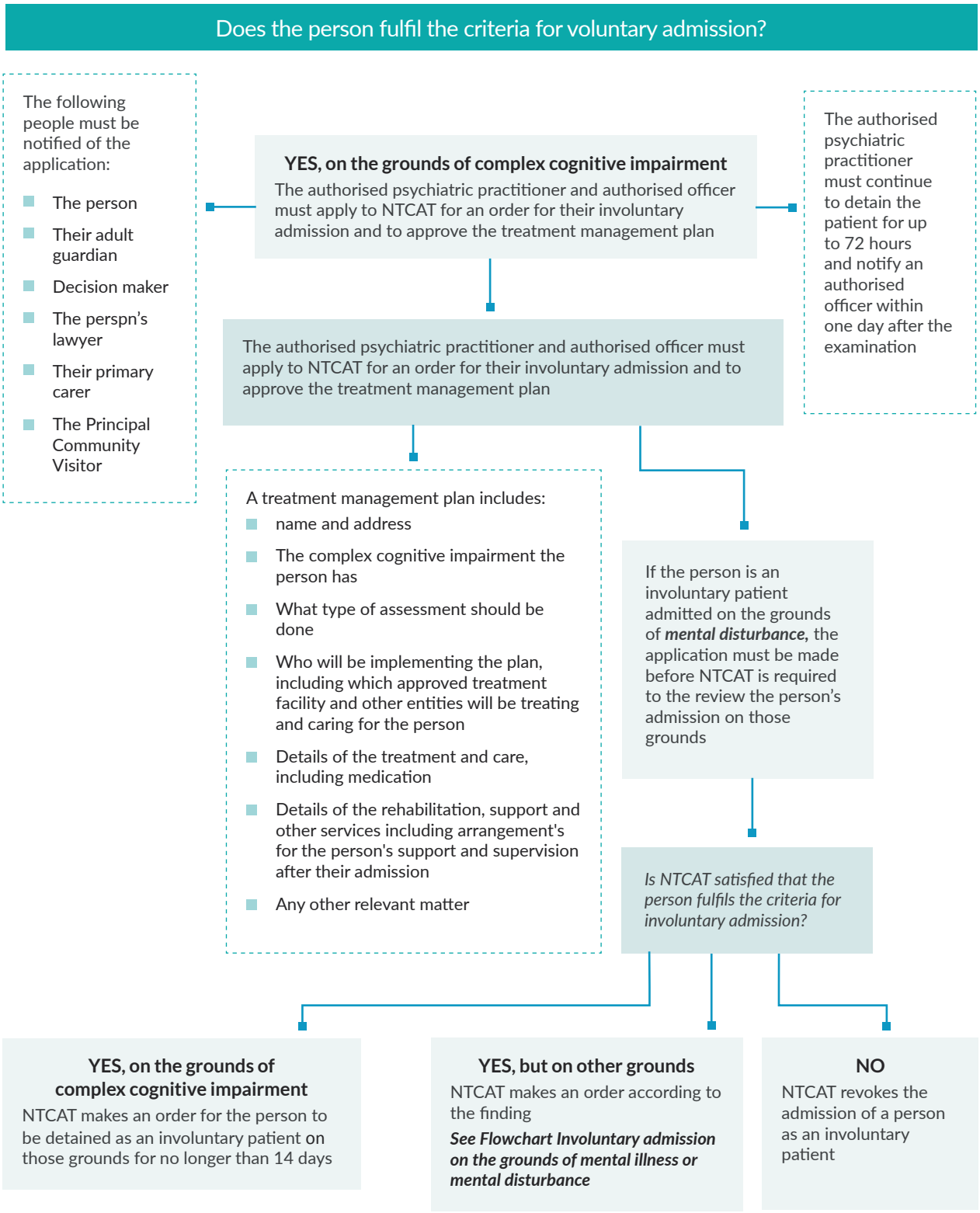
(v) the principal community visitor.

The practitioner does not need to notify the involuntary patient's primary carer if they believe it would not be in the patient's best interests to do so. If this is the case, they must specify reasons why in their application.

Review

Under section 44G, an authorised psychiatric practitioner must examine the person not less than once every 72 hours after NTCAT makes the order for the person's admission and detention on the grounds of complex cognitive impairment.

Flow chart 4. Involuntary admission on the grounds of complex cognitive impairment



Other jurisdictions

Western Australia

Under section 24 of the *Mental Health Act 2014* (WA), the making of involuntary treatment orders can only be made by a psychiatrist. A psychiatrist cannot make an inpatient treatment order in respect of a person unless satisfied, having regard to the criteria specified in section 25(1) of the legislation, that the person is in need of an inpatient treatment order.

The psychiatrist must, before deciding whether or not to make an inpatient treatment order in respect of a person, consider whether the objects of the Act would be better achieved by making a community treatment order in respect of the person.

Section 25 provides the criteria for involuntary treatment order. A person is in need of an inpatient treatment order only if all of these criteria are satisfied —

(a). that the person has a mental illness for which the person is in need of treatment;

(b). that, because of the mental illness, there is —

(i) a significant risk to the health or safety of the person or to the safety of another person; or

(ii) a significant risk of serious harm to the person or to another person;

(c). that the person does not demonstrate the capacity required by section 18 to make a treatment decision about the provision of the treatment to himself or herself;

(i) that treatment in the community cannot reasonably be provided to the person;

(ii) that the person cannot be adequately provided with treatment in a way that would involve less restriction on the person's freedom of choice and movement than making an inpatient treatment order.

A decision whether or not a person is in need of an inpatient treatment order or a community treatment order must be made having regard to the guidelines published under section 547. These guidelines must be published by the Chief Psychiatrist for the purpose of making decisions about whether or not a person is in need of an inpatient treatment order or a community treatment order under subsection 547(1)(a).

Queensland

Under section 301(1)(b) of the *Mental Health Act 2016* (QLD), the Chief Psychiatrist has the function of to the extent practicable, to ensure the involuntary examination, assessment, treatment, care and detention of persons complies with the Act.

The Chief Psychiatrist has developed specific policies that an authorised doctor, AMHP, AMHS administrator, or other person performing a function or exercising a power under the Act must comply with that include:

- **Chief Psychiatrist Policy** – Examination and assessment
- **Chief Psychiatrist Policy** – Treatment Criteria, Assessment of Capacity and Less Restrictive way of Treatment.

An authorised doctor in making an assessment is required under section 43(4) to take reasonable steps to find out whether there is a less restrictive way for the person to receive treatment and care for the person's mental illness, including, for example, by searching the person's health records to find out whether the person has made an advance health directive or has a personal guardian.

Section 142 provides guidance to admission to high security unit stay of order if the Mental Health Court makes a forensic order for a person.

3.2 Voluntary admission

This relates to the ability for a person to have capacity and give informed consent, see section 1.2 of the Discussion paper.

Part 5 of the Act regulates voluntary admissions. A person's adult guardian or decision maker can make an application for the person to be admitted as a voluntary consumer under section 27. In those circumstances, the voluntary consumer must be examined by an authorised psychiatric practitioner no later than 24 hours after the application is made.

The authorised psychiatric practitioner must not admit the consumer under section 27(2) unless they are satisfied that:

- the person is willing to be admitted and
- the person does not fulfil the criteria for admission on the grounds of mental illness or mental disturbance and
- the person is likely to benefit from being admitted.

If these criteria are not made out, the examining practitioner must refuse to admit the person, inform the adult guardian or decision maker of the decision, and inform them of their review rights.

Flow chart 5. **Voluntary admission** (section 25)

Who can apply to be a voluntary patient?

- Anyone aged 14 years and over can apply to be admitted voluntarily
- Anyone under 18 years can have their parent or guardian apply to be admitted voluntarily

Is admission automatic?

No, admission is subject to a psychiatric examination

The authorised psychiatric practitioner determines whether you fit the criteria for voluntary admission, including capacity to give informed consent

Then what happens?

Another authorised psychiatric practitioner must carry out another examination no later than 72 hours after admission

After the examination, the practitioner has three choices:

Admission confirmed

Practitioner is satisfied that informed consent for voluntary admission and treatment has been given

Admission refused

The practitioner must inform the person why they are refusing admission. That person can apply to NTCAT to review the decision and the practitioner must explain how to do this

Admission to be reviewed

When the practitioner is unable to form the view that the person is giving informed consent, they can still confirm the admission but must apply to NTCAT to review the admission and determine capacity to give consent

Other jurisdictions

Western Australia

Under section 255 of the *Mental Health Act* 2014 (WA), a voluntary patient can only be admitted as an inpatient of an authorised hospital by a medical practitioner. Section 256 then requires that the admission of a voluntary patient as an inpatient of an authorised hospital must be confirmed by a psychiatrist.

Queensland

A person may access voluntary mental health services through admission to hospital within the Queensland health system. In some cases the severity of symptoms, their level of distress and risk of harm to either themselves or others, the person may require specialised treatment and be referred for assessment and admission to a mental health (psychiatric) inpatient unit, which is regulated under the *Mental Health Act* 2016 (QLD) (the QLD Act).

3.3 Youth

Current approach

The *MHRS Act* does not contain any definition for 'youth', a 'child' or an 'adolescent'. Rather, section 25 of the *MHRS Act* contains the following in relation to the voluntary admission of a person:

(1). A person who is 14 or over may apply to be admitted to an approved treatment facility as a voluntary patient.

(2). A parent or guardian of a person who is under 18 may apply to have the person admitted to an approved treatment facility as a voluntary patient.[106]

The admission of a person under 18 as a voluntary patient is further regulated under section 26 of the *MHRS Act* as follows:

(1). A person under 18 must not be admitted to an approved treatment facility as a voluntary patient unless the person can be cared for and treated.

(2). As soon as practicable after a person under 18 is admitted to an approved treatment facility as a voluntary patient, a practitioner must notify a parent or guardian of the person that the person has been so admitted.

(3). However, the practitioner may decide not to notify a parent or guardian of the person if the practitioner is of the opinion that giving the notification is not in the person's best interests.

(4). If the practitioner decides not to notify a parent or guardian of the person because of subsection (3), the practitioner must give to the Tribunal a written report of the decision and the reason for it in the approved form.

(5). A notification under subsection (2) may be given orally or in writing but must be in a language that can be understood by the reliever of the notification.

(6). If a practitioner believes, on reasonable grounds, the person has suffered or is suffering maltreatment, the practitioner must notify an authorised officer not later than 48 hours after the admission.

(7). A practitioner must make a record of each of the following in accordance with approved procedures:

(a). A notification under subsection (2);

(b). A decision under subsection (3) not to notify a parent or guardian of the person and the reasons for it;

(c). A notification to an authorised officer under subsection (6).[107]

Part 6 of the *MHRS Act* that regulates involuntary admissions includes reference to a 'person', without reference to age.

Case law

In the case of *Gillick v West Norfolk and Wisbech Area Health Authority & Anor* [1986],[108] the House of Lords in England established the principle that the child's parents can consent to the medical treatment of the child, however, this right is only valid until the child attains 'a sufficient understanding and intelligence to enable him or her to understand fully what is proposed' commonly referred to as 'the *Gillick* competency'.[109]

The *Gillick* competency applies in circumstances where the child has necessary understanding and intelligence to understand the nature of the treatment and appreciate its effects. Further, the Gillick competency alsoprovides that a parents ability to consent to medical treatment on behalf of a child reduces gradually as the child's capacities and maturity grows.

The *Gillick* competency was upheld in the Australian High Court in the case of *Secretary, Department of Health and Community Services (NT) v JWB and SMB* (1992)[110] (*Marion's Case).* In *Marion's Case*, the High Court considered the sterilisation of a young girl with an intellectual disability. The case acknowledged the unwillingness for courts to interfere with family privacy and autonomy, but also highlighted the complex balance between parents or family interests and the protection of the child's right to bodily integrity.[111]

In Marion's case the High Court acknowledged that the 'capacity of a child to give informed consent to medical treatment depends on the rate of development of each individual'.[112]

Discussion

Mental health legislation across Australia sets out the criteria for health practitioners to determine capacity of the person to make treatment decisions.[113] However, across Australia there are different approaches to assessment of capacity for children, which impacts on voluntary admission and consent to treatment.

An additional factor when considering the mental health treatment for a child is the consent of the parent, the authority that stems from a caring relationship and is implicitly understood to be the determination of what is best for the welfare of the child.[114] When this has been considered by the courts, it is accepted that a child or young person under 18 may make decisions about their own medical treatment if they are assessed as capable of understanding its significance.[115] This requires evaluation of the child's maturity and intelligence[116] when seeking consent and in doing so, the clinician must be satisfied that 'the child understands that there is a decision that needs to be made, that decision have consequences, that the child understands both the benefits and risks of treatment and the possible wider implications of the treatment'.[117]

The transition period between childhood mental health services and adult mental health is a vulnerable period.[118] The period of pre-adolescence through to the early adult years is a time of challenges and risks, and this is a period where mental illnesses may begin to present in a young person.[119] In the mental health setting, the transition of a person from child and adolescent mental health services to adult mental health services typically occurs between 18-21 years.[120] This aligns with traditional age boundaries of service provision that overlaps important development milestones for emerging adults.[121] During this transition period, young people may disengage from using mental health services at higher rates than other age groups.[122] Youth and transitional mental health services should recognise the importance of an individualised approach and the considers the unique experiences and also the universal pressures of entering adulthood.[123]

International law

A persons aged under 18 years accessing mental health services have rights under the *United Nations Principles for the Protection of Person with Mental Illness and for the Improvement of Mental Health Care* and they have additional rights under the *United Nations Convention on the Rights of the Child.*

Article 12(1) of the *United Nations Convention on the Rights of the Child* provides that signatories shall assure the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.

