

Report on the review of Forensic  
Mental Health and Disability Services  
within the Northern Territory

January 2019

Final

## Acknowledgements<sup>1</sup>

The Review Panel acknowledges and respects traditional custodians and Aboriginal and Torres Strait Islander elders past and present.

The Review Panel recognises the social and cultural differences that exist between and within communities of Aboriginal and Torres Strait Islander people. Where the term Indigenous is used in this document, it refers to a person of Aboriginal and/or Torres Strait Islander descent who identifies as an Aboriginal person or a Torres Strait Islander person, and is accepted as such by the community in which he or she lives.

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<sup>1</sup> This acknowledgement draws on work done by Queensland Health in their Queensland Mental Health Planning documentation.

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## Glossary

### **Cognitive Impairment**

Cognitive impairment is a broad term used to denote difficulties in learning, understanding, concentrating and remembering. Cognitive Impairment may be associated with a range of clinical or diagnostic labels including Intellectual Disability, brain injury, dementia and may be associated with Autism Spectrum Disorders (ASD) and FASD. A person who has CI is likely to have difficulty in self-regulation and self-management, decision making and communication. This impairment is not confined to people of a certain age, gender or any other demographic.

### **Correctional Client (Patient)**

An individual who is subject to a custodial order in the NT prison system as a result of a guilty verdict and is currently an inmate of the NT correctional system, who is receiving services from NT Health for either a mental illness or cognitive impairment.

### **Forensic Disability Services**

Assessment and support services provided by NT Health to individuals with a cognitive impairment who have been subject to an order from the criminal justice system, or who are still being processed by the court system

### **Forensic Health Services**

For the purposes of this report forensic health services refers to forensic mental health services and forensic disability services collectively consistent with the language provided to the panel in the Terms of Reference. The panel notes that the term usually refers to *all* health services provided to those in contact with the criminal justice system including primary care and services for physical health care, however it is not used in that sense in this report.

### **Forensic Mental Health Services**

Assessment, treatment and support services provided by NT Health to individuals with a mental health problem who are, or have been, in contact with the criminal justice system. These can be forensic patients, correctional patients or individuals still being processed through the court system.

### **Forensic Client (Patient)**

An individual found not guilty by reason of mental illness or mental impairment or found unfit to stand trial who have been made the subject of an order under Part IIA of the NT Criminal Code.

### **Mental Illness**

Means an underlying pathological infirmity of the mind, whether of long or short duration and whether permanent or temporary, but does not include a condition that results from the reaction of a healthy mind to extraordinary stimuli (although such a

condition may be evidence of a mental illness if it involves some abnormality and is prone to recur) (NT Criminal Code s43A)

### **Mental Impairment**

Mental impairment includes senility, intellectual disability, mental illness, brain damage and involuntary intoxication (NT Criminal Code s43A).

### **Part IIA Order**

An order of the Supreme Court of the Northern Territory under the legislative authority of the NT Criminal Code. A Part IIA order determines the placement and associated conditions of an individual found not guilty of a crime by reason of mental illness or mental impairment, or one found unfit to stand trial, in a designated facility for the purposes of assessment, treatment, care or support.

### **Settings**

The locations where health services are provided to patients or clients. For forensic mental health and disability services this can include courts, youth detention, correctional custody, secure care facilities, supported accommodation (secure and non-secure), community health services and inpatient facilities.

## Executive Summary

People with mental health problems and intellectual and cognitive disability are markedly over represented at all points in the criminal justice system (CJS). As such forensic mental health and disability services are required to provide assessment, treatment and care for these individuals not only during their contact with the CJS, but also into the community. In addition, individuals may be found by courts, because of their mental illness or disability, not to be criminally responsible or to be unfit for trial. This patient cohort also requires the input of Forensic Mental Health and Disability Services. This report provides the findings of an expert independent review of Northern Territory (NT) Health services provided to people in contact with the criminal justice system or within the youth justice system, who have a mental health problem or a cognitive impairment. It was commissioned by the Northern Territory Government on the authority of the NT Minister for Health and overseen by the NT Department of Health.

The review was not triggered by a single event. The review examines services to different groups of people related by a central experience of involvement with the criminal justice system. However, the individuals at the centre of this review may be receiving health care in a variety of settings, from different organisations, from different practitioners and have different legal frameworks influencing their care. The review examined forensic mental health service delivery, forensic disability services, health services in youth justice detention, community mental health and disability services for people leaving the criminal justice system, relevant legislation and court processes and interfaces between these elements. This review was a system and policy review and not a clinical case file review.

The findings of the review panel detailed below are based on the views of the panel with regard to best practice and appropriate policy responses in contemporary comparable systems. This review makes a number of recommendations to improve service delivery within the forensic mental health and disability program and improve compliance with human rights obligations. These recommendations are summarised on the following pages. The overall level of resourcing for forensic mental health services, and mental health services generally, in the NT requires revision and adjustment. In the absence of additional

resources, and particularly staffing resources, the gains made from implementation of the recommendations made in this report will be sub-optimal. The Territory could benefit from some targeted new facilities, but it also has a number of relatively new assets that are operating well below their physical capacity due to a lack of staff. It is important to communicate that additional clinical and disability support staff are required to improve practice and outcomes.

There is a prevailing need for a clear clinical pathway of care with a stepped resource model for individuals subject to Part IIA orders and others in contact with the criminal justice system who require forensic mental health or disability services consistent with the aims of the AHMAC national principles for forensic care, the position statement of the RANZCP and the intent of policy direction 5 of the National Disability Strategy. There is a need to model a forensic clinical pathway that allows patients to move through a least restrictive care paradigm, have their clinical and risk management needs met and progress back toward community placement. This is a fundamental objective of any forensic care system. There are also opportunities identified to improve responses to Aboriginal and Torres Strait islander clients through the development of partnerships and targeted responses.

Improvements are necessary in the provision of specialist mental health services to correctional inmates. The forensic mental health teams at both the Alice Springs and Darwin facilities have nominal accountability for specialist service provision to correctional inmates in addition to their responsibilities with Part IIA clients. There is evidence to suggest however that the majority of resources go to forensic clients and that there is therefore a dearth of specialist mental health and disability services provided to correctional patients with primary care services carrying this accountability.