Other jurisdictions

South Australia

The *Mental Health Act 2009* (SA) contains a definition of 'child' to be a 'person under 18 years of age'.[124] However, the age that a child is assumed to have decision making capacity from the age of 16 years as per section 4:

(1). This Act applies to children in the same way as to person of full age, subject to the following:

(a). a right conferred on a person under this Act may, if the person is a child under 16 years of age, be exercised by a parent or guardian of the child on behalf of the child;

(b). an obligation under this Act to give a document to a person is, if the person is a child under 16 years of age, to be treated as an obligation to give the document to a parent or guardian of the child, and operates to the exclusion of any further obligation under this Act to send or give the document to a guardian, medical agent relative, carer or friend;

(c). an obligation under this Act to give information to a person (including information about the person's illness, any order that applies to the person, his or her legal rights, the treatment and other services that are to be provided or offered to the person and what alternatives are available) is, is the person is a child under 16 years of age, to be treated as an obligation to give the information to a parent or guardian of the child…

As a guiding principle, care and treatment for a child should be tailored to recognise the different developmental stages of each child.[125]

Victoria

The Victorian legislation does not define 'child', but does define 'parent' to be *'in relation to a person under the age of 18 years, includes the following –*

(a). a person who has custody or daily care and control of the person;

(b). a person who has all the duties, powers, responsibilities and authority (whether conferred by a court or otherwise) which by law parents have in relation to their children;

(c). any other person who has the legal right to make decision about medical treatment of the person.'[126]

Under section 75, if a patient is under 18 years of age and does not have a capacity to give informed consent to medical treatment, the medical treatment may be administered to the patient with the consent of:

> *(a). a person who, in relation to the patient, has the legal authority to consent to medical treatment and who, in the circumstances, is reasonably available, willing and able to make a decision concerning the proposed treatment…*[127]

If the parent is not reasonably available or not willing or able to make a decision concerning the proposed medical treatment, the authorised psychiatrist is able to consent to the treatment[128] if they are satisfied (amongst other factors)[129] that the patient would benefit from the medical treatment.[130]

Queensland

When treating 'minors' under the Mental Health Act 2016 (QLD), clinicians are guided by the following principle:

'To the greatest extent practicable, a minor receiving treatment and care must have the minor's best interests recognised and promoted, including, for example, by receiving treatment and care separately from adults if practicable and by having the minor's specific needs, wellbeing and safety recognised and protected.'[131]

Section 14 that regulates the meaning of 'capacity to consent to be treated' includes at subsection (4) that the section does not affect the common law in relation to –

> *(a).* 'the capacity of a minor to consent to be treated; or
>
> *(b).* a parent of a minor consenting to treatment of the minor.'[132]

New South Wales

The voluntary admission of a child is regulated under section 5 of the *Mental Health Act 2007* (NSW) as follows:

> *(1).* An authorised medical officer must, as soon as practicable after admitting a person under the age of 16 years as a voluntary patient, take all reasonably practicable steps to notify a parent of the person of the admission.

(2). *An authorised medical officer must discharge a person of 14 or 15 years of age who has been admitted as a voluntary patient if a parent of the person objects to the admission to the officer, unless the person elects to continue as a voluntary patient.*

(3). *A person under the age of 14 years must not be admitted as a voluntary patient if a parent of the person objects to the admission to an authorised medical officer.*

(4). *An authorised medical officer must discharge a person under the age of 14 years who has been admitted as a voluntary patient if a parent of the person requests that the person be discharged.*[133]

Similarly with the *MHRS Act*, there is no age-specific reference for the involuntary admission for a child.

Western Australia

In performing a function or making a decision for a child receiving treatment under the *Mental Health Act 2014* (WA), the primary consideration is what is in the best interests of the child.[134] A child is presumed to not have the capacity to make a decision about a matter relating to themselves, unless the child is shown to have that capacity.[135]

If a child does not have the capacity to make a decision about a matter relating to themselves, the child's parent or guardian may make the decision on the child's behalf.[136] When a person or body is required under the Act to decide what is or not in the best interests of a child patient, they must have regard to the views of the parent or guardian.[137]

Under the Western Australian legislation, a person has capacity to make a decision if they are able to understand any information and advice about the decision, the matters involved in the decision, the effect of the decision, be able to weigh up these factors and communicate the decision.[138]

Children can be admitted involuntarily under an inpatient treatment order. The order cannot exceed 14 days from the day on which the order is made,[139] but a continuation order for a further 28 days may be made after the first order lapses.[140]

3.4 Apprehension by Police

Current approach

Under section 8 of the Act, a power or function conferred or imposed by the Act is to be exercised or performed so that:

(a). *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*

(b). *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 of 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 circumstance*

When admitting and treating a person as an involuntary patient, the following principle applies under section 10(b):

Where the person needs to be taken to an approved treatment facility or into custody for assessment, the assistance of a police officer is to be sought only as a last resort and there is no other means of taking the person to the approved treatment facility or into custody.

The ability for police to apprehend a person is regulated under section 32A. Under that section, if a police officer believes on reasonable grounds (i.e. they do not need to exercise any clinical judgement to form the belief) that:

(a). a person may require treatment or care under the Act having regard to the appearance and behaviour of the person; and

(b). the person is likely to cause serious harm to himself or herself or to someone else unless apprehended immediately; and

(c). it is not practicable in the circumstances to seek the assistance of an authorised psychiatric practitioner, a medical practitioner or a designated mental health practitioner.

Then the police officer may apprehend that person under section 32A(2) and then bring the person to an appropriate practitioner for an assessment as soon as practicable.

The police officer may use any reasonable force and assistance to apprehend the person, and is allowed to enter private premises or any other private place where they reasonably believe the person may be found. They must give details to the practitioner the reasons why they apprehended the person and any force they used to apprehend the person.

Discussion

The principle in section 10(b) for police assistance only to be sought 'as last resort' recognises that the presence of police has the ability to escalate an already highly emotive scenario. It has been suggested in practice, police and emergency workers are usually the first point of call if the community or a person have concerns over another person's behaviour.

In the circumstances where police assistance is required, section 32A prescribes specific criteria that must all be satisfied before they can apprehend a person:

- if the police officer reasonably believes the person requires as assessment because of how that person appears or how they are behaving, **and** they are causing serious harm to themselves or to someone else **and**
- the person cannot be assessed by a practitioner unless they are apprehended and taken to a practitioner.

In the legislation, 'serious harm' is not defined ('harm' is defined under section 4, *'includes financial harm and loss of reputation'*). This may put police in a scenario where they are unable to apprehend the person because they are not causing harm that is 'serious' enough to justify their apprehension. And this may be appropriate for the purposes of using police as a 'last resort', or it gives rise to a situation where one may effectively have to wait for a person's condition to deteriorate before satisfying the criteria.

Other jurisdictions

Western Australia

In Western Australia, a police officer may apprehend a person under section 156 of the Mental Health *Act 2014* (WA) if the police officer reasonably suspects the person:

- has a mental illness and
- because of the mental illness, the person needs to be apprehended to protect the health or safety of that person or that of another person or
- prevent the person causing, or continuing to cause, serious damage to property (although 'serious damage' is not defined).

So the 'serious harm' criterion does not apply. Police officers in Western Australia have a lower threshold to justify the apprehension of someone who may need to be assessed.

South Australia

In South Australia, the *Mental Health Act* 2009 (SA) requires there to be a 'significant' risk of the person causing harm to themselves or to property to justify police apprehension under section 57(1).

Under the *MHRS Act* a police officer can detain a person for assessment and will have that person in their custody until they are brought to a practitioner 'as soon as practicable' under section 33(3). An issue raised in early consultation has been the uncertainty of how long a person can be detained under police custody whilst waiting to be brought before an appropriate practitioner, particularly in a remote community where clinical resources may be limited. This potentially creates a situation where a person is in police custody who, due to their condition is unable to be safely released into the community and is therefore subject to a restrictive, non-therapeutic setting that is not in line with the overarching objects of the Act.

Queensland

In Queensland, section 32 of the *Mental Health Act 2016* (QLD) authorises a doctor or authorised mental health practitioner to do the following in circumstances where someone is subject to an 'examination authority':

(a). enter a place stated in the authority or another place in which the doctor or authorised mental health practitioner considers the person may be found, and any other place necessary for entry to either of those places, to find the person and

(b). examine the person, without the person's consent, at-

(i). the place at which the person is found; or

(ii). if the doctor or authorised mental health practitioner considers it clinically appropriate – an authorised mental health service or public sector health service facility; and

(c). detain the person at the place at which the person is examined

(i). if the place is an authorised mental health service or public sector health facility – for a period of not more than 6 hours, starting when the person first attends at the service or facility for the examination; or

(ii). otherwise – for a period, of not more than 1 hour starting when the person is found at the place

Under section 34, a doctor or authorised mental health practitioner may ask a police officer for help in exercising or performing a function under that section.

3.5 Leave

Current approach

Leave for involuntary patients

Section 166 of the *MHRS Act* regulates how an involuntary patient can take leave:

(1). This section applies to a person who:

(a). is admitted to an approved treatment facility as an involuntary patient; and

(b). is not a prisoner.

(2). An authorised psychiatric practitioner may grant the person leave of absence from the facility.

(3). Leave of absence:

(a). must not be granted except in accordance with approved procedures; and

(b). must be recorded in the approved form; and

(c). is subject to the conditions determined by the practitioner.

(4). An authorised psychiatric practitioner may cancel the leave if satisfied, on reasonable grounds:

(a). the person is likely to suffer from serious mental or physical deterioration as a result of a change in the person's mental state; or

(b). the person is likely to cause harm to himself or herself or to someone else; or

(c). the person has failed to comply with a condition of the leave.

(5). The practitioner who cancels the leave must take all reasonable steps to inform the person or the person's representative that the leave has been cancelled.

Leave for voluntary patients

Section 29 of the *MHRS Act* sets out the right of a voluntary patient to 'leave' a facility, but only by in the context of discharge. The legislation is silent on regulating a voluntary patient's ability to take leave while being admitted in an approved treatment facility.

Discussion

Leave for involuntary patients

The decision to grant a person leave from a treatment facility is a clinically informed decision. It requires the authorised psychiatric practitioner to balance the ability of the patient to work towards recovery and autonomous decisions, and the risk that circumstances may leave to their patient being at risk of harming themselves, or others, or potentially absconding the facility. Under the current regulatory framework, an involuntary patient may be granted leave form the hospital so long as the three preconditions are fulfilled:

- Leave must not be granted except in accordance with the approved procedures
- Leave must be recorded in the appropriate form
- Leave is subject to conditions determined by the authorised psychiatric practitioner[141]

The Authorised Procedure, Leave of Absence and Missing Patients, sets out the factors an authorised psychiatric practitioner can take into account when deciding to grant leave to a person undergoing involuntary treatment and care:

An APP may authorise leave of absence for an involuntary patient detained at an ATF if:

- *a period of leave is likely to benefit the health and wellbeing of the patient;*
- *contributes to the patient's individual discharge plan; or*
- *if the patient requires any surgical or medical treatment.*

Any decision to allow a patient leave should take into account the reason for which the patient has admitted and the principle of the least restrictive alternative.[142] Some jurisdictions have seen a shift of the considerations that authorised practitioner should take into account, further promoting the recovery-focussed care model in the regulatory framework.

Leave for voluntary patients

The Leave of Absence Approval and Agreement Form (commonly referred to as 'Form 51'), that sets out an agreement between an authorised psychiatric practitioner and a patient (whether voluntary or involuntary) to authorise leave from the facility contains the following:

I understand that as a voluntary patient I can leave the facility (i.e. be discharged pursuant to s29) at any time. I also understand while in the facility I have agreed… [to make] appropriate arrangements for taking leave whilst I am a patient of the service. I understand that an Authorised Psychiatric Practitioner may enter an agreement with a person who has been admitted to hospital voluntarily to leave the hospital for a period of leave. I understand that this does not mean the person has been formally discharged from hospital or from the voluntary treatment arrangement […]

However, there have been concerns about the ability for a voluntary consumer to go on a period of leave while being admitted, and it has been raised that voluntary consumers 'report frustration or confusion about their ability to have leave'[143] and the rules being administered to approve leave 'are based on legislation for involuntary consumer but have been applied to voluntary consumers'.[144] Legislating for the ability for voluntary consumers to take leave is not included in legislation across jurisdictions, and this may be because the ability to take leave is inherent within the rights of a voluntary consumer by nature of their decision to participate and make informed decisions about their recovery.

International law

The United Nations Principles for the protection of persons with mental illness and the improvement of mental health provides at Principle 15.3:

Every patient not admitted involuntarily shall have the right to leave the mental health facility at any time unless the criteria for his or her retention as an involuntary patient, as set forth in Principle 16, apply, and he or she shall be informed of that right.

Other jurisdictions

Victoria

In Victoria, the granting of leave to an involuntary patient is regulated under section 64 of the *Mental Health Act 2014*. Under section 64, an authorised psychiatrist may grant a leave of absence from a designated mental health service to a person who is subject to an inpatient order for:

- the purpose of receiving treatment or medical treatment; or
- for any other purpose that the authorised psychiatrist is satisfied is appropriate.

When determining whether to grant leave, the authorised psychiatrist must have regard to:

- the purpose of the leave and
- if satisfied on the evidence available that the health and safety of the person or the safety of any other person will not be seriously endangered as a result.

In determining whether to grant a leave of absence to a person the authorised psychiatrist must, to the extent that is reasonable in the circumstances, have regard to all of the following—

(a). the person's views and preferences about the leave of absence and the reasons for those views and preferences, including the recovery outcomes that the person would like to achieve;

(b). the views and preferences of the person expressed in his or her advance statement;

(c). the views of the person's nominated person;

(d). the views of a guardian of the person;

(e). the views of the person's carer, if the authorised psychiatrist is satisfied that the decision will directly affect the carer and the care relationship;

(f). the views of a parent of the person if the person is under the age of 16 years;

(g). the views of the Secretary to the Department of Human Services, if the person is the subject of a custody to Secretary order or a guardianship to Secretary order.

The Victorian Health Department adds on their website that *'newly admitted compulsory patients should not be granted leave, even for brief periods, until the treating team has developed enough familiarity with them to make a valid assessment of their mental state and risk. An explanation of this policy and its rationale should be communicated verbally and in the ward information pack.'*

Queensland

The *Mental Health Act 2016* (QLD) contains a provisions for 'escorted day leave' for a patient in an authorised mental health service at section 220(7), which means the patient, for a period of not more than 1 day and not overnight is authorised to be physically away from the service and is required to remain in the physical presence of a health service employee while physically away from the service section 220(7)(b).

The legislation does not go further to explain what considerations are taken into account to grant escorted day leave, and the leave is mentioned in section 220 to ensure that the section does not apply to those on escorted day leave, as per section 220(6).

South Australia

In South Australia, a leave of absence for involuntary patients is regulated under section 26 of the *Mental Health Act 2009* (SA):

(1). The director of a treatment centre may, by a statement in writing in the form approved by the Chief Psychiatrist, grant an involuntary inpatient leave of absence from the centre for any purpose and period that the director considers appropriate and specifies in the notice.

(2). Leave of absence may be granted subject to any conditions that the director considers appropriate and specifies in the notice.

(3). The director must ensure that the patient is given a copy of the notice by which the patient is granted leave of absence before the patient commences the leave.

Section 8(2) of the *Mental Health Act 2009* (SA) states that *'A person admitted as a voluntary inpatient at the treatment centre may leave the centre at any time unless an inpatient treatment order then applied to the person'.*

The voluntary patient is required to receive a statement of rights that communicates their right to leave as a voluntary patient. The Statement of Rights contains the following regarding leave: *Leave from the treatment centre is encouraged and supported as part of your treatment and care plan.*

Please discuss your leave requirements and plans with a member of staff.[145]

Tasmania

Section 60 of the *Mental Health Act 2013* (Tas) regulates an involuntary patient's ability to take leave. Leave can be for a continuous period of not more than 14 days under section 60(3A). The leave may be granted on such conditions as the approved medical practitioner consider necessary or desirable for the patient's health or safety or the safety of other person. A leave of absence under section 60 is reviewable by the Tasmanian Mental Health Tribunal under section 191.

Section 60(1) stipulates that an approved medical practitioner may grant an involuntary patient leave of absence from an approved hospital, and the leave can be for 'clinical or personal reasons' under section 60(2). Leave for personal reasons can only be granted on application from the patient or a person who, in the opinion of the approved medical practitioner, has a genuine interest in the patient's welfare.

The legislation also allows an involuntary patient to ask any staff member in the approved hospital for help making an application, and section 60(4) prescribes that the staff member is to:

(a). *render that help to the best of his or her ability; or*

(b). *arrange for another staff member of the approved hospital to render that help.*

Section 60(13) states that an approved medical practitioner who refuses an application for leave under this section is to:

(a). *give notice of the refusal, with reasons, to the applicant (together with a statement of rights in a CCP approved form); and*

(b). *if the applicant was someone other than the patient, give notice of the refusal, with reasons, to the patient (together with a statement of rights in a CCP approved form); and*

(c). *place a copy of the notice of refusal, with reasons, on the patient's clinical record.*

3.6 Search and seizure powers

Discussion

Search and seizure powers provide the authority for patients, visitors and possessions (including postal mail) to be searched and items to be seized prior to entry into a mental health service. There are different types of searches depending on the context, which may include:

- *General search:* revealing the contents of the person's outer garments, general clothes or hand luggage without touching the person or the luggage. This may also include the person opening their hands or mouth for visual inspection; or shake their hair vigorously.
- *Scanning search:* means a search of the person by electronic or other means that does not require the person to remove the person's general clothes or to be touched by another person.
- *Personal search:* conducted by authorised person running their hands over the outer clothing also commonly known as a 'frisk search'.
- *Search requiring the removal of clothing:* a search which involves the person removing their clothing in a private place, usually only in the presence of persons of the same gender. These searches are also known as 'full searches' or 'strip search'.
- *Search of possessions:* this may include a search of mail or other personal items that enter the premises.
- *Search of the internal body cavities:* not generally legislated in mental health services, these are forensic procedures conducted by medical professionals under misuse of drugs legislation.

Searches and seizure of items ensures the protection and safety of patients, other people in the approved treatment facility and staff. Legislation must attempt to ensure a balance between upholding the safety of others with conducting searches in a way that preserves and autonomy and dignity of the person being searched.

Other jurisdictions

Queensland

Under the *Mental Health Act 2016* (QLD), particular persons are authorised to conduct searches of postal articles, involuntary patients, classified patients (voluntary) and visitors to specific services. The searcher must carry out the search in a way that respects the person's dignity to the greatest possible extent; and cause as little inconvenience to the person as is practicable in the circumstances.

Summary of searches under the Mental Health Act 2016 (QLD) Chapter 11, Part 7:[146]

Under what circumstances?	Applicable service	Authorised person to search	Who does the search apply to?	Type of search
Postal article or other thing received at a service for a patient	Authorised mental health service (Health Service)	Mental Health service administrator or delegate	Involuntary or Voluntary patient	• Search using an electronic scanning device or a physical examination
Belief that a patient may possess a harmful thing	Mental Health Service or Public sector health service facility	Doctor or a health practitioner	Involuntary or Voluntary patient	• General search • Scanning search • Personal search • Search requiring the removal of clothing (with approval of health service administrator or person-in charge of public sector health service facility) • Search of possession
On admission or entry to a service	High security units, mental health services or part of a mental health service, approved by the Chief Psychiatrist	Authorised security officer	Involuntary patient	• General search
On a visit to a service	High security unit, mental health services or part of a mental health service, approved by the Chief Psychiatrist	Authorised security officer	VisitorNote: refusal to be searched may result in refusal of entry	• General search • Scanning search • Personal searches • Search of the visitor's possessions

The Act has specific provisions for the treatment of items seized during the search, depending on the category of the thing seized. If the seized thing is believed to be harmful or if evidence of the commission or intended commission of an offence.

The Act also requires that a receipt for seized thing for a thing seized to the person from whom it was seized must be issued and the receipt must describe generally the thing seized and its condition.

Access to seized thing is permitted (if not harmful thing) until the thing is forfeited or returned to the owner person and must allow its owner to inspect it and, if it is a document, to copy it.

Victoria

The *Mental Health Act* 2014 (Vic) sets out powers relating to searching a person under section 354 of the Act. The term 'search' is defined as a search of a person or of things in the possession or under the control of a person that may include

> *(a). quickly running the hands over the person's outer clothing or passing an electronic metal detection device over or in close proximity to the person's outer clothing; and*
>
> *(b). requiring the person to remove only his or her overcoat, coat or jacket or similar article of clothing and any gloves, shoes and hat; and*
>
> *(c). an examination of those items of clothing; and*
>
> *(d). requiring the person to empty his or her pockets or allowing his or her pockets to be searched.*

The Act contains detailed requirements of the authorised person to preserve the privacy and dignity of the patient during the search at section 355 and places following obligations onto the person conducting the search from subsection (2):

(2). The authorised person must inform the person to be searched of the following matters:

> *(a). Whether the person will be required to remove clothing during the search*
>
> *(b). Why it is necessary to remove the person's clothing.*

(3). The authorised person must ask for the person's cooperation.

(4). The authorised person must conduct the search—

(a). in a way that provides reasonable privacy for the person searched; and

(b). as quickly as is reasonably practicable; and

(c). if the person being searched is of or under the age of 16 years, in the presence of a parent of the person or, if it is not reasonably practicable for a parent to be present, another adult.

(5). The authorised person must conduct the least invasive kind of search practicable in the circumstances.

(6). A search that involves running the hands over the person's outer clothing must be conducted by—

(a). an authorised person of the same sex as the person searched; or

(b). a person of the same sex as the person searched under the direction of the authorised person.

Section 356 provides the power to seize and detain things found as a result of the search. A thing may be seized if the authorised person is reasonably satisfied that the thing presents a danger to the health and safety of the person or another person or could be used to assist the person to escape.

Once the thing is seized, section 356(2) required the authorised person to make a written record that:

(a). specifies the thing seized and detained; and

(b). specifies the name of the person from whom the thing was seized and detained; and

(c). specifies the date on which the thing was seized and detained; and includes any other prescribed details.

Any thing that is seized must be securely stored, unless the thing is:

- a prohibited weapon or a controlled weapon,
- a drug of dependence or a substance, material, document or equipment used for the purpose of trafficking a drug
- a firearm
- something that the authorised person believed would present a danger to the health and safety of the person or another person if it was to be returned

In those circumstances, under section 356(4), the authorised person must give the thing to the police.

Tasmania

The Tasmanian *Mental Health Act* 2013 (Tas) regulates search not only of the person, but extends those powers to the mental health facility. Section 111(6) sets out what can be searched under the legislation:

(6). A search may be of –

- *(a). any part of the (Mental health unit); or*
- *(b). anything in the (Mental health unit); or*
- *(c). anything being delivered to or removed from the (mental health unit) or any vehicle, conduit or other thing being used in connection with that delivery or removal; or*
- *(d). any forensic patient, visitor, staff member or other person in the SMHU; or*
- *(e). clothing, personal belongings, physical aids, containers or any other thing in or under the possession or control of a forensic patient, visitor, staff member or other person in the SMHU; or*
- *(f). the information held on a computer, mobile phone or other device.*

The search may be carried out for the management, good order or security of the mental health unit, or for the safety of any person in the mental health unit under section 111(1). However, searches cannot apply to privileged visitors unless the person authorising the search specifically expresses to do so in writing.

The search of a person, or of anything in or under a person's possession or control, may be conducted without the person's consent. Subsection 111(8) states that if a person other than a forensic patient or a health facility staff member refuses to submit to or hinders a search, an authorised person may direct the person to leave the mental health unit forthwith or by a specified time.

Part Four:
Monitoring

...Respecting and responding to different needs, goals and preferences.

Part Four: Monitoring

Consider for your submission:

- What do you think of the current approach to regulating the use of restrictive practices under the *MHRS Act?*
- How do you think the legislation can further promote the elimination of restrictive practices?
- How do you think the legislation can support the role of the Chief Psychiatrist?
- What do you think about how the legislation regulates electroconvulsive therapy (ECT)? Can we make improvements?

4.1 The Chief Psychiatrist

Current approach

The role of Chief Psychiatrist is key to deliver mental health care with clinical governance, ensure safety and quality, and have oversight over treatment and care administered under the mental health legislation.

The *MHRS Act* does not currently have specific provisions for the appointment, functions or powers of the Chief Psychiatrist. Instead, the Act allows the Chief Executive of the Department of Health (DoH) to delegate any powers and functions to the Chief Psychiatrist, as a public sector employee.

In 2019, the Department of Health commissioned a review into the role and function of the Chief Psychiatrist (the Chief Psychiatrist Review). The review made a number of recommendations to enhance the role's authority within the mental health system and interdepartmentally.

Discussion

A common theme of feedback from the Chief Psychiatrist Review is that the position must provide oversight in the quality and safety in mental health service delivery across the Northern Territory. The Chief Psychiatrist Review identified five core aspects of a quality and safety role: workforce development; compliance with the mental health legislation and operationalising service standards; oversight of complaints and investigations; national participation and strategic direction. This would be further supported by the suggestion for the Chief Psychiatrist be statutorily required to Chair the Approved Procedures and Quality Assurance Committee (APQAC).

In relation to the *MHRS Act*, the Chief Psychiatrist could be incorporated in the legislation to:

(i). establish and approve procedures to be used in administration of the Act

(ii). receive reports and notifications from the Person in Charge of an approved treatment facility or an approved treatment agency, Authorised Psychiatric Practitioners and other clinicians, and the Community Visitor Program regarding admission, requests for examination and assessment and treatment of persons receiving care and treatment under the Act

(iii). provide recommendations to the courts when requested to do so, for the purposes of making an order for the admission, detainment or treatment of a person

(iv). approve interstate mental health orders

(v). chair the APQAC

It is also suggested that to support the function of compliance, the Chief Psychiatrist have powers of direct intervention. These powers could be initiated by the Chief Psychiatrist; or at the request of the patient under the *MHRS Act;* or at the request of any person who, in the opinion of the Chief Psychiatrist, has a proper interest in the patient's health, safety or welfare. However, the power of intervention is only exercisable after the Chief Psychiatrist has made inquiries into the relevant prescribed matter and is satisfied from those inquiries that intervention is essential to the patient's health, safety or welfare.

Examples of how this may be expressed in the *MHRS Act* is illustrated below:

Current Provision	Possible amendment
18 – Approved procedures The Chief Executive Officer (CEO) can approve procedures to be used in administration with the Act, but must not approve procedures for Northern Territory Civil Administration Tribunal (NTCAT) or the Community Visitor Program (CVP).	This function would transfer to the Chief Psychiatrist.
20 - Approved treatment facilities and approved treatment agencies The Minister must not make a declaration that: a place or premises (or part of a place or premise) be an approved treatment facility or a body or organisation to be an approved treatment agency unless the Minister receives a report from the Chief Health Officer (CHO) that the place or premise, or body or organisation has the conditions appropriate to make such a declaration.	The Minister would seek a report from the Chief Psychiatrist.
21 – Persons-in-charge of approved treatment facilities and agencies The CEO must appoint a person to be the person-in-charge (PIC) of each approved treatment agency and approved treatment facility.	The Chief Psychiatrist will appoint a person to be a PIC of an approved treatment facility or approved treatment agency.
22 – Authorised psychiatric practitioners The CEO may appoint a person to be an authorised psychiatric practitioner.	The Chief Psychiatrist will appoint a person to be an authorised psychiatric practitioner.
23 – Designated mental health practitioners The PIC of an approved treatment agency or facility may apply to the CEO to have a person employed by the agency or at the facility appointed as a designated mental health practitioner. The CEO may appoint or refuse to appoint the person.	The PIC would apply to the Chief Psychiatrist to have a person appointed.
23A – Authorised officers The CEO may, in accordance with approved procedures, appoint a public sector employee employed in the agency to be an authorised officer with functions and powers conferred by the Act.	The Chief Psychiatrist would appoint a public sector employee in the agency to be an authorised officer.
28 – Notification of admission Where a person remains as a voluntary patient for more than 6 months, the PIC must notify the CEO and NTCAT of the length of time the person has been admitted.	The PIC would also notify the Chief Psychiatrist.
61 – Mechanical restraint	A new provision would be drafted for the Chief Psychiatrist to monitor compliance with the mechanical restraint provisions.
62 – Seclusion of patients	A new provision would be drafted for the Chief Psychiatrist to monitor compliance with the seclusion provisions.