The panel acknowledges that the vast majority of individuals receiving services subject to this review are male however it was apparent that there is a lack of clear service pathways that recognise the specific needs of women and girls. The Northern Territory Government should incorporate into its clinical services planning a specific set of responses for women and girls in the criminal and youth justice systems.

There are strong arguments for a closer relationship between forensic mental health services and forensic disability services within NT Health. There are obvious similarities of process, and clinical overlaps between the two forensic teams within NT Health, with the shared cohort that is, those who have both cognitive impairment and mental health problems, amongst the Part IIA clients of around 50%.

The report makes recommendations about potential changes to legal oversight arrangements, improvements in system management and clinical governance, improved data collections and improvements in service relationships in the youth detention environment.

There are clearly a large number of committed professional staff working hard to provide positive outcomes from health services to those involved in the criminal justice system. This review acknowledges their work and the circumstances they are operating under. It can be difficult for governments to take action when there is equivocation about the appropriate directions for reform and a risk of action being divisive rather than effective. This does not reflect the panels experience during the consultation for this review. There was universal agreement on the need for action, significant and shared frustration at current service failings, and a real desire for a clear circuit breaker on system conflicts.

The Northern Territory is a long way from a contemporary system design for its forensic services despite abundant good will and endeavour amongst staff and a genuine desire across agencies to improve outcomes. It is the sincere hope of this panel that concerted action and genuine partnership can improve the outcomes in the forensic mental health and disability system and for the vulnerable group of individuals it serves.

## List of Recommendations

### Recommendation 1

The Northern Territory Government needs to immediately increase the resource base for forensic mental health service provision in the Northern Territory by:

- a. Repurposing the Complex Behaviour Unit at Holtz to a health run forensic inpatient facility catering for both mental health and disability presentations and dual diagnosis.
- b. Allowing a broader diagnostic category to utilise the secure care facility at Alice Springs and the cottages in Darwin with both forensic disability and forensic mental health clients being eligible.
- c. Increasing the availability of community based mental health supports, in collaboration and partnership with Aboriginal CCHS to allow relevant Part IIA clients to return to their community and/or country.
- d. Increase the availability of specialist forensic psychiatry positions by at least doubling current positions to assist with meeting the existing functions prescribed to the forensic service in Darwin.
- e. Allocate resources to specialist forensic positions in Alice Springs, including a dedicated forensic psychiatry position.
- f. Ensure that there is appropriate access to Aboriginal mental health workers with forensic skills in the forensic teams.
- g. Improved availability of forensic psychology services
- h. Improved availability of secure supported accommodation in the community in both Darwin and Alice Springs.

### Recommendation 2

The Northern Territory Government model the resource needs for responses to clients with cognitive impairment based on projections of future demand volume aligned to a reference model provided by the NSW Corrections State-wide Disability Service for the enhancement of multidisciplinary resources for this group. It should be noted that it is expected that there will be economies available through the sharing of resources across

the two forensic specialties and more effective management of those with dual diagnoses who are estimated to be up to 50% of the Part IIA cohort.

### **Recommendation 3**

#### **The Northern Territory Government:**

- a. **Develops as a matter of urgency, a territory wide services plan for clients of forensic mental health and forensic disability services that incorporates secure inpatient or residential care, secure supported accommodation and access to community based forensic supports at a minimum. The role and responsibility of, and interface with, the National Disability Insurance Scheme should be made clear in the plan.**
- b. **Should prepare this plan immediately however it should be updated to utilise the outputs from the Forensic component of the National Mental Health Services Planning Framework to determine service resource need for the mental health component when that tool becomes available.**
- c. **Develops a resourcing strategy to fund the components of that plan acknowledging there is underutilised capacity already within the system that could be repurposed through the provision of additional staffing resources.**

### **Recommendation 4**

- a. **The Northern Territory Government shifts operational authority for the Complex Behavioural Unit at the Darwin (Holtz) Correctional Complex to NT Health, and degazettes the facility as a correctional unit in favour of changing the legal status to a health facility, approved as a treatment facility within the meaning of the Mental Health and Related Services Act. Appropriate changes to the existing security arrangements, staffing and physical asset should be made to allow this change to occur.**
- b. **Additional resources should be allocated to enable care to be delivered by NT Health. In addition, funding should be allocated to utilise the unused bed capacity at the CBU consistent with the designated functionality of the unit identified by the services plan from Recommendation 1. It is likely that this will**

involve high acuity, sub-acute and potentially non-acute mental health wings, at least one dedicated wing for those with a cognitive impairment and could also provide dedicated areas for women and young people from youth detention facilities.

#### **Recommendation 5**

- a. The Northern Territory Government should improve the resourcing of the forensic mental health team onsite in the CAHS to improve local relationships and service arrangements. This includes the establishment of appropriate senior medical positions in forensic psychiatry.**
- b. In alignment with later recommendations regarding the future arrangements with Forensic Disability Services, the forensic CAHS staff should be involved in the operation of the secure care facility adjacent to the Alice Springs Correctional precinct and be part of a Territory wide Forensic Service.**
- c. An operational protocol should be developed by the two health services and endorsed by the Department of Health that provides the mechanism for movement between specialist forensic facilities across the TEHS and CAHS.**

#### **Recommendation 6**

**The Northern Territory Government should resource forensic mental health services to provide comprehensive suicide and self-harm assessment in the prison environment and ensure that these resources are adequate to allow for effective, equivalent 'community based' specialist mental health care to the general prison population. In the absence of additional resourcing the forensic mental health team cannot fulfil this task.**

#### **Recommendation 7**

**The Northern Territory Government should incorporate into its clinical services planning a specific set of responses for women and girls in the criminal and youth justice systems. This may require the establishment of, or repurposing of, physical assets. At a minimum it requires the development of a sexual safety policy for secure facilities. In undertaking this**

work specific consultation should be held with Aboriginal and Torres Strait Islander people to ensure that the specific needs of Aboriginal and Torres Strait Islander women are met.

#### **Recommendation 8**

The Northern Territory Health Department should merge the operational responsibilities of the Office for Disability with regard to Part IIA clients and the Forensic mental health teams in TEHS and CAHS to create a single Forensic Health Service. The secure care facilities available to both services should be designed and staffed, with appropriate interdisciplinary training, to manage both cohorts based on consumer need rather than diagnostic grouping.