Current Provision	Possible amendment
65 – Clinical trials and experimental treatments A person must not perform a clinical trial or experimental treatment on a person who is an involuntary patient or subject to a community management order unless the trial or treatment is approved by an ethics committee nominated by the CHO.	The Chief Psychiatrist to nominate the ethics committee.
67 – Licensing of premises The occupier of a premises may apply to the CEO for a license to permit electroconvulsive therapy to be performed on the premises. The CEO must consider an application and may grant or refuse to grant the license. When considering the application, the CEO must take into account the recommendations from the CHO on a range of factors including but not limited to, the suitability of the applicant to hold the license, the suitability of premises, whether the equipment complied with prescribed standards and other specific conditions.	The CEO would receive and take into account the recommendations from the Chief Psychiatrist.
68 – Renewal of licence The holder of a licence must apply to the CEO to renew the licence. The CEO may before considering the application, obtain a report from the CHO regarding the suitability of the applicant to hold the licences, suitability of premises, whether the equipment complies with prescribed standards and other specific conditions.	The CEO would obtain a report from the Chief Psychiatrist.
70 – Cancellation of licence The CEO may, by notice in writing to the holder of a licence, cancel the licence.	The Chief Psychiatrist may, by notice in writing to the holder of the licence, cancel the licence. It has been suggested that the Chief Psychiatrist be given power to temporarily suspend a licence.
71 – Amendment of licence The CEO may, by notice in writing to the holder of the licence, revoke or vary a condition to which the licence is subject or impose further conditions on the licence.	The Chief Psychiatrist may revoke or vary a condition to which the licence is subject or impose further conditions of the licence.
72 – Review of a certain decision A person aggrieved by a decision of the CEO may apply to the Ombudsman for an investigation of the decision.	A person aggrieved by a decision of the CEO, or the Chief Psychiatrist, may apply to the Ombudsman for an investigation of the decision.
73 – Returns The holder of the licence must submit a return containing details of the electroconvulsive therapy performed during the month on the licensed premises, to the CEO after the end of each month.	The holder must submit the return to the Chief Psychiatrist and the CEO.
74 – Pre-assessment advice The court may request advice from the CHO regarding the availability of resources to assess the person in order to determine whether the person is in need of treatment under the Act. As soon as practicable after receiving the request, the CHO must give the court written advice that includes whether or not it is practicable to conduct an outpatient assessment of the person.	The court would request advice from the Chief Psychiatrist. After receiving a request, the Chief Psychiatrist must give the court written advice.
75 – Admission order The CHO may apply to the court at any time to extend the admission order granted by the court.	This function would transfer to the Chief Psychiatrist.

Current Provision	Possible amendment
75A – Determination that a person not required to be admitted If a person is admitted as an involuntary patient under s75, an authorised psychiatric practitioner or NTCAT may determine the person is no longer required to be so admitted at the facility. If that determination is made, the CHO must inform the court upon resumption of proceedings.	This function to inform the court would transfer to the Chief Psychiatrist.
77 – Dismissal of charge The court may request from the CHO a certificate stating whether at the time the alleged offence was being committed, that the person was suffering a mental illness or mental disturbance –and whether the mental illness or mental disturbance materially contributed to the person's conduct.	The court would make that request to the Chief Psychiatrist.
78 – Request for a voluntary treatment plan The court may request from the CHO an assessment of, and if appropriate a voluntary treatment plan, for the person if the court is of the opinion the person suffers from a mental illness or disturbance that is likely to have contributed to the conduct constituting the offence and the court is satisfied the person recognises that they suffer from a mental illness or disturbance and has made, or is willing to make, a conscientious effort to address problems associated with the mental illness or disturbance –and prosecution and the person consent to the offence being dealt with under this Division.	The court would make that request to the Chief Psychiatrist.
82 – Persons-in-charge to notify Commissioner of Correctional Services The PIC of an approved treatment facility to which a prisoner has been admitted as a voluntary patient has an obligation to notify the Commissioner of Correctional Services as soon as practicable after a range of circumstances, including but not limited to, if the prisoner requests to be returned to the custodial correctional facility, the prisoner no longer consents to their admission, a decision has been made to discharge the prisoner form the facility or the prisoner is transferred to another facility.	The PIC to notify the Commissioner of Correctional Services and the Chief Psychiatrist.
86 – Arrangements The Commissioner of Correctional Services and the CHO may make arrangements to ensure the security and good order of prisoners receiving treatment under the Act.	This function would transfer from the CHO to the Chief Psychiatrist.
87 – Information To be given to the patients no later than one day after a person is admitted or a Community Management Order is made, an authorised psychiatric practitioner must provide information about the person's rights and entitlements under the Act and how they may be exercised, advocacy and legal services available to the person, and any other information relating to the person's admission and treatment the CEO considers relevant.	The authorised psychiatric practitioner would provide any other information that the Chief Psychiatrist considers relevant.
91 – Disclosure of information Information under this section must not be disclosed unless recommended from the CEO, CHO, NTCAT and Principal Community Visitor, Ombudsman or Commissioner for Health and Community Services Complaints to disclose the information.	Include the Chief Psychiatrist as an authorised position.
99(2) – Withholding of certain correspondence A person cannot be denied or restricted to sending or receiving letters or postal articles from prescribed positions in subsection (2), including but not limited to, the Minister, the CEO, member of Parliament, principal community visitor or community visitor, PIC and the CHO.	Include the Chief Psychiatrist as a prescribed position.

Current Provision	Possible amendment
100 – Internal complaints procedure A person being treated in an approved treatment facility or agency, or their decision maker, representative or person with a genuine interest in the person, may make a complaint to the PIC. The PIC must forward to the CEO and the principal community visitor a report detailing the pattern of complaints every six months. The PIC must also inform the CEO if after an investigation of a complaint, the PIC considers that a person may have committed an offence, a breach of discipline or professional misconduct. Upon being informed, the CEO must immediately notify police, or take appropriate action under the Public Sector Employment and Management Act 1993 or notify the relevant professional body.	The report detailing pattern of complaints would be forwarded to the CEO, the principal community visitor and the Chief Psychiatrist. The PIC would inform the CEO and the Chief Psychiatrist if they considered after an investigation of a complaint that a person may have committed an offence, a breach of discipline or professional misconduct. Action taken after that remains the function of the CEO.
109 – Reports by community visitors *112 – Reports by community visitor panels* *112A – Reports by special community visitor panels* The principal community visitor may make a report to the CEO where they believe that the PIC of an approved treatment agency or facility has not taken adequate or reasonable action to implement a recommendation made by a community visitor, a community visitor panel, or a special community visitor panel.	The principal community visitor may forward the report to the CEO and the Chief Psychiatrist.
116 –Detection of offences The principal community visitor must inform CEO (of the Department of Health or another agency, as appropriate) if suspects that an offence may have been committed.	The principal community visitor must inform the CEO and the Chief Psychiatrist.
125 – Review of reports NTCAT may give written direction to the CEO relating to a practice, or interpretation of, this act arising out of a matter contained in the report or where is considered a person may be guilty of professional misconduct, it must notify the relevant professional body.	The NTCAT may give written direction to the CEO and/or the Chief Psychiatrist.
145 – Approved Procedures and Quality Assurance Committee	Include a provision that requires the Chief Psychiatrist to Chair the Approved Procedures and Quality Assurance Committee (APQAC).
156 – CEO may consent to transfer The CEO may consent to an interstate transfer.	This function would transfer to the Chief Psychiatrist.
159 - Amendment of documents Where the CEO considers that a document relating to the admission as an involuntary patient is incorrect or defective and it has not been amended within 21 days after the direction from the CEO requiring the amendment, the CEO may order the discharge of the person as an involuntary patient or do anything that is necessary to obtain a document in substitution for the incorrect or defective document.	This function would transfer to the Chief Psychiatrist.

Other jurisdictions

In New South Wales, the Chief Psychiatrist is not a statutory position. All statutory functions associated with the *Mental Health Act 2007 (NSW)* are fully integrated into the Ministry of Health. The position of Chief Psychiatrist is viewed as working in partnership and providing high level advice to, the Director of the Mental Health Branch, Department of Health NSW. The Chief Psychiatrist also provides professional leadership to NSW mental health clinicians, clinical input to policy development and implementation.

Although there is no national standard approach, the most common aspects of the role in the Australian Capital Territory, Tasmania, South Australia, Western Australia, Victoria and Queensland includes:

- overall responsibility for the oversight of mental health treatment and care
- promotion of patient rights
- administration of the relevant Mental Health Act and monitoring compliance
- authorising treatment facilities oversight over restrictive practices (Electroconvulsive therapy, seclusion, mechanical restraint etc)
- conducting investigation related to clinical events
- a role in interstate transfers of individuals subject to the provision of the relevant mental health act.

4.2 Regulating restrictive practices

Current approach

Restrictive practices or restrictive interventions restricts the rights or freedom of movement of a person with the primary purpose of protecting the person or others from harm. Section 7 of the *National Disability Insurance Scheme (Authorisations) Act 2019* sets out the different categories of restrictive practices that broadly include:

(a). seclusion;
(b). chemical restraint;
(c). mechanical restraint;
(d). physical restraint; and
(e). environmental restraint.

The *MHRS Act* directly prohibits the use of mechanical restraint and seclusion except in circumstances where no less restrictive method of control is applicable or appropriate. There are also provisions for the use of medications must only be for therapeutic or diagnostic purposes and not as punishment or for the convenience of others, which relates to chemical restraint. A summary of the existing provisions is provided in the following table.

	Mechanical restraint (section 61)	Seclusion (section 62)
Definition	The application of a device (including a belt, harness, manacle, sheet and strap) on a patient's body to restrict the patient's movement, but does not include the use of furniture (including a bed with sides and a chair with a table fitted on its arms) that restricts the patient's capacity to get off the furniture.	The confinement of the patient at any time of the day or night alone in a room or area from which free exit is prevented.
Prohibition	A person must not apply mechanical restraint to a patient.	A person must not keep a patient in seclusion.
Exceptions	An exception may apply if there is no other less restrictive method of control is applicable or appropriate and it is necessary for one or more of the following: • for the purpose of medical treatment of the patient • to prevent the patient from causing injury to themselves or another • to prevent the patient from persistently destroying property • to prevent the patient from absconding from the facility.	An Exception may apply if no other less restrictive method of control is applicable or appropriate and it is necessary for one or more of the following: • for the purpose of the medical treatment of the patient • to prevent the patient from causing injury to themselves or another • to prevent the patient from persistently destroying property • to prevent the patient from absconding from the facility.

	Mechanical restraint (section 61)	Seclusion (section 62)
Consent	Mechanical restraint may be applied to a patient without the patient's consent.	A patient may be kept in seclusion without his or her consent.
Approvals	Mechanical restraint of a patient must not be applied unless the form and its duration is approved by an authorised psychiatric practitioner or in the case of an emergency, by the senior registered nurse on duty. If approved by the senior registered nurse on duty, they must notify an authorised psychiatric practitioner as soon as practicable so the practitioner can review and if necessary, re-determine the decision and note it in the patient's case notes.	A patient may be kept in seclusion only where it is approved by an authorised psychiatric practitioner or in the case of an emergency, by the senior registered nurse on duty. If approved by the senior registered nurse on duty, they must notify an authorised psychiatric practitioner as soon as practicable so the practitioner can review and if necessary, re-determine the decision and note it in the patient's case notes.
Duration	Mechanical restraint must not be applied to a voluntary consumer for longer than a continuous period of 6 hours.	A voluntary consumer must not be kept in seclusion for longer than a continuous period of 6 hours.
Observations	A patient to whom mechanical restraint is applied: • must be kept under continuous observation by a registered nurse or medical practitioner • must be reviewed, as clinically appropriate to his or her condition, by a registered nurse at intervals not longer than 15 minutes • must be examined by a medical practitioner at intervals not longer than 4 hours	A patient kept in seclusion: • must be visited by a registered nurse at intervals not longer than 15 minutes • must be examined by a medical practitioner at intervals specified in approved procedures • must be reviewed by an authorised psychiatric practitioner in accordance with approved procedures
Requirements	A patient to whom mechanical restraint is applied: • must be supplied with bedding and clothing that is appropriate in the circumstances • must be provided with food and drink at appropriate times • must have access to adequate toilet facilities • must be provided with any other psychological and physical care appropriate to the patient's needs.	A patient kept in seclusion: • must be supplied with bedding and clothing that is appropriate in the circumstances • must be provided with food and drink at appropriate times • must have access to adequate toilet facilities • must be provided with any other psychological and physical care appropriate to the patient's needs
Records	The person-in-charge of an approved treatment facility must ensure that a record is kept of: • the form of mechanical restraint applied • the reasons why mechanical restraint was applied • the name of the person who approved the mechanical restraint being applied the name of the person who applied the mechanical restraint • the period of time the mechanical restraint was applied. The person-in-charge of an approved treatment facility must ensure that a copy of the record is placed on the patient's medical records. The principal community visitor must ensure those records are inspected by a community visitor at intervals not longer than 6 months.	The person-in-charge of an approved treatment facility must ensure that a record is kept of: • the reasons why a patient was kept in seclusion • the name of the person who approved the patient being kept in seclusion • the name of the person who kept the patient in seclusion • the length of time the patient was kept in seclusion The person-in-charge of an approved treatment facility must ensure that a copy of the record is placed on the patient's medical records. The principal community visitor must ensure that these records are inspected by a community visitor at intervals not longer than 6 months.

	Mechanical restraint (section 61)	Seclusion (section 62)
Notifications	If a patient to whom mechanical restraint has been applied has an adult guardian or decision maker, the person-in-charge of the approved treatment facility must ensure that the adult guardian or decision maker notified of the following as soon as practicable after the application of the restraint: • that mechanical restraint was applied to the patient • the form of mechanical restraint applied • the reasons why mechanical restraint was applied • the period of time the mechanical restraint was applied.	• The person-in-charge of the approved treatment facility must ensure that the patient's adult guardian or decision maker is notified of the following as soon as practicable after the seclusion: • that the patient was kept in seclusion • the reasons why the patient was kept in seclusion • the length of time the patient was kept in seclusion
Release	If a medical practitioner, senior registered nurse on duty or an authorised psychiatric practitioner is satisfied that the continued application of mechanical restraint to a patient is not necessary, they must, without delay, release the patient from the restraint.	If a medical practitioner, senior registered nurse on duty or an authorised psychiatric practitioner is satisfied that it is not necessary to continue to keep the patient in seclusion, the patient must be released without delay.

The *MHRS Act* contains provisions for the use of medications must only be for therapeutic or diagnostic purposes and not as punishment or for the convenience of others, however it does not include provisions for chemical restraint. Section 63(1)(c) of the *MHRS Act* does not allow for non-psychiatric treatment of a patient, including administration of medication requiring a prescription or medical supervision.

The Health and Community Services Complaints Commission has recommended the *MHRS Act* include a clear definition of chemical restraint and provision of appropriate safeguards, including oversight and record keeping; and be consistent with existing disability legislation.[147]

Discussion

Restrictive practices are serious interventions typically only used where there is a significant risk to the person involved or others and as a last resort as all other less-restrictive options have been considered and found unsuitable. Restrictive practices are regulated across different settings, for example including disability support services and mental health services, in some sectors the terms 'challenging behaviour' or 'behaviours of concern' are used to describe the persons behaviour at the time the restrictive practices is used. However, there are no universal definitions, processes or regulatory frameworks for the use of restrictive practices in Australia.

All Australian Health Ministers have endorsed the *National Safety Priorities in Mental Health: a National plan for reducing harm* (the National plan). The National plan identified four priority areas for national action including 'reducing use of, and where possible eliminating, restraint and seclusion' for people with mental health issues.[148] Working towards eliminating the use of seclusion is a policy priority in Australian mental health care and has been supported by changes to legislation, policy and clinical practice to varying degrees in all jurisdictions.[149]

Across Australia, the use and reporting of restrictive practices in mental health settings is closely regulated and scrutinised.[150] The use of restrictive practices, specifically the use of seclusion and restraint in mental health, is regulated across Australia under legislative frameworks that operate differently in each jurisdiction. In some jurisdictions, restrictive practices (or restrictive interventions) are used to encompass different categories of restrictive practices, which in some jurisdictions includes chemical restraint. In other jurisdictions, including the Northern Territory, only seclusion and mechanical restraint is defined and regulated in mental health settings through legislation.

Research and contemporary policy related to the use of restraint indicates that reducing seclusion and restraint will minimise physical and psychological harm experienced by people accessing services and staff.[151] The evidence supports that the reduction and elimination (where possible) of seclusion and restraint can be achieved within mental health services.[152] However, globally, in mental health and other health settings work towards reducing the use of restrictive practices have been implemented with varying success.[153]

Research within Australia to examine and compare the success of regimes to reduce the use of seclusion of restraint is difficult, as no two jurisdictions are the same. There are many factors that impact the success of the strategies to reduce the use of restrictive practices however, research highlights that legislation is a key variant in the success of efforts to reduce the use of restrictive practices is legislation.[154]

Legislation that regulates the use of seclusion, restraint or any other restrictive practice in mental health setting must address:

- preserving the fundamental human rights of the patient;

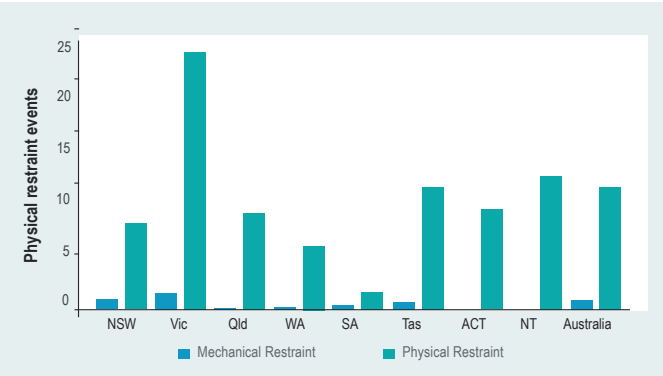
- maintaining the therapeutic relationship;
- ensure monitoring, reporting and notification process are robust and transparent;
- ensure the safety of patients and staff; and
- satisfy that the primary purpose for the use of the restrictive practice is the least restrictive means of protecting the person or others from harm.

This section considers the role of legislation in efforts to reduce the use of restrictive practices. However, it is also acknowledged that other variants also have a role in the reduction of restrictive practices including for example therapeutic environment, staff training and prevention tools that are not addressed in this paper.

National data

In December 2018, the Australian Institute of Health and Welfare (AIHW) reported for the first time the data on the use of seclusion, mechanical and physical restraint by hospital. Over the last 5 years, the national seclusion rates in public sector acute mental health hospital services have reduced by an average annual rate of 6.7% and the number of seclusion events has reduced nationally by 4.1%.[155] The Northern Territory rates of seclusion decreased in 2018-19, however these rates were the highest rate of seclusion in public sector acute mental health hospital services with 13.6 seclusion events per 1,000 bed days, compared with New South Wales, which had the lowest (6.0). AIHW qualifies that data for smaller jurisdictions, like to Northern Territory should be interpreted with caution as small changes in the number of seclusion events can have a significant impact on the jurisdictions overall seclusion rate.[156]

The AIHW graph below shows the national rates of restraint by jurisdiction as events per 1,000 bed days.[157]



The Northern Territory is above that national average for the use of physical restraint however no events of mechanical restraint used by the public sector acute mental health hospital were reported.

Other jurisdictions

The use of restraint and seclusion is regulated in all jurisdictions using different approaches. All jurisdictions regulate restrictive practices to ensure that it is used only as a last resort when no other least restrictive option is available and to prevent harm to the patient or others. This section also aims to highlight how other jurisdictions have different approaches to the reporting of restrictive practices, post-event debriefing, notification processes and reduction and elimination planning.

Tasmania

The *Mental Health Act 2013* (Tas) is the only jurisdiction in Australia to provide a definition of chemical restraint as meaning 'medication given primarily to control a person's behaviour, not to treat a mental illness or physical condition'.

Victoria

The *Mental Health Act 2014* (VIC) regulates broader types of restraint under Part 6 Restrictive Interventions, key points include:

- Restrictive interventions involve the use of bodily restraint (physical and mechanical restraint) and seclusion.
- The regulation of restrictive interventions applies to all people receiving mental health services in a designated mental health service **regardless of the person's legal status** under the *Mental Health Act 2014 (VIC)* **or age**.
- A restrictive intervention may only be used after all reasonable and less restrictive options have been tried or considered and have been found to be unsuitable in the circumstances.
- Bodily restraint may be used where necessary to administer treatment or medical treatment.
- When a restrictive intervention is used, the person's key support people must be notified and a report provided to the Chief Psychiatrist.[158]

- Notification may include:
  - the nominated person;
  - guardian;
  - a carer, if the authorised psychiatrist is satisfied that the use of the restrictive intervention will affect the carer and the care relationship;
  - a parent, if the person is under the age of 16 years;the Secretary to the Department of Human Services, if the person is the subject of a custody to Secretary order or a guardianship to Secretary order.
  - the Secretary to the Department of Human services, if the person is the subject of a custody to Secretary order or a guardianship to Secretary order.

South Australia

The *Mental Health Act 2009* (SA) defines restrictive practice, in relation to a patient, includes:

(a). the use of physical, mechanical or chemical means to restrain the patient; and

(b). seclusion or the confinement of the patient on his or her own in an area from which he or she cannot leave of his or her own volition;

The inclusion of 'chemical' within the definition of restrictive practices provides scope for regulation of chemical restraint within SA. However, under sections 90(2) and (3) of the *Mental Health Act 2009* (SA) the Chief Psychiatrist may issue standards that are to be observed in the care or treatment of patients. Chief Psychiatrist Standards have been developed in relation to; Recording and Reporting; and Application and Observation Requirements which outline the requirements of health services:

- to record information and make notifications to the Office of the Chief Psychiatrist, to enable the monitoring of the use of restraint and seclusion; and
- to implement observation standards in relation to restraint and seclusion use, consistent with local, national and international best practice.

The Chief Psychiatrist Standards are binding on any hospital as a condition of the licence in force in respect of any private hospital premises. The Standards provide a more flexible approach to updating record, reporting and observation standards as they can be updated without legislative amendment.

Queensland

The *Mental Health Act 2016* (QLD) under Chapter 8 Use of mechanical restraint, seclusion, physical restraint and other practices. Chapter 8 regulates use of restraint, and the appropriate use of medication for patients in authorised mental health services.

Queensland legislation also has requirements for reduction and elimination planning, which is a plan developed by an authorised doctor that provides information on the reduction and elimination of either or both the use of mechanical restraint and/or the seclusion of the relevant patient.

A reduction and elimination plan must include—

(a). the name of the relevant patient; and

(b). information, if any, about—

(i). the previous use of mechanical restraint on, or

(ii). seclusion of, the relevant patient; and

(iii). strategies previously used to reduce the use of

(iv). mechanical restraint on, or seclusion of, the

(v). relevant patient; and

the effectiveness of the strategies mentioned in subparagraph [ii]; and

(c). information about the strategies proposed to reduce, and eliminate, the use of mechanical restraint on, or seclusion of, the relevant patient in the future.

The Chief Psychiatrist may then approve reduction and elimination plan if satisfied the strategies mentioned are appropriate for the relevant patient.

New South Wales

New South Wales in addition to legislation have developed policy directives related to restrictive practices that support the principle of Trauma Informed Care.

"NSW Health services understand and respond to the prevalence and impacts of trauma, supporting care that does not traumatise or re-traumatise the person. Services provide care that is person-centred and recovery-oriented and upholds human rights. Services recognise that seclusion and restraint can be very traumatic for many people and may increase distress, re-traumatise and trigger memories from past trauma. Trauma informed care is applied in all health settings. Services recognise and address provocative and triggering practices and behaviour.

NSW Health services also recognise and respond effectively to the risk of trauma for staff.

NSW Health services recognise that many Aboriginal people have experienced and continue to experience significant intergenerational and other trauma. They take this into account when designing and providing care.

Services consider cultural obligations (e.g. Aboriginal family and community roles) and personal backgrounds of staff when allocating roles during a seclusion or restraint episode." (159)

International law

In 2013, the United Nations Committee on the Rights of Persons with Disabilities (the Committee) in its the initial report of Australia, that persons with disabilities, especially cognitive impairment and psychosocial disability, are 'routinely subjected to unregulated and under-regulated behaviour modification or restrictive practices such as chemical, mechanical and physical restraint and seclusion'.(160)

The Committee recommended in its concluding observations that Australia must 'take immediate steps to end such practices, including by establishing an independent national preventive mechanism to monitor places of detention—such as mental health facilities, special schools, hospitals, disability justice centres and prisons—in order to ensure that persons with disabilities, including psychosocial disabilities, are not subjected to intrusive medical interventions.'(161)

The review into the Northern Territory's mental health legislation provides an opportunity to align with international law and other jurisdictions to regulate the use of other restrictive practices in the mental health service, develop modern strategies to reduce their use and where possible, eliminate the use of seclusion and restraint.

4.3 Electroconvulsive therapy (ECT)

Current approach

Part 9, Division 2 of the *MHRS Act* regulates electroconvulsive therapy (ECT). Sections 66(1) and 665(1A) of the *MHRS Act* states as follows:

(1) A person must not person electroconvulsive therapy on another person unless:

(a) The other person gives informed consent to the treatment; or

(b) Informed consent for the treatment is obtained from an adult guardian or decision maker for the person, or from the Civil and Administrative Tribunal, in accordance with Part 4 of the Advance Personal Planning Act 2013.

(1A) Subsection (1) does not apply if the treatment is performed in accordance with this section and approved procedures.