#### **Recommendation 9**

The Northern Territory Government should resolve the involvement of Part IIA patients in the NDIS and have their eligibility documented in the appropriate intergovernmental agreements. An individual found not guilty by reason of mental illness or unfit to plead, and therefore with no criminal conviction, who is managed by the health system and resident in a health facility, should be eligible for the NDIS.

#### **Recommendation 10**

The Northern Territory Government should:

- a. 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.
- b. Provide the MHRT with the necessary financial and human resources to take on this additional responsibility.

#### **Recommendation 11**

The Northern Territory Government should:

- a) consider the development of a 'benchbook' related to mental health and disability service delivery and its interface with the criminal justice system.

- b) negotiate an interagency protocol between NT Attorney-General's Department and NT Health that:**
  - I. recognises the resource impost of court reports on NT Health, and creates a volume based price signal in the form of a budget transfer from Attorney-Generals to Health that balances the legitimate requirement for judicial information with clinical care.**
  - II. Defines the different types of reports necessary, their purpose and the required authority and qualifications of the signatory parties.**
  - III. Provides for standardised templates for routine reports.**

#### **Recommendation 12**

- a) The Northern Territory Government should, in the context of the recommendations regarding enhanced resourcing and operational responsibility for the CBU, seek to establish an inpatient specialty service for children and young persons in the youth justice system. This service should be built on best practice principles and be designed with the relevant expertise provided by Child and Youth MH specialists. Noting the potential operational challenges of establishing such a service, in the interim a joint protocol for service delivery involving the FMHS and CAMHS service should be established as a matter of urgency.**
- b) The Northern Territory Government should resource the Child and Youth MHS to provide FMHS, with further review of the overall model of care undertaken by a Child and Youth MH specialist.**
- c) As a matter of urgency Territory Families and NT Health should agree a joint policy on the management of suicide and self-harm in youth detention facilities and a policy on the appropriate clinical management of segregation of young persons in the facilities.**

#### **Recommendation 13**

**Northern Territory Health should as a matter of priority develop a MH 'services plan' that articulates the expected componentry of the service system in broad terms, their anticipated delivery settings and functions and on what basis the Department provides**

funds to services for these components. Identifying gaps and priorities in service elements should form a part of this planning process and the NMHSPF can be used for this purpose. It should identify territory wide specialty services and the inter-regional protocol for accessing these services. It should also identify the expected role relationships between forensic services and the other parts of the mental health treatment system, the disability service system including the NDIS, access to community mental health services and disability support services in remote communities and primary care services in the corrections environment.

Similarly, NT Health must ensure that an equivalent services plan exists and is maintained as current, for the disability service system. This plan should identify the links within that system to forensic clients and to the general mental health system.

#### **Recommendation 14**

Northern Territory Health should use the outputs from the NMHSPF and its forensic adjunct to identify quantitatively future mental health workforce needs and develop a structured plan to attract and retain that workforce. A similar approach should be adopted with regard to using the outputs from Recommendation 11 above to identify workforce needs and responses for Disability services.

#### **Recommendation 15**

The Northern Territory Government should ensure that there are appropriate Interdepartmental MOUs in place between NT Health and the Department of Attorney-General and Justice, and NT Health and Territory Families that reflect the statutory responsibilities of each agency and describe the basic frameworks for how these will be operationalised. These MOUs should form the basis of operational protocols between local services and provide for the establishment and operation of interagency forums for managing challenging cases.

#### **Recommendation 16**

Northern Territory Health should engage a suitably senior psychiatrist or other senior mental health policy expert from another jurisdiction to identify a role framework and

any associated legislative arrangements for an enhanced role for the Chief Psychiatrist in the Northern Territory. At a minimum this should include developing a territory wide clinical governance framework and leading on clinical system services plans.

**Recommendation 17**

The Northern Territory Government establish a statutory annual reporting requirement to publish data on forensic patients that captures the numbers entered into the system, those exited, those continuing, the average duration of orders, those held in custodial services, and those unable to be found placements in the locations preferred by the overseeing body (be it Supreme Court or MHRT).

**Recommendation 18**

Northern Territory Health should establish a formal forensic health service partnership with the Aboriginal Community Controlled Health sector to build on their skill sets with Aboriginal communities and to provide the capacity for individuals on Part IIA orders to return to their communities when clinically appropriate. This partnership should involve the design of culturally appropriate service models for both mental health and disability in these communities.

**Recommendation 19**

Northern Territory Health should take active steps to support culturally appropriate services for forensic clients including access to interpreters, service design initiatives, and models of care. NT Health should establish a Forensic Consumer and Carer Liaison Panel, with appropriate representation of Indigenous people, to provide input to policy directions and service design initiatives.

**Recommendation 20**

The Northern Territory Government liaise with staff at the World Health Organisation to gain access to the 'Quality Rights Training' package for staff of NT Health and other relevant agencies and organisations, consistent with national commitments made in the Fifth National Mental Health Plan.

**Recommendation 21**

**Oversight of the implementation of the recommendations in this report should be undertaken by an Implementation Oversight Panel auspiced by the Office of the Chief Minister. The panel should include the Office of the Public Guardian, the NT Community Visitor Program, the Aboriginal Community Controlled Health Services sector, the Northern Australia Aboriginal Justice Agency (NAAJA) and appropriate senior representation from NT Health, Territory Families, the Attorney-Generals Department and NT Corrections. The panel should also be informed by appropriate consumer and carer inputs, with appropriate proportional representation of Aboriginal and Torres Strait Islander persons, with those inputs sourced in a way that allows genuine participation.**

## Background to the Review

### Preamble

People with mental health problems and intellectual and cognitive disability are markedly over represented at all points in the criminal justice system (CJS). As such forensic mental health and disability services are required to provide assessment, treatment and care for these individuals not only during their contact with the CJS, but also into the community. In addition, individuals may be found by courts, because of their mental illness or disability, not to be criminally responsible or to be unfit for trial. This patient cohort also requires the input of Forensic Mental Health and Disability Services. These services are some of the most difficult and contentious areas of health policy. Policy makers sometimes find it challenging to articulate the importance of balancing public protection with patient welfare and ensuring that in protecting the rights of individuals they are seen to give equal weight to public safety. The victims of the actions and their families, quite reasonably, wish for an appropriate punitive response and can resent anything that seems to mitigate accountability in the perpetrator. Health professionals and their administrative bodies are concerned to ensure the safety of treating staff and given the individual's history can elevate risk management above the need for therapeutic care. The justice system, with all its accompanying infrastructure, naturally elevates the legal process of decision making which can be lengthy and opaque, and the media have limited time and print space to articulate the more complex policy issues surrounding how the balance of community and individual rights is achieved. In short, the systems and stigma that surrounds these people make them some of the most marginalised and powerless individuals in our society.