An application to perform ECT on a patient can be made to NTCAT and under section 66(2) of the MHRS Act, the Tribunal may authorise ECT if it:

(a) is satisfied that the person is unable to give informed consent to the treatment; and

(b) receives a report from 2 authorised psychiatric practitioners that they are satisfied, after considering the person's clinical conditions, history of treatment and other appropriate alternative treatments, that [ECT] is a reasonable and proper treatment to be administered and that without the treatment the person is likely to be administered and that without the treatment the person is likely to suffer serious mental or physical deterioration;

(c) and is satisfied that:

(i) all reasonable efforts have been made to consult the person's primary carer; or

(ii) there is a valid reason for not complying with subparagraph (i).[162]

The *MHRS Act* also authorises that ECT may be administered to an involuntary patient where two authorised psychiatric practitioners are satisfied that it is immediately necessary to save the person's life,[163] to prevent the person suffering serious mental to physical deterioration,[164] or to relieve severe distress.[165] If ECT is performed under these circumstances, the authorised psychiatric practitioner must make a report to NTCAT as soon as practicable after it is performed.[166] The report must contain:

(a) the reasons why the authorisation of the tribunal was not obtained, and

(b) the number of treatments performed, and

(c) the person's response to the treatment; and

(a) details of any significant side effects of the treatment on the person.[167]

At least two medical practitioners must be present when ECT is performed: one must be experiences and trained in accordance with approved procedures in performing ECT, and one must be experienced in administering anaesthesia.[168]

Discussion

ECT is a therapeutic medical procedure for the treatment of severe psychiatric disorders, with a primary purpose to relieve psychiatric symptoms.[169] ECT is a safe and effective treatment for 'where its antidepressant effect is found to be superior to medication strategies,'[170] but should only be administered 'for an illness where there is adequate evidence of effectiveness and an appropriate clinical indication.'[171]

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is responsible for the training, educating and representation of psychiatrists in Australia and New Zealand. RANZCP is also responsible for setting the professional standards for the practice of psychiatry in Australia and New Zealand. In October 2019, RANZCP released a position statement (Position Statement 74)[172] on ECT. Position Statement 74 supports the use of ECT as a 'highly effective treatment with a strong evidence base, particularly for the treatment of severe depressive disorders'.[173] The key messages from Position Statement 74 are as follows:

- ECT is a treatment for a number of psychiatric disorders. It is used to treat severe depression, mania and psychosis, and occasionally other conditions.
- There have been substantial developments which have improved the safety and practice of ECT in recent years.
- ECT should be available where clinically indicated and not limited by cost, service availability, age or other medical conditions, or overly restrictive legislation.
- Psychiatrists prescribing and administering ECT must be appropriately trained and should engage in ongoing education to promote and share best practice information with colleagues.
- Psychiatrists should continue to challenge the stigma and discrimination associated with ECT, and promote access to ECT treatment where clinically indicated.[174]

In August 2019, the Northern Territory's Health and Community Services Complaints Commission released an Investigative Report that was critical of section 66 of the *MHRS Act* that legislated for 'emergency' administration of ECT (i.e. without prior authorisation from NTCAT). The Health and Community Services Complaints Commission made a number of findings and recommendations to Government regarding the operation of the *MHRS Act* and highlighted a number of inadequacies in the legislation. Amongst those findings what that the *MHRS Act* should make it clear that NTCAT must be separately and promptly notified of every occasion when unauthorised ECT treatment is performed on the basis of s66(3). The rationale being:

'such an approach is crucial in order for oversight of a patient's treatment to be appropriately informed, and for the requirement in s66(4) that performance of emergency ECT be reported to [NTCAT] 'as soon as practicable' to be satisfied'.[175]

The RANZCP in Position Statement 74 was critical of 'legislative restrictions' that reduced access to ECT, in particular 'by strictly limiting the number of times that ECT can be applied…and requiring tribunal approval for each course of ECT' which had a potential effect of 'compromising clinical care'. [176]

When determining the best way forward and removing ambiguity, a balance needs to be achieved between protecting the rights of the patients with adequate oversight, without comprising clinical care.

Other jurisdictions

Australian Capital Territory

Part 9.2 (sections 147-166) of the *Mental Health Act 2015* (ACT) regulates electroconvulsive therapy. Adults with decision making capacity can consent to ECT.[177] For an adult who does not have decision making capacity, ECT may be administered if the person has an advance consent direction consenting to ECT, it is administered in accordance with the direction, and they do not refuse or resist.[178]

However, ECT may also be administered to a person without decision making capacity if it is administered in accordance with an ECT order or an emergency ECT order. These orders are made by application to the ACT Civil and Administrative Tribunal (ACAT) by the Chief Psychiatrist or a doctor.[179] The ACAT has consultation obligations under the legislation when deciding to make an order, including the patient's nominated person,[180] their guardian,[181] and if the patient is under 18, the persons with parental responsibility over the patient.[182]

ECT orders are granted by the ACAT in a hearing[183] of the application. The ACAT may make an ECT order in relation to the patient if satisfied that:

- the person has a mental illness[184]
- they do not have decision-making capacity to consent to ECT[185] or an advance consent direction refusing consent to ECT[186]

- the administration of ECT is likely to result in a substantial benefit to the person[187] and either all other reasonable forms of treatment have not been successful,[188] or the ECT is the most appropriate treatment reasonably available.[189]

The Chief Psychiatrist and a doctor may make a joint application to the ACAT for an emergency ECT order. When deciding whether to grant the emergency ECT order, ACAT must take into account the views and wishes of the person including in any advance agreement or consent direction[190] and the views of the people appearing in the proceedings.[191] The ACAT may make an emergency ECT order if it is necessary to save the person's life or prevent the likely onset of a risk to the person's life within 3 days.[192]

Part Five:

Forensic provisions

This section was jointly developed by the Department of Health and Department of the Attorney General and Justice

...Improving access to mental health services, to people in the criminal justice system.

Part Five: Forensic provisions

Consider for your submission:

- Is the current legislation effective in regulating forensic mental health? Can we make improvements to the legislation?
- Should forensic provisions be contained in its own piece of legislation?
- Do you think the legislation provides effective and appropriate clinical pathways for forensic clients? How can the Northern Territory improve this?

Introduction

The legislative regime that regulates forensic mental health in the Northern Territory is covered by two pieces of legislation: Part 10 of the *MHRS Act* and Part IIA of the *Criminal Code Act 1983* (the Criminal Code).

Part 10 of the *MHRS Act* covers the court procedures for 'summary offences' in the Local Court. Part IIA of the Criminal Code provides for 'Mental impairment and unfitness to be tried', including establishing court-imposed supervision orders and the defence of mental impairment. The provisions apply to proceedings before the Supreme Court and committal proceedings. Where an accused person suffers from mental illness or cognitive impairment, the procedures and processes of the court vary significantly depending on whether the matter is heard and determined summarily in the Local Court or in the Supreme Court. An explanation of the differences and the current processes under both legislation is set out in greater detail below.

Recommendations for amendments to legislation regulating forensic mental healthcare have emerged from a number of reviews and independent reports over recent years. In particular:

(1). Northern Territory Law Reform Committee's *'Report on the Interaction between people with Mental Health Issues and the Criminal Justice System'* May 2016[193] (NTLRC Report)

(2). Senate Community Affairs References Committee's *'Indefinite Detention of People with Cognitive and Psychiatric Impairment in Australia'* November 2016[194] (the Senate Community Affairs Reference Committee)

(3). Dr Peter Norrie, B.H.B, M.B.Ch.B, FRANZCP *'Report on the Independent Review of Part IIA Orders'* April 2018[195] (the Norrie Report)

(4). David McGrath Consulting *Report on the review of Forensic Mental Health and Disability Services within the Northern Territory'* January 2019[196] (the Forensic Review)

This section of the Discussion Paper acknowledges the investigations, findings and recommendations made to Government on the operation of forensic services within the existing legislative regime.

This Discussion Paper provides an opportunity to build upon these recommendations and investigate opportunities to build a strong legislative regime to support implementation of recommendations about forensic operations, infrastructure, staffing and funding.

This Discussion Paper raises the proposition that greater alignment and consistency between Part IIA of the Criminal Code and the *MHRS Act* may provide more effective support and service delivery to forensic clients. The aim of the legislation is to balance the provision of care and treatment of the supervised person whilst ensuring community safety. As part of an evidence-based approach, Government is seeking submissions about whether the *MHRS Act* and/or Part IIA of the Criminal Code need amending to achieve these objectives.

What does 'forensic client' mean?

The Forensic Mental Health Services (FMHS) in the Northern Territory provides specialist mental health treatment to:

(1). General prisoners who need specialist mental health inpatient treatment while they are serving their custodial sentence

(2). People who are subject to a custodial supervision order or a non-custodial supervision order under Part IIA of the Criminal Code

(3). People who are found not guilty of offences because of mental illness

(4). Offenders, or persons accused of offences, who are referred for assessment by courts or other agencies

(5). Shared FMHS and Forensic Disability Unit clients.

For the purposes of this Discussion Paper, reference to 'forensic client' will include those who are regulated under Part 10 of the *MHRS Act* or Part IIA of the Criminal Code. It is acknowledged the *MHRS Act* and the Criminal Code intersects with the *Disability Services Act 1993*. The *Disability Services Act 1993* regulates forensic disability clients who receive services and supports from the Forensic Disability Unit, and any considerations to improve Part IIA of the Criminal Code or Part 10 of the *MHRS Act* will impact on the operation of this legislation. A review into the *Disability Services Act 1993* is due to commence before the end of 2020.

5.1 Procedure for summary criminal offences (Local Court)

Section 3 of the Criminal Code classifies criminal offences in the Northern Territory as either indictable or summary offences. An indictable offence is generally an offence that attracts a penalty of imprisonment for a period of greater than two years. A summary offence is any offence that is not an indictable offence.

Summary offences and some indictable offences (if capable of being tried summarily) are prosecuted in the Local Court which is the Northern Territory's court of summary jurisdiction.

Current approach

Pre-assessment advice, assessment order and reports under the MHRS Act

Under sections 74 and 74A of the *MHRS Act*, the court may request advice from the CHO about whether a person accused of a summary offence is in need of treatment, and whether there are resources available to do so.[197] The court may then adjourn the proceedings and order the accused to be assessed and for a report to be produced for the court.[198] The report of assessment must state whether or not the accused satisfies the criteria for involuntary admission on the grounds of mental illness or mental disturbance.[199]

If the accused does satisfy the criteria for involuntary admission, the report must state whether an approved treatment facility is available for their admission,[200] the recommended duration of the admission,[201] and any recommendations for the accused's conveyance and security while at the facility.[202]

If the criteria for involuntary admission are not satisfied, the report must state whether the accused requires involuntary treatment in the community,[203] or whether the person requires other treatment under the Act[204] (and what type of treatment).[205]

Admission order under the MHRS Act

If the court is of the opinion that accused satisfies the criteria for involuntary admission on the grounds of mental illness or mental disturbance, the court may adjourn the proceedings and order for the accused to be detained in the approved treatment facility for an examination and assessment.[206] The adjournment period must not exceed the duration of the admission recommended in the report, or 15 days – whichever is shorter.[207]

Even though the accused may be admitted under a court order, an authorised psychiatric practitioner or NTCAT may determine they are no longer required to be admitted at the facility.[208] Either the accused returns to custody[209] or, if granted bail, is released from the facility[210] and the CHO must inform the court upon the resumption of proceedings.[211]

Voluntary Treatment Plan under the MHRS Act

Under Part 10, Division 3 of the *MHRS Act*, if the accused pleads guilty, or is found guilty of an offence and recognises that they have a mental illness or mental disturbance that requires treatment, the court may order for the person to enter into a voluntary treatment plan. Proceedings may be adjourned for up to six months to allow the accused to complete the voluntary treatment plan and report back to the court. Upon successful completion of the voluntary treatment plan, the court has the option to dismiss the charge or to deal with the person under the *Sentencing Act 1995*.

Dismissal of Charge under the MHRS Act

In criminal proceedings before the Local Court, the court may request a certificate from the CHO that states whether, at the time of the conduct constituting the alleged offence, the person was suffering from a mental illness or mental disturbance;[212] and whether it is likely that the mental illness or mental disturbance materially contributed to the conduct comprising the offence.[213] Upon receiving a section 77 certificate, the court must dismiss the charge if satisfied that, at the time of the offence the accused was suffering from a mental illness or mental disturbance,[214] and as a consequence, the accused –

- did not know the nature and quality of their conduct,[215] or
- that it was wrong,[216] or
- was not able to control their actions.[217]

Mental Health Diversion List

Practice and procedure in the Local Court is also governed by Practice Direction. The Local Court Mental Health Diversion List (MHDL) was established in 2016, and was designed to divert persons who have possible mental health issues or a cognitive impairment that have been charged with in the Local Court. It is established by Practice Direction,[218] not by legislation.

An accused is eligible to be referred to the MHDL if the person appears to have a mental illness or mental disturbance within the meaning of the *MHRS Act*. The *MHRS Act* provisions available to the MDHL include:

- Pre-assessment advice[219]
- Assessment order and report[220]
- Admission order[221]
- Dismissal of charges[222]

The purpose of the MHDL is to better support and recognise the mental health related needs of the accused person. The MHDL has the following aims:

- *to assist those people to address their mental health or cognitive impairment needs related to their criminal behaviour;*
- *to improve their mental health and general well-being;*
- *to improve the safety of the community and reduce recidivism; and*
- *to reduce the use of criminal justice punishment for criminal behaviour related to mental health issues and cognitive impairment'.*[223]

A key feature of the MHDL is the allocation of court clinicians from the Forensic Mental Health Services to assist the court in achieving the above aims.[224]

Fitness for Trial

A significant deficiency of Part 10 of the *MHRS Act* is that it does not provide for unfitness to stand trial, as does Part IIA of the Criminal Code. The result is that the Local Court does not have the power to determine unfitness to stand trial for summary matters. If the issue of unfitness to stand trial or plead is raised in relation to a summary offence, the court must not proceed further with the charge.[225] If the offence is one within the jurisdiction of the Supreme Court, the matter may be referred to the Supreme Court.

Discussion

The Local Court has a number of powers under the *MHRS Act* (as well as the *Sentencing Act 1995*) in relation to accused persons suffering from mental illness or cognitive impairment. Regardless of whether there has been any prior indication that the accused may be suffering from a mental illness or cognitive impairment, their mental state and presentation in court (whether in custody or on bail),[226] in addition to information given to the court,[227] may trigger the Court's powers under Part 10 Division 1 (sections 73A-76) of the *MHRS Act*.

The unconditional nature of a dismissal of charge is said to create a 'problematic relationship'[228] between the provisions within the *MHRS Act* and hearing a matter summarily in the Local Court. If the Local Court is hearing a mental impairment matter and the accused is in need of a court ordered treatment in the form of a supervisory order, the matter would need to be referred to the Supreme Court that has jurisdiction under Part IIA of the Criminal Code to issue treatment or supervision orders. This may not be appropriate for some types of summary offences.

In its report, the NTRLC commented:[229]

It is conceptually difficult to reconcile the provisions of section 77 of the [MHRS Act] with the provisions of Part IIA, Division 1, of the Criminal Code. Given that both statutory provisions deal with a mental impairment defence and the gravity of some offences dealt with summarily in the Magistrates Court there appears little, if no, justification for creating two different regimes.

The Law Reform Committee also reported on and identified deficiencies in the section 77 process and outcomes. The article *'A Judge Short of a Bench: Mental Impairment and Fitness to Plead in the NT Legal System'*[230] was cited[231] in the NTRLC's report, and it referred to two concerns about section 77:

1. A person with a mental illness which may have led them to engage in criminal conduct will be released without any supervision or treatment; and
2. There is a general perception that a s77 order 'may amount to letting a person evade responsibility for their action'.[232]

Further, when a finding has been made that the offending was caused by mental illness or mental disturbance, simply dismissing the charge without further treatment or therapeutic intervention or supervision for the accused does not help to improve public safety, address the cause of offending, nor does it prevent a person who may pose a risk to themselves or the community from 'falling through the cracks'.[233]

Acknowledging the problems with section 77 and the lack of procedures in the Local Court more generally to adequately deal with accused persons with mental illness, the NTLRC made a number of recommendations, including:

- Questions relating to a defendant's fitness to stand trial should be dealt with by a Mental Health Court or Mental health Diversion List (recommendation 19)
- The process should be adapted from those procedures under Part IIA of the Criminal Code (recommendation 20)
- Section 77 be amended to include a discretionary power of the Court to make therapeutic supervisory orders similar to orders under Part IIA of the Criminal Code, but with variation to ensure more simplified processes suited to the Local Court jurisdiction and that such therapeutic orders should be made for a specified period of time (no longer than 12 months) (recommendation 18).

It is noted that Government is yet to implement these recommendations. This review provides the opportunity to consider how the recommendations may be implemented in the context of a broader review of the mental health legislation.

Other jurisdictions

South Australia

Division 3A of the *Criminal Law Consolidation Act 1935* (SA) sets out the provisions for person with mental impairment charged with summary and minor indictable offences. Orders made under Division 3A apply when the court has found that the objective elements of the summary or minor indictable offence are established but the accused is either:

- not guilty of the offence because the defendant was mentally incompetent to commit the offence[234] or
- the defendant was mentally unfit to stand trial for the offence.[235]

In this circumstance, the court has a number of options available under section 269NB:

- dismiss the charge and release the defendant unconditionally
- declare the defendant to be liable to a supervision order
- make an order to release the defendant on licence for a period specified by the court (this period must not exceed 5 years) and under certain conditions
- adjourn the proceedings
- remand the defendant on bail
- make any other order the court thinks fit.

In South Australia, the paramount consideration of the safety of the community outweighs the principle that restrictions on the defendant's freedom and personal autonomy should be kept to a minimum.[236]

Queensland

Under section 22 of the *Mental Health Act 2016* (QLD) the Magistrates Court may dismiss a complaint 'for a simple offence' if the court is reasonably satisfied, on the balance of probabilities, that the person charged with the offence was, or appears to have been, of unsound mind when the offence was allegedly committed or is unfit for trial.[237] The meaning of 'simple offence' is 'any offence (indictable or not) punishable, on summary conviction before a Magistrates Court, by fine, imprisonment, or otherwise.[238]

The Magistrates Court can order an authorised doctor to examine the person for the purposes of determining whether a treatment authority should be made for that person, or if recommendations should be made for their treatment and care.[239]

New South Wales

New South Wales assented the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* (NSW) in June 2020 that repealed the former *Mental Health (Forensic Provisions) Act 1990* (NSW). The new legislation implemented principal reforms recommended by the NSW Law Reform Commission in two forensic reviews in 2012[240] and 2013.[241]

Part 2 of the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* applies to criminal proceedings before a Magistrate[242] and strengthens the ability for the Local Court to make diversion orders with mental health or cognitive impairments in summary proceedings. Section 15 provides a list of considerations that a magistrate can refer to when making a diversion order including seriousness of the offending,[243] the defendant's criminal history[244] and suitability of sentencing options available if the defendant is found guilty of the offence.[245] The Magistrate can also consider whether a treatment or support plan has been prepared in relation to the defendant and the content of the plan,[246] and consideration of the victims of the crime and community safety.[247]

If a person subject to a diversion order fails to comply with a condition of their treatment or support plan, the Magistrate may order the defendant to appear back before the court to deal with that person at law, up to 12 months from the date of the order.[248]

Western Australia

Forensic mental health is regulated under the *Criminal Law (Mentally Impaired Accused) Act 1996* (WA), separate legislation to the *Mental Health Act 2014* (WA). Division 2 (section 15-17) regulates proceedings in courts of summary jurisdiction.

For offences that can be tried summarily, the court must also determine whether it is satisfied that the accused will or will not be mentally fit to stand trial within six months. If it is satisfied that the accused will not become mentally fit to stand trial within six months, the court must make an order[249] to dismiss the charge and either release the accused or make a custody order.[250] If it is not

satisfied, the court must adjourn the proceedings (for a period no longer than six months)[251] in order to see whether the accused will become mentally fit to stand trial.[252]

For indictable offences that are able to be heard in summary jurisdiction, the court must follow the procedure in the *Criminal Procedure Act 2004* (WA) and the accused, while not mentally fit, is presumed to plead not guilty to the charge.[253]

5.2 Procedure for indictable criminal offences (Supreme Court)

Some offences are too serious, complex or difficult to be dealt with by the court of summary jurisdiction (Local Court). In the Northern Territory, indictable offences of this nature are tried in the Supreme Court.

The Supreme Court has review and decision-making jurisdiction under Part IIA of the Criminal Code with respect to the supervision, treatment and care of a person found not guilty by way of mental impairment or found unfit to plead.

Current approach

Defence of mental impairment

A person is presumed not to have been suffering a mental impairment when they committed an alleged offence, unless the contrary is proved on the balance of probabilities.[254] The mental impairment defence is established if the court find that the accused was, at the time of carrying out the offence, suffering from a mental impairment, and as a consequence of that impairment:

- they did not know the nature and quality of their conduct[255]
- they did not know their conduct was wrong[256] or
- they were not able to control their own actions.[257]

If the defence of mental impairment is raised during the trial, this is tried separately.[258] This means the court hears evidence about the accused's mental competence and the defence or prosecution can make an application to the court for the accused to be examined by a psychiatrist.[259]

The accused person may raise the defence at the trial of the proceedings. In such circumstances, the accused may enter a plea of 'not guilty' by reason of mental impairment. The accused is at liberty to raise the defence at any stage during their trial. The defence of mental impairment may also be raised by the court on its own initiative or by the court upon an application by the prosecution. After hearing all the evidence, the jury must determine whether on the balance of probabilities the defence has been established,[260] and whether the accused:

- is not guilty of the offence charged[261]
- is not guilty of the offence charged because of their mental impairment[262]
- committed the offence charged or an alternative offence.[263]

If the defence is established, the accused must be found not guilty because of mental impairment.[264] Where an accused is found not guilty on grounds of mental impairment, the court must impose a 'supervision order' pursuant to Division 5 of Part IIA or otherwise order that the accused be released unconditionally.

Fitness to stand trial

A person who is charged with an offence is presumed to be fit to stand trial.[265] This presumption may be rebutted[266] if the person charged with an offence is unable to:

- understand the nature of the charge against them, or
- plead to the charge and to exercise the right of challenge, or
- understand the nature of the trial, or
- follow the course of the proceedings, or the substantial effect of any evidence that may be given in support of the prosecution, or give instructions to their legal counsel.[267]

If the question of fitness is raised by the prosecution or the defence, the party raising the issue bears the onus of proving it.[268] If the question is raised by the court, no party bears the onus of rebutting the presumption - but the prosecution has responsibility for overseeing the handling of the matter.[269]

Special hearing

The real and substantial question regarding the accused's fitness to be tried is determined by a jury in a special hearing unless the parties agree the accused is unfit under section 43T. A special hearing is separate to the criminal trial. The special hearing determines whether the accused who is found not fit to stand trial:

- is not guilty of the offence charged

- is not guilty of the offence charged because of their mental impairment, or
- committed the offence or an alternative offence.[270]

If the jury at a special hearing find the accused person not guilty of the offence, that finding is taken to be a finding of not guilty at a criminal trial and the court must discharge the person.[271]

If the jury at a special hearing finds the accused is not guilty because of mental impairment, this finding is taken to be the same as if it was made in a criminal trial. The court must either declare the person liable to supervision (in the form of a supervision order)[272] or order the person to be released unconditionally.[273]

If the jury at a special hearing finds that the accused committed the offence charged (or an alternative offence), that findings is found to be taken as a qualified finding of guilt. This is different to a finding of guilt by law, so this means that the accused must be further prosecuted in respect to the same conduct and circumstances.[274] The jury's finding is subject to appeal as if it was a finding of guilt in a criminal trial.[275] The court must declare the accused person is liable to supervision (in the form of a supervision order) or order the person to be released unconditionally.[276]

Supervision orders

The Supreme Court must[277] make a supervision order where the court declares the person liable to supervision:

- if an accused person is found not guilty because of mental impairment[278]
- where there is a finding of not guilty because of mental impairment following a special hearing under section 43X(2) or a qualified finding of guilt under section 43X(3), or
- where the parties agreed that the evidence establishes a defence of mental impairment under section 43XB

The Criminal Code establishes two types of supervision orders:

1. Custodial supervision order – commits the accused person to custody either in a correctional facility[279] or in another place the court considers appropriate[280]
2. Non-custodial supervision order – releases the accused person, subject to conditions that the court consider appropriate.[281]

A custodial supervision order committing the person to a custodial correctional facility must only be made if there is no practicable alternative available.[282]

If the court declares that the accused is liable to supervision, a report must be prepared to the court on the mental impairment, condition or disability of the accused. This report must be submitted within 30 days (or another agreed time) after the declaration.[283] The report must contain the accused's diagnosis and prognosis; a history of past treatment and how the accused has responded to past treatment; and a suggested treatment plan for managing the accused's mental impairment, condition or disability.[284]

Restrictions on a supervised person's freedom and autonomy are to be kept to a minimum that is consistent with maintaining and protecting the safety of the community.[285] In determining whether to make an order under Part IIA, the court must have regard to the following:[286]

- whether the accused person or supervised person is likely to endanger himself or herself or another person because of his or her mental impairment, condition or disability
- the need to protect people from danger
- the nature of the mental impairment, condition or disability
- the relationship between the mental impairment, condition or disability and the offending conduct
- whether there are adequate resources available for the treatment and support of the supervised person in the community
- whether the accused person or supervised person is complying or is likely to comply with the conditions of the supervision order
- any other matters the court considers relevant.

Review of supervision orders

Unless varied, reviewed or revoked, a supervision order is for an indefinite term.[287] Reviews are available to the court under sections 43ZK (at least annually) and 43ZG (a major review) of the Criminal Code. A supervised person can also apply to the Supreme Court for a variation or revocation of the supervision order.[288]

The court has the ability to request the following reports to assist in their review of a supervision order:

1. Section 43ZK report – if the court makes a supervision order for a person, regular reports (at intervals no longer than 12 months) are submitted to the court that details the treatment and services provided to the supervised person and details of any changes to the supervised person's mental impairments or changes to the supervised person's treatment plan.

2. Section 43ZL report – when the court is considering whether to make, vary or revoke a supervision order, or determining whether to release a supervised person, the victim (or victim's next of kin, if the victim is deceased) may prepare and submit a report to inform the court of their views.

The court must not make an order under this Part that either releases a supervised person from custody or significantly reduces their supervision unless the court has obtained two expert reports from two different experts, and considered the reports under section 43J (condition report) and 43ZK (periodic report) and, if available, section 43ZL (view of victim or next of kin).[289]

If the court considers that it will assist in determining whether to make, vary or revoke a supervision

order, it may also on its own initiative, request a report setting out the views of the accused or supervised person's next of kin and family; and if the person is a member of an Aboriginal community, a report setting out the views of the community.[290]

If the application to vary or revoke a supervision order is refused by the court, the supervised person must not make another application within 12 months after the date of the court's refusal (or after any other period the court fixes).[291]

Discussion

Part IIA of the Criminal Code was introduced in 2002 and has not been subject to a major review since.

The NTLRC recommended that the definition of 'mental illness' at section 43A of the Criminal Code should refer to (and therefore be aligned with) the definition of mental illness in the *MHRS Act*.'

One feature of Part IIA that has attracted attention and criticism is section 43ZC of the Criminal Code which provides that a supervision order must be for an indefinite term.

The Senate Community Affairs References Committee's report, 'Indefinite detention of people with cognitive and psychiatric impairment in Australia' made the following observations at paragraph 3.9

...the NT is one of the few Australian jurisdictions that still issues forensic orders with indefinite terms of duration. Ostensibly, the NT Supreme Court conducts annual reviews in which it must consider, amongst many things, the risk to any individual or the community if the accused is released. However, this process essentially reverses the onus of decision making from requiring a justification to detain, to requiring a justification to release...

Recommendation 10 of the Report on the review of *Forensic Mental Health and Disability Services within the Northern Territory* [292] of January 2019 recommended that:

The Northern Territory Government should establish relevant legislative provisions to allow for the Mental Health Review Tribunal to make decisions about the detention, treatment and release of forensic clients. These provisions should draw on examples of safeguards available in other jurisdictions, such as NSW and Queensland.[293]

Further, Recommendation 16 of the Norrie Report recommended considering whether the ongoing management of orders could be transferred from the legal system, by setting up a Tribunal to supervise and monitor the status of those on long term orders.[294] Dr Norrie adds that 'this transfer would release the Supreme Court from a significant amount of ongoing review work and with the Tribunal process put the NT more in line with other jurisdictions'.[295]

Currently only the Supreme Court has review and decision making jurisdiction for indictable offences, with respect to the supervision, treatment and care of a person found not guilty by way of mental impairment or unfit to plead. Importantly, the court (including by jury) determines whether the person is unfit to stand trial and/or not guilty by way of mental impairment, and it is the court that declares the person is liable to supervision. Given this decision making relates to questions of guilt for serious criminal charges, it is appropriate this question only be dealt with by a court, not a tribunal.