For these reasons it is important when given an opportunity to express an opinion on the care provided to this group and the legal framework that underpins it, to be direct about shortcomings and potential improvements, and to take the necessary time to articulate the policy framework that should be the basis of the community debate that applies to these people. This report attempts to do that within the context of the Northern Territory community which, although unique in itself, is faced with managing these challenges with similar parameters to those described above. It must do so however with its own complexity

made clear, its geography, highly uneven population distribution, skilled workforce challenges and the need for culturally competent services given the significant over representation of Aboriginal and Torres Strait Islander people. The primary purpose of this report however is to improve outcomes from this system for everyone in the Northern Territory.

### About this Report

This report provides the findings of an expert, independent review of Northern Territory (NT) Health services provided to people in contact with the criminal justice system or within the youth justice system, who have a mental health problem or a cognitive impairment. It was commissioned by the Northern Territory Government on the authority of the NT Minister for Health and overseen by the NT Department of Health. It should be noted that at the time of the review the NT Minister for Health also concurrently held the role of the Northern Territory Attorney-General.

The review was not triggered by a single event. The review examines services to different groups of people related by a central experience of involvement with the criminal justice system. However, the individuals at the centre of this review may be receiving health care in a variety of settings, from different organisations, from different practitioners and have different legal frameworks influencing their care.

There were a number of tragic adverse events within the NT Health system as it interrelates with the legal system, in the preceding twelve months to the commissioning of this review. These events were subject to either judicial based enquiries, internal analysis or widespread media scrutiny. While the features of the cases involved differed in substantive ways, the fundamental relationship with some form of custodial order was a common theme. As a result, the Government has taken a proactive approach to examining its policy and service delivery approaches with a view to improving the overall system responses to people with mental illness and/or disability involved in the criminal justice system.

The review examined forensic mental health service delivery, forensic disability services, health services in youth justice detention, community mental health and disability services for people leaving the criminal justice system, relevant legislation and court processes and interfaces between these elements.

### Terms of Reference

The Terms of Reference for this review were provided to the panel by NT Health, on the authority of the Minister for Health. The Terms of Reference can be found in Appendix A to this report.

### Comment on the Scope of the TORs

The TORs are demonstrably broad and effective prosecution of the entirety of the remit, if interpreted in an expansive light, would not have been possible within the designated time period for completion of the review. As a result, the panel clarified the interpretation of the TORs with those involved in the review governance structure and agreed that consideration of issues to do with disability services would be within the ambit of those cohorts identified in the first paragraph of the TORs. That is those with a forensic disability issue and would focus specifically on models of care for that group and the relationships and interfaces with mental health services. The panel assessed this to mean those who meet the diagnostic criteria for intellectual disability or cognitive impairment, or some form of dual diagnosis inclusive of a mental illness. An investigation of the broader disability system within the context of the nascent National Disability Insurance Scheme (NDIS) would require a different mix of expertise on the review panel, notwithstanding the eminent disability sector expertise already available to the panel.

Further, as far as a practicable, the focus of deliberations with regard to mental health services would be on services to people in contact with the criminal justice system and commentary on the remainder of the mental health system would be limited to its impact on that group.

## Governance of the Review

The review was commissioned by Northern Territory Health on the authority of the Minister for Health. The Terms of Reference endorsed by Government identified that a steering committee would be established to oversight the work of the review panel, provide guidance on evidence gathering and make decisions on the appropriate fact checking and review mechanisms. The steering committee included senior health system representatives involved in both mental health and disability along with senior representation from the community controlled aboriginal health services sector.

The Department commissioned a lead consultant to lead the review process, design the evidence gathering methodology and have primary accountability for delivering the final report. The lead consultant was supported by an expert panel of four individuals with particular areas of expertise that were relevant to the review objectives. Details on the qualifications, skills and experience of the review team is available at Appendix A.

## Review Method

Data to inform the outcomes of this review was sourced from interviews with key informants, review of the relevant legislation and assessment of key policy documents, guidelines and procedures. The reviewers also closely assessed the contents of prior reviews and investigations related to the cohorts in scope and assessed the applicability of the recommendations made at those times to the current circumstances. The reviewers also considered the relevant international standards and principles and examples from other jurisdictions, and material available in the academic and grey literature.

A total of 82 individuals were interviewed as part of this process including key staff from government agencies, statutory oversight bodies, Aboriginal Health Services, legal services and Non-Government Organisations. Submissions were also sought from key agencies.

Panel members also conducted site visits in both Alice Springs and Darwin, including visits to both correctional centres, to the relevant secure care facilities at both sites, to primary

health services within the sites, to Don Dale Youth Justice facility, to community mental health services and to examples of secure community accommodation.

## Policy Basis of Forensic Mental Health and Disability Services

Forensic Mental Health and Forensic Disability services pertain to specific health services provided to a known cohort subject to orders from the criminal justice system or who are still being processed by the courts. The precise definition of the cohort in scope for forensic mental health and disability services varies somewhat from jurisdiction to jurisdiction, and in some states can include civil patients who cannot be safely managed by general psychiatry. At the core of the definition however is the conceptualisation of the provision of assessment, treatment or support services for those who would otherwise be guilty of committing a serious crime who are unable to be tried or prosecuted by the court system due to a mental illness or a cognitive impairment.

### Legal Basis

The criminal justice system in those jurisdictions that have evolved from the English common law provides for a defence of “mental illness” to be raised against the prosecution of a crime. The consequences of such a defence are generally spelt out in specific legislation, however the defence itself is not always so defined and is derived from common law rules based on the case of M’Naghten in England in the 19<sup>th</sup> century. Evolution of the common law outcomes of the M’Naghten case over time has seen the defence requiring a defendant to be suffering from a mental impairment, and concurrently not have a knowledge of the nature and quality of the illegal act undertaken or its wrongfulness. In some jurisdictions an inability to control the offending conduct is also a criteria within the legislative description.<sup>2</sup> Specific details of the relevant legislation in the Northern Territory appears later in this report.

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<sup>2</sup> Brown D, Farrier D, Egger S, McNamara L, Steel A, Grewcock M and Spears D (2012). Criminal Laws. The Federation Press. Sydney. P 515-517.

Individual jurisdictions have codified the defence with slightly different emphases but with a fundamental connectedness to the preceding principles. For example, the Commonwealth Criminal Code 1995 provides a definition of mental impairment as follows<sup>3</sup>:

### 7.3. Mental impairment

- (1) **A person is not criminally responsible for an offence if, at the time of carrying out the conduct constituting the offence, the person was suffering from a mental impairment that had the effect that:**
  - (a) **the person did not know the nature and quality of the conduct; or**
  - (b) **the person did not know that the conduct was wrong (that is, the person could not reason with a moderate degree of sense and composure about whether the conduct, as perceived by reasonable people, was wrong); or**
  - (c) **the person was unable to control the conduct.**
- (2) The question whether the person was suffering from a mental impairment is one of fact.
- (3) A person is presumed not to have been suffering from such a mental impairment. The presumption is only displaced if it is proved on the balance of probabilities (by the prosecution or the defence) that the person was suffering from such a mental impairment.
- (4) The prosecution can only rely on this section if the court gives leave.
- (5) The tribunal of fact must return a special verdict that a person is not guilty of an offence because of mental impairment if and only if it is satisfied that the person is not criminally responsible for the offence only because of a mental impairment.
- (6) A person cannot rely on a mental impairment to deny voluntariness or the existence of a fault element but may rely on this section to deny criminal responsibility.
- (7) If the tribunal of fact is satisfied that a person carried out conduct as a result of a delusion caused by a mental impairment, the delusion cannot otherwise be relied on as a defence.
- (8) In this Code:

**mental impairment** includes senility, intellectual disability, mental illness, brain damage and severe personality disorder.
- (9) The reference in subsection (8) to **mental illness** is a reference to an underlying pathological infirmity of the mind, whether of long or short duration and whether permanent or temporary, but does not include a condition that results from the reaction of a healthy mind to extraordinary external stimuli. However,

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<sup>3</sup> Criminal Code (Cth) 1995 accessed @ <https://www.legislation.gov.au/Details/C2017C00235>

such a condition may be evidence of a mental illness if it involves some abnormality and is prone to recur.

Importantly the defence, if found valid by the court, carries two key elements for the future of the defendant. First, they are not guilty of the crime for which they have been charged and a special verdict of not guilty by reason of mental illness (or equivalent language) applies, and thus no conviction. Second, they can still be subject to an ongoing order by the court at the cessation of proceedings that involves detention and care for their mental illness in an appropriate environment. In the majority of jurisdictions this would be a treatment facility run by health professionals in a non-correctional setting.<sup>4</sup> The rationale for this is *a)* the individual is not guilty of a crime and *b)* their primary need is for medical care and rehabilitation, with treatment for mental health problems in a correctional setting being difficult as 'prison security requirements take precedence over mental health programs and policies.'<sup>5</sup>

The purpose of the ongoing order is either to ensure the individual receives the necessary medical care and rehabilitation to assist in recovery from the effects of mental illness and allow the individual to resume their place in the community<sup>6</sup>, or to ensure that an individual with cognitive impairment receives appropriate supports to manage their disability. It is fundamentally not a punitive order. The individuals being treated under these orders are generally referred to as 'forensic patients.'

#### Principles of Care

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is the peak professional medical body for psychiatry in Australia and New Zealand. The RANZCP provides leadership on clinical practice and associated principles of care and provides a reference point for improving care over time. In November 2016 the RANZCP released a position statement on 'Principles for the treatment of persons found not criminally

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<sup>4</sup> Brown et al (2012) Page 527.

<sup>5</sup> Ibid.

<sup>6</sup> R v KMD [No 2] [2017] NTSC 18 (8 March 2017)

responsible or not fit for trial due to mental illness or cognitive disability.<sup>7</sup> This position statement begins:

*'Patients who are acquitted on insanity grounds – or found unfit to stand trial – deserve effective, ethical care and management. The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is concerned that these vulnerable patients are subject to laws and detention conditions that may violate their human rights and cause long-term harm. It is of major concern that many people with mental illness in Australia and New Zealand are being held in jails or corrective services custody despite having never been convicted of a crime or placed on remand. Furthermore, the conditions of release are becoming increasingly severe and punitive. These restrictions can last for life.'*

The position statement identifies six principles endorsed by the RANZCP to be applied to the treatment and detention of forensic patients. The RANZCP advocates the adoption of these principles in all Australian and New Zealand jurisdictions and continue to advocate that all forensic patients receive treatment in accordance with these principles. These principles are<sup>8</sup>:

- Forensic patients must receive equity of access to health care and legal representation.
- Forensic patients must be managed by mental health services not correctional services
- Decisions regarding detention, release or transfer must be made by courts or independent statutory bodies
- Treatment must be in the least restrictive environment appropriate, consistent with individual circumstances and the safety of the community
- The level of security required for any individual should be based on a valid professional risk assessment
- Rehabilitation and effective treatment is required to decrease recidivism

Each of these stated principles is expanded upon within the position statement and references to the underlying elements will be made throughout the course of this report.

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<sup>7</sup> Royal Australian and New Zealand College of Psychiatrists (2016). Position statement 90. Principles for the treatment of persons found not criminally responsible or not fit for trial due to mental illness or cognitive disability. Accessed @ [https://www.ranzcp.org/Files/Resources/College\\_Statements/Position\\_Statements/PS-90-Principles-for-the-treatment-of-persons-foun.aspx](https://www.ranzcp.org/Files/Resources/College_Statements/Position_Statements/PS-90-Principles-for-the-treatment-of-persons-foun.aspx)

<sup>8</sup> Ibid.

The RANZCP position statement builds on work done through the 'Health' policy structures under the Council of Australian Governments (COAG) framework. The Australian Health Ministers Advisory Council (AHMAC), an officers body under the COAG Health Council, released a 'National Statement of Principles for Forensic Mental Health' (the National Statement)<sup>9</sup> in 2006, a document which is still current national policy.