It is also noted that the implementation of recommendations to transfer ongoing oversight of supervision orders to a tribunal may have significant resource and operational impacts in establishing a specialist tribunal (whether or not that is part of the NTCAT), ensuring that tribunal has the appropriate expertise, and moving the current framework from the Supreme Court.

Other jurisdictions

New South Wales

The Mental Health and Cognitive Impairment Forensic Provisions Act 2020 (NSW) introduced a special verdict of 'act proven but not criminally responsible because of mental health or cognitive impairment'[296] where a defence of mental health impairment or cognitive impairment is raised and is successful. This new verdict recognises the impact of the criminal act on victims (in comparison to the phrase 'not guilty by reason of mental illness'). This verdict is not a conviction, but recognises that the accused did in fact, commit the act.[297]

Australian Capital Territory

Part 13 of the *Crimes Act 1900* (ACT) deals with Unfitness to Plead and Mental Impairment. Section 308 lists criteria for the court to consider when making an order for detention and includes consideration of:

- the nature and extent of the accused's mental dysfunction or mental illness
- including the effect it is likely to have on the person's behaviour in the future
- whether or not, if released, the accused's health and safety is likely to be substantially impaired or
- whether the accused is likely to be a danger to the community
- the nature and circumstances of the offence with which the accused is charged

- the principle that a person should not be detained in prison unless no other reasonable option is available; and
- any recommendation made by the tribunal as to how an accused person should be dealt with.

Where mental competency is raised in the context of criminal proceedings, the court refers the matter to Australian Capital Territory Civil & Administrative Tribunal (ACAT) for the person to be dealt with in accordance with the provisions of the *Mental Health Act 2015*. The court can make any orders it thinks appropriate in relation to the accused, including release on bail.[298] If ACAT determines the accused is unfit to plead, the court conducts a 'special hearing'.[299]

Following a special hearing for a serious offence pursuant to section 319(2) of *the Crimes Act 1900* (ACT), the Supreme Court must order that the accused be detained in custody until ACAT orders otherwise unless, in consideration of the criteria for detention in section 308, it is satisfied that it is more appropriate to order that the accused submit to the jurisdiction of ACAT to enable ACAT to make a mental health order.

Queensland

Forensic orders are made by Queensland's Supreme Court or District Courts under any of sections 613, 645 or 647 of the Criminal Code 1899 (QLD). These orders require a person to be admitted to an authorised mental health service to be dealt with under Mental Health Act 2016 (QLD). A forensic order under the Criminal Code allows the involuntary treatment and care of a person for a mental condition and, if necessary, detention in an authorised mental health service.

Western Australia

When deciding the question of mental fitness to plead, under the *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) the judicial officer may: 'order examination by a psychiatrist or other appropriate expert; order a report by a psychiatrist or other expert to be submitted to the court; adjourn the proceedings; or make any other order the judicial officer thinks fit.[300]

Pursuant to section 14, the court may grant the accused bail, or remand the accused in custody, or make a hospital order. Section 22 of the *Criminal Law (Mentally Impaired Accused) Act 1996* sets out the types of orders that may be made where a person is found not guilty on account of unsoundness of mind, including custody orders.

Under section 24, a custody order requires a mentally impaired accused to be 'detained in an authorised hospital, a declared place, a detention centre or a prison, as determined by the Board, until released by an order of the Governor'. In April 2016, the Government of Western Australia reviewed their forensic mental health legislation and released a final report[301] discussed custody orders and indefinite detention at page 13:

A significant majority of the submissions received by the Review expressed strong views against indefinite custody orders and called for the term of the custody order to be limited by the court imposing the custody order…

The Report considers that the introduction of a fixed term custody order (based on the sentence of an unimpaired offender who is convicted) is problematic from the perspective of community safety, in that there is a risk that a mentally impaired accused may be released prematurely in relation to their readiness to reintegrate into the community.[302]

The Report made no recommendation to change the regulatory regime regarding the indefinite nature of custody orders, but did make a recommendation (Recommendation 16) to establish a working group to review the operation of indefinite custody orders under the Act.

Victoria

Before remanding a defendant in custody in an appropriate place a judge must receive a certificate under section 47 of the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* stating that the facilities or services necessary for that order are available.[303] A protective principle enshrined in the Victorian legislation that is similar to the provisions of the Criminal Code in the NT is contained in section 12(4) of the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* which states that the judge must not remand a defendant in custody in a prison unless satisfied that there is no practicable alternative in the circumstances.

Where an accused is acquitted on grounds of mental impairment, section 23 of the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* requires the court to either declare the person liable to supervision under Part 5, or

release them unconditionally. Section 27 states that supervision orders are of indefinite duration, however, section 28 requires the court to set a nominal term (as in the NT) and there are specific review provisions and criteria for custodial supervision orders set out in sections 31 and 32.

South Australia

In SA the court may specify in a supervision order the person's detention in a hospital for the purpose of treatment. However, the court is required to fix a limiting term to supervision orders with reference to the term of imprisonment that would otherwise have applied had the defendant been found guilty of the matters alleged. At the end of the limiting term, a supervision order lapses.[304]

5.3 Clinical pathway for forensic clients

The 'clinical pathway' for a person describes the systems and processes that recognise how a person's treatment needs are supported to ensure progress towards attaining independence and physical, mental, social and vocational ability is evaluated and supported.

The National Statement of Principles for Forensic Mental Health identified the barriers that confront forensic mental health services, particularly for forensic clients transitioning through the criminal justice and mental health systems:[305]

Correctional system	*General (mainstream) mental health system*	*Other human services*
There are inherent difficulties in providing a mental health service within a correctional facility given the major focus of correctional facilities being secure containment and the focus of mental health services being diagnosis, treatment and rehabilitation. [305]	*A boundary between forensic mental health and general mental health services is created by the client's involvement in the criminal justice system.*[305]	*The stigma and fear of forensic clients often creates boundaries between forensic mental health services and other human service agencies. This can result in other agencies being unwilling to provide ongoing support, care and treatment.*[305]

The Forensic Review identified the 'prevailing need for a clear clinical pathway of care with stepped resource model for persons subject to Part IIA orders and others in contact with the criminal justice system'. The clinical pathway for a forensic client is complex as both the interface between the criminal justice and mental health systems must balance the treatment of the individual and safety of the community.(306) NT Health supported the recommendation in principle, advising that further consideration and research would be undertaken.(307)

Other jurisdictions

Queensland

The Mental Health Act 2016 (QLD) establishes the role of an 'authorised doctor' as an appointed role with responsibilities for providing appropriate patient treatment and care for a forensic patients. The authorised doctor is appointed by the 'administrator' (person-in-charge equivalent) of an authorised mental health service,(308) and in circumstances where the administrator of the authorised mental health service is a psychiatrist, the administrator is an authorised doctor.(309) The Chief Psychiatrist may make a policy about the competencies necessary for a person to be an authorised doctor and is also able to end the appointment of an authorised doctor.(310)

The QLD Act has provisions that provide treatment and care for 'classified patients', which includes a person who is subject to a:

- recommendation for assessment;
- treatment authority;
- an inpatient forensic order (mental health);
- treatment support order and is transported from a place of custody and is admitted into an inpatient facility.

The 'classified patient' terminology used in QLD Act is different to the *MHRS Act* which currently refers to anyone of a custodial forensic order, youth detainee or adult in remand as a as a prisoner when admitted into an inpatient facility. The evaluation of the QLD Act conducted in 2019 found that improved access to treatment and care for classified patients and better governance process and notification requirements to the Chief Psychiatrist for classified patients.

In Queensland, the Mental Health Court receive advice from assisting psychiatrists on the meaning and significance of clinical evidence and issues relating to the treatment and detention needs of people under *Mental Health Act 2016* (QLD).

New South Wales

Recently, NSW introduced the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* (NSW Forensic Act). The NSW Forensic Act sets out aims to: "divert people with mental health impairment or cognitive impairment who are charged with low-level offending out of the criminal justice system and into care, treatment, support and supervision. Diversion can benefit both the offender and the wider community by addressing the causes of offending. It serves to reduce reoffending by addressing, treating and/or controlling the offending behaviour. A 2019 study conducted by the Kirby Institute of the University of New South Wales showed that among those with a serious mental illness receiving a treatment order by the court rather than a punitive sanction, the reoffending rate was 12 per cent lower than the punitive sanction group."

Under section 14(a) of the NSW Forensic Act the Magistrate may make an order to dismiss a charge and discharge the defendant into the care of a responsible person, unconditionally or subject to conditions. This provides a flexibility to the court to nominate a 'responsible person' that is appropriate to the defendants clinical pathway, i.e. care, treatment, support and supervision needs.[311]

Appendix A Mental health reform across Australia

At the local and national level, activity is occurring in the private and public sectors that will either directly impact, influence or reform the operation of mental health legislation in the Northern Territory.

Northern Territory:

Private hospital facility

Healthscope Limited has announced it will invest approximately $16 million in building a Mental Health and Alcohol and other Drugs 18-bed inpatient unit at Darwin Private Hospital.

Veteran Wellbeing Centre

The Australian Government Department of Veterans' Affairs has announced that a Veteran Wellbeing Centre will be located Darwin and available to current and former serving Australian Defence Force members, including reservists, and their families.

Alternatives to acute mental health settings

The Department of Health is examining alternatives to most acute mental health settings to better support coordination of services from acute to community settings. This includes the Mental Health

Trial of the Mental Health Co-response Model

The Mental Health Co-Response Model is being trialled in Darwin to provide targeted care and treatment of people suffering acute mental health episodes in the community as an early intervention to reduce the incidents of acute in-patient admissions. The trial is a collaboration between the Department of Health, NT Police and St John Ambulance.

Nationally

Productivity Commission inquiry into Mental Health

Inquiry to examine the effect of mental health of people's ability to participate in and prosper in the community and workplace, and the effects it has more generally on our economy and productivity.

Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (the Disability Royal Commission)

The Disability Royal Commission will deliver a final report to the Australian Government by 29 April 2022. In this report, the Royal Commission will recommend how to improve laws, policies, structures and practices to ensure a more inclusive and just society.

National mutual recognition of civil mental health orders - the National Mutual Recognition Project

Action 26 of the *Fifth National Mental Health and Suicide Prevention Plan* commits Australian governments to improving the consistency of mental health legislation across jurisdictions. The mutual recognition of mental health orders is an important first step towards improved consistency, with a view to ensuring seamless and safe care for consumers and better integration of mental health and related services in Australia. The national legislative scheme is due to be delivered to COAG Health Council by December 2021.

Renewal of National Mental Health Policy

The Fifth National Mental Health and Suicide Prevention Plan commits governments to renew the National Mental Health Policy. Completion of National Mental Health Policy is due in December 2020.

Revise National Mental Health Performance Framework:

The National Mental Health Performance Framework 2020 superseded the former National Mental Health Performance Framework, developed in 2005. The revised framework aims to improve all health outcomes for all Australians living with mental illness and ensure sustainability of the Australian health system. The framework supports Australian and state and territory governments' commitment to improving accountability and transparency at the Mental Health Service Organisation level.

National Safety and Quality Digital Mental Health Standards

The Australian Commission on Safety and Quality in Health Care (the Commission) has developed draft National Safety and Quality Digital Mental Health (NSQDMH) Standards. Public consultations ran from March - May 2020. The Standards aim to provide safety and quality assurance for digital mental health service users, and best practice guidance for service providers and developers.

Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

On 29 June 2020, the Australian Human Rights Commission released the 'Implementing OPCAT in Australia' report that makes recommendations on how Australia is implementing the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). The report found that the progress towards implementation to date has been slow, and makes 17 recommendations to improve implementation.[312]

If the information in this document has affected you, 24/7 support is available from the following services:

Beyond Blue 1300 224 636 www.beyondblue.org.au

Lifeline 13 11 14 www.lifeline.org.au

Kids Helpline 1800 55 1800 www.kidshelpline.com.au

Online information and support at www.ReachOut.com
Your GP can also help you access the services you need.

Endnotes

[1] Australian Health Ministers' Advisory Council, Commonwealth of Australia (2013) *A national framework for recovery-orientated mental Health services: Policy and Theory*.

[2] Australian Health Ministers' Advisory Council, Commonwealth of Australia (2013) *A national framework for recovery-orientated mental Health services: Policy and Theory*.

[3] Rayner, S et al. *A new paradigm of youth recovery: Implication for youth mental health service provision*, Australian Journal of Psychology 2018; 70: 330-340, 331; Australian Health Ministers' Advisory Council, Commonwealth of Australia (2013) *A national framework for recovery-orientated mental Health services: Policy and Theory*.

[4] *Mental Health Act 2014* (WA) Schedule 1 – Charter of Mental Health Care Principles, Purpose B.

[5] *Mental Health Act 2014* (WA) Schedule 1 – Charter of Mental Health Care Principles, Principle 4.

[6] *Mental Health Act 2015* (ACT) s5(a).

[7] *Mental Health Act 2015* (ACT) s6(c).

[8] *Mental Health and Related Services Act 1998* (NT) s7(4).

[9] *Mental Health and Related Services Act 1998* (NT) s7(6).

[10] *Mental Health and Related Services Act 1998* (NT) s7(5).

[11] *Mental Health and Related Services Act 1998* (NT) s7(1).

[12] *Mental Health and Related Services Act 1998* (NT) s7(7).

[13] *Mental Health and Related Services Act 1998* (NT) s14.

[14] *Mental Health and Related Services Act 1998* (NT) s15.

[15] *Mental Health and Related Services Act 1998* (NT) s15A.

[16] *PBU & NJE v Mental Health Tribunal* [2018] VSC 564 at [142].

[17] Wolstenholme, M. Current Trends in Mental Health Legislation, Government of Western Australia Mental Health Commission, p. 10.

[18] *PBU & NJE v Mental Health Tribunal* [2018] VSC 564 at [148].

[19] Wolstenholme, M. *The experiences of the legal processes of involuntary treatment orders: Tension between the medical and legal frameworks.* International Journal of Law and Psychiatry 38 p 45.

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