The National Statement addresses responses to a broader group of individuals than the RANZCP document, however within the same global thematic of people in contact with the criminal justice system. The relevant target groups encompassed within Forensic Mental Health within the AHMAC framework include:

- Offenders or alleged offenders referred by police, courts, legal practitioners or independent statutory bodies for psychiatric assessment and/or treatment
- Alleged offenders detained, or on conditional release, as being unfit to plead or not guilty by reason of mental impairment
- Offenders or alleged offenders with mental illness ordered by courts or independent statutory bodies to be detained as an inpatient in a secure forensic facility
- Prisoners/young offenders with mental illness requiring secure inpatient hospital treatment
- Selected high-risk offenders with a mental illness referred by releasing authorities
- Prisoners/young offenders with mental illness requiring specialist mental health assessment and/or treatment in prison
- People with mental illness in mainstream mental health services who are a significant danger to their carers or the community and who require the involvement of a specialist forensic mental health service
- The Principles are not intended to apply to those who suffer intellectual disability or substance abuse without co-morbid mental illness

The rationale for 'the National Statement' is articulated as follows<sup>10</sup>:

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<sup>9</sup> Australian Health Ministers Advisory Council (AHMAC) 2006. 'National Statement of Principles for Forensic Mental Health'. Accessed @ <https://www.aihw.gov.au/getmedia/e615a500-d412-4b0b-84f7-fe0b7fb00f5f/National-Forensic-Mental-Health-Principles.pdf.aspx>

<sup>10</sup> Ibid. p3.

*The National Statement of Principles for Forensic Mental Health aims to provide cohesion and credibility so that optimal diagnosis, treatment and rehabilitation can be provided to clients of forensic mental health services. While states and territories are responsible for the delivery of forensic mental health services, the services should be delivered within a framework provided by nationally agreed principles.*

*The Principles apply to clients in the adult and juvenile justice system. Services must appropriately provide for the special needs of people with comorbid physical and mental disorders and intellectual disabilities. Specific attention should ensure optimal outcomes for special groups such as women, youth, Aboriginal and Torres Strait Islander peoples, culturally diverse peoples, and older persons. The application of these Principles in relation to the particular developmental needs and rights of young people with a mental illness involved in the criminal justice system is crucial. It is recognised that the health status of prisoners/young offenders in general is lower than that of the community and that this should be considered in the determination of services and resource allocation.*

‘The National Statement’ acknowledges that service boundaries and competing professional cultures between health, criminal justice and other human services agencies are central to many of the challenges faced in service delivery and policy. ‘The Statement’ seeks national consistency in mental health legislation and in the interim period before that is achieved, effective cross border agreements between jurisdictions.

AHMAC determined in ‘the National Statement’ that 13 principles were necessary to be applied to forensic mental health services across Australian jurisdictions. The 13 principles are as follows:

- **Equivalence to the non-offender** - Prisoners and those in the community who are under the supervision or control of the criminal justice system have the same rights to availability, access and quality of mental health care as the general population.
- **Safe and Secure Treatment** - Treatment and care will be provided in an appropriate environment compatible with the treatment and rehabilitation needs of the individual and the community’s need for safety.
- **Responsibilities of the Health, Justice and Correctional Systems** - The provision of mental health care for offenders is the joint responsibility of the Health, Justice (including police and court systems) and Correctional systems and is to be addressed in partnership.

- **Access and Early Intervention** - A prisoner/young offender, whether remanded, sentenced or in police custody, should have timely referral and access to specialist mental health services when appropriate.
- **Comprehensive forensic mental health services** - A comprehensive forensic mental health service is a specialised mental health service providing integrated in-patient services, prison mental health services, court liaison services, and community mental health services, in a coordinated clinical and administrative stream.
- **Integration and Linkages** - Forensic mental health services include: in-patient services; prison mental health services; court liaison services; community mental health services; and linkages with general mental health services and consumer and carer organisations.
- **Ethical Standards** - The right of all clients to respect for individual human worth, dignity and privacy is not waived by any circumstance, regardless of an individual's history of offending or their status as a forensic mental health client or a prisoner/young offender. The capacity or right to consent is not forfeited as a result of a history of offending or status as a prisoner/young offender.
- **Staff: Knowledge, Attitudes and Skills** - The forensic mental health workforce requires a high degree of professionalism and strong clinical leadership. In light of the specialised and often challenging nature of forensic mental health service delivery, it is recognised that appropriate training and support are required to maintain a highly skilled workforce.
- **Individualised care** - Forensic mental health services should meet the changing needs of an individual, taking into account the entirety of their biological, psychological, social, cultural and spiritual context.
- **Quality and Effectiveness** - Forensic mental health services must have in place a quality improvement process which through performance outcomes identifies opportunities for improvement in the delivery of services and includes action to address identified deficiencies. This improvement process must involve carers and consumers.
- **Transparency and Accountability** - There is a risk that forensic mental health services will fail to maintain the standards expected of a specialist health service and

will develop idiosyncratic practices. This risk is minimised by services being subject to processes of accreditation against national standards for mainstream services, external and peer review. The National Standards for Mental Health Services provide appropriate benchmarks for forensic mental health services.

- **Judicial determination of detention/release** - Decisions to detain, release or transfer mentally ill individuals found not guilty or unfit for trial because of a mental illness or intellectual impairment should be made by courts or independent statutory bodies of competent jurisdiction, not by a political process or the Governor/Administrator in Council.
- **Legal reform** - Legislation must recognise the special needs of people with a mental illness involved in the criminal justice system and comply with the International Covenant on Civil and Political Rights, the United Nations Principles on the Protection of People with a Mental Illness and the Improvement of Mental Health Care.

The Northern Territory Government participates in AHMAC through its Chief Executive of Health and signed on to the National Statement. AHMAC in turn is a subsidiary body of the COAG Health Council, a group constituted by Health Ministers from across Australian jurisdictions inclusive of the Northern Territory, and itself a subsidiary body of COAG. As such the national statement forms a policy commitment of the Northern Territory Government.

The National Disability Strategy 2010-2020<sup>11</sup> forms the commitment of Australian Governments to improving outcomes for people with a disability. This strategy makes a specific policy commitment at objective 2, policy direction 5 to more effective responses from the criminal justice system to people with disability who have complex needs or heightened vulnerabilities. The actions identified against policy direction 5 refer specifically to individuals found not guilty by reason of mental impairment or those unfit to stand trial. The Strategy identifies the process of development of a national statement of principles for

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<sup>11</sup> [https://www.dss.gov.au/sites/default/files/documents/12\\_2017/final\\_-\\_national\\_disability\\_strategy\\_australian\\_government\\_action\\_plan\\_-\\_5\\_dec\\_2017.pdf](https://www.dss.gov.au/sites/default/files/documents/12_2017/final_-_national_disability_strategy_australian_government_action_plan_-_5_dec_2017.pdf)

this group with the specific intent of identifying safeguards throughout legal processes. This national statement of principles remains under consideration by individual jurisdictions. The Northern Territory is a signatory to the National Disability Strategy.

#### Australia's International Treaty Obligations

The Fifth National Mental Health Plan is the central policy document for the provision of mental health services in Australia. It acknowledges that '*the Australian Government has committed to international agreements that place a responsibility on our mental health system to meet agreed international standards.*'<sup>12</sup> These agreements include commitments to protect the human rights of its citizens including specific commitments relevant to forensic patients. According to the United Nations *Standard Minimum Rules for the Treatment of Prisoners*<sup>13</sup>: 'persons who are found to be not criminally responsible, or who are later diagnosed with severe mental disabilities and/or health conditions, for whom staying in prison would mean an exacerbation of their condition, shall not be detained in prisons, and arrangements shall be made to transfer them to mental health facilities as soon as possible.'<sup>14</sup> There are also obligations to 'ensure if necessary the continuation of psychiatric treatment after release and the provision of social-psychiatric aftercare.'

According to the *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care* (United Nations General Assembly, 1991), 'all persons have the right to best available mental health care' and 'every patient shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient's health needs and the need to protect the physical safety of others.'<sup>15</sup> The Australian Health Ministers' Advisory Council has reaffirmed these principles and expanded upon them in the *National Statement of Principles for Forensic Mental Health*.

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<sup>12</sup> Commonwealth of Australia. Fifth National Mental Health and Suicide Prevention Plan. 2017.

<sup>13</sup> *The Mandela Rules*, (United Nations General Assembly, 2015)

<sup>14</sup> Royal Australian and New Zealand College of Psychiatrists (2016). Position statement 90. Principles for the treatment of persons found not criminally responsible or not fit for trial due to mental illness or cognitive disability. Accessed @ [https://www.ranzcp.org/Files/Resources/College\\_Statements/Position\\_Statements/PS-90-Principles-for-the-treatment-of-persons-foun.aspx](https://www.ranzcp.org/Files/Resources/College_Statements/Position_Statements/PS-90-Principles-for-the-treatment-of-persons-foun.aspx)

<sup>15</sup> Ibid.

Australia has ratified the *United Nations Convention on the Rights of Persons with Disabilities* (2008) (CRPD) which commits states to take all necessary measures to combat stigma and enable disabled people to fully participate in society. Australia has also ratified the CRPD's associated 'Optional Protocol' which provides a monitoring mechanism for breaches of the Convention. The Convention and 'the Protocol' apply to forensic patients. The RANZCP position statement 90 notes 'The rights to justice and freedom from arbitrary detention have been breached [in Australia] by the indefinite incarceration of forensic patients and the lack of needed treatment, support and planning for their return to the community. The right to freedom from cruel and degrading treatment may have been compromised by detention in prison due to lack of forensic facilities, the excessive use of solitary confinement (seclusion) to control forensic patients and the lack of effective legal remedies for mistreatment.'<sup>16</sup>

The Fifth National Mental Health Plan acknowledges that 'international norms and standards are generally seen as the minimum acceptable standard for health policy'. The Fifth Plan recognises international agreements that may have relevance to mental health policy in Australia and the obligations that these treaties bring. In addition to those agreements referenced above the plan also identifies the importance of the International Covenant on Civil and Political Rights, the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Convention on the Rights of the Child, International Covenant on Economic, Social and Cultural Rights, Convention on the Elimination of All Forms of Discrimination Against Women, International Convention on the Elimination of All Forms of Racial Discrimination and the United Nations Declaration on the Rights of Indigenous Peoples.<sup>17</sup>

The Northern Territory Government is a signatory to the Fifth National Mental Health Plan and its policy objectives.

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<sup>16</sup> Ibid.

<sup>17</sup> <http://www.coaghealthcouncil.gov.au/Portals/0/Fifth%20National%20Mental%20Health%20and%20Suicide%20Prevention%20Plan.pdf>

## Description of the current Northern Territory approach

The Terms of Reference for the review identify four different groups that are in scope for this review. There are differences in the current legislation and service structures for these groups and these are detailed below for the purposes of establishing a baseline for change. It is important to be clear that Forensic Mental Health Services are provided to a broad group of individuals and not just to legislatively defined ‘forensic mental health patients’.

### Those Not Guilty by reason of Mental Illness (NGMI) or Unfit to Stand Trial (Forensic Mental Health Patients)

#### Legislation<sup>18</sup>

The first piece of legislation pertinent to those not guilty by reason of mental illness or those unfit to stand trial is the Criminal Code Act (NT) and its provisions contained under Part IIA. Under this part the defence of mental impairment is established if the Supreme Court finds that a person charged with offence was, at the time of carrying out the conduct constituting the offence, suffering from a mental impairment and as a consequence of that impairment<sup>19</sup>:

- did not know the nature and quality of the conduct;
- did not know that the conduct was wrong (that is he or she could not reason with a moderate degree of sense and composure about whether the conduct, as perceived by reasonable people, was wrong); or
- was not able to control his or her actions.

The defence of mental impairment can be raised at any time during a person’s trial by the defence, by the prosecution or by the court on its own initiative<sup>20</sup>. If the defence of mental impairment is established, the person must be found not guilty because of mental

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<sup>18</sup> Parts of this section are drawn directly from a briefing note to the Expert Panel provided by NT Health.

<sup>19</sup> Criminal Code Act (NT) s 43C

<sup>20</sup> s 43F

impairment<sup>21</sup>. The effects of a finding of not guilty by reason of mental illness under s43I are:<sup>22</sup>

- If an accused person is found not guilty because of mental impairment, the court must:
  - (a) declare that the accused person is liable to supervision under Division 5; or
  - (b) order that the accused person be released unconditionally.
- If the court makes a declaration under subsection (2)(a), the court may also make the interim orders it considers just, including one or more of the following orders:
  - (a) an order for the bail of the accused person;
  - (b) an order that the accused person be remanded in custody (whether in a custodial correctional facility or another place the court considers appropriate);
  - (c) an order for the examination of the accused person by a psychiatrist or other appropriate expert;
  - (d) if the court makes an order referred to in paragraph (c) – an order that a report of the results of the examination be produced before the court.
- **The court must not make an interim order remanding the accused person in custody in a custodial correctional facility unless the court is satisfied there is no practical alternative given the circumstances of the accused person (*our emphasis*).**

The criminal code also contains provisions for determining when a person is unfit to stand trial in s43J, a separate legal category to those not guilty by reason of mental illness. This section states:

- (1) A person charged with an offence is unfit to stand trial if the person is:
  - (a) unable to understand the nature of the charge against him or her;
  - (b) unable to plead to the charge and to exercise the right of challenge;
  - (c) unable to understand the nature of the trial (that is that a trial is an inquiry as to whether the person committed the offence);
  - (d) unable to follow the course of the proceedings;

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<sup>21</sup> s 43C (2)

<sup>22</sup> s 43I

(e) unable to understand the substantial effect of any evidence that may be given in support of the prosecution; or

(f) unable to give instructions to his or her legal counsel.

(2) A person is not unfit to stand trial only because he or she suffers from memory loss.

If a defendant is found unfit to stand trial, the judge has the capacity to grant a supervision order of a similar nature to orders for those found not guilty by reason of mental illness.

To declare a person liable to supervision, the Supreme Court will ordinarily have some expert medical evidence before it regarding the accused persons state of mind, at least at the time of the alleged offence.

Once a declaration and interim order have been made, Forensic Mental Health Services and/or Disability Services of the Department of Health will become actively involved, although they may already have provided substantial clinical advice to the court. The Chief Executive of Health does not become involved in the application or administration of Part IIA until some considerable way into the process. Generally, the Chief Executive only gets involved once the Supreme Court has declared that an accused person is liable to supervision and following an interim order pending any supervision. Interim orders generally provide that the accused person should be remanded in custody until a supervision order is made.<sup>23</sup>

It is also important to note that a s43ZA certificate from the Department of Health's Chief Executive stating that "facilities or services are available in [the proposed appropriate place] for the custody, care or treatment of the person" is a necessary prerequisite to the Supreme Court order. Issue of an s43ZA certificate is at the discretion of the Chief Executive of the Department of Health.<sup>24</sup>

The Supreme Court has the option to place the individual subject to a supervision order under either a custodial or non-custodial order. If the Supreme Court orders a Custodial

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<sup>23</sup> Department of Health briefing note to Expert Panel.

<sup>24</sup> Department of Health briefing note to Expert Panel.

Supervision Order (CSO) the person is committed to custody in either a custodial correctional facility or an appropriate place (such as a Secure Care Facility). If the Supreme Court orders a Non-Custodial Supervision Order (NCSO) the person is to be released. However, often a NCSO contains various rules and safeguards that commit the person to adhere to the treatment plan provided by the treating team and to reside at a specified location.<sup>25</sup>

The Supreme Court must not make a custodial supervision order committing the accused person to custody in a custodial correctional facility unless it is satisfied that there is no practicable alternative given the circumstances of the person.<sup>26</sup> The Supreme Court has original jurisdiction for all Part IIA matters.

Importantly s 43ZC of the Criminal Code Act specifies that a supervision order is for an indefinite term. Any of the following persons however may apply to the court for an order varying or revoking a supervision order; the Director of Public Prosecutions; the supervised person; a person having the custody, care, control or supervision of the supervised person; or any other person who has an interest that the court recognises as proper for the purposes of making the application.<sup>27</sup>

If, on an application to vary or revoke a supervision order by the supervised person, the court refuses the application, the supervised person must not make another application within 12 months after the date of the court's refusal or any other period (which may be lesser or greater) the court fixes.<sup>28</sup>

On hearing the application, the court may confirm the supervision order the subject of the application; or revoke the supervision order and release the supervised person unconditionally; or vary the conditions of the supervision order; or vary the custodial or non-custodial nature of the order.<sup>29</sup>

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<sup>25</sup> Ibid.

<sup>26</sup> Criminal Code Act (NT) s 43ZA (2)

<sup>27</sup> s 43ZD (1).

<sup>28</sup> s 43ZD (3)

<sup>29</sup> s 43ZD (4)

The court must also fix a term that is appropriate for the offence concerned and specify the term in the order. The term fixed is to be equivalent to the period of imprisonment or supervision (or aggregate period of imprisonment and supervision) that would, in the court's opinion, have been the appropriate sentence to impose on the supervised person if he or she had been found guilty of the offence charged. If the court is of the view that life imprisonment would have been an appropriate penalty for the offence charged the court must fix the period it would have set as the non-parole period for the offence under the Sentencing Act (NT) if the supervised person had been found guilty of the offence charged.<sup>30</sup>

At least 3 months (but not more than 6 months) before the expiry of the term fixed in respect of a supervision order, the court must conduct a major review to determine whether to release the supervised person the subject of the supervision order from it.<sup>31</sup>

On completing the major review, unless the court considers that the safety of the supervised person or the public will or is likely to be seriously at risk if the supervised person is released, the court must release the supervised person unconditionally.<sup>32</sup>

If the court considers that the safety of the supervised person or the public will or is likely to be seriously at risk if the supervised person is released unconditionally, the court must either; confirm the supervision order, or vary the conditions of the supervision order, or vary the custodial or non-custodial nature of the order.<sup>33</sup>

The Act also places on onus on the NT Health system to provide relevant expert reports on individuals subject to orders throughout the life of the orders. Within 30 days of a determination by the court of a need for supervision the CEO NT Health must provide a report that contains a diagnosis and prognosis of the accused persons mental impairment, condition or disability; details of the accused person's response to any treatment, therapy

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<sup>30</sup> s 43ZG

<sup>31</sup> Ibid.

<sup>32</sup> Ibid.

<sup>33</sup> Ibid.

or counselling he or she is receiving or has received and any services that are being or have been provided to him or her; and a suggested treatment plan for managing the accused person's mental impairment, condition or disability. Further at intervals of not more than 12 months, until the supervision order is revoked, NT Health must submit a report to the court on the treatment and management of the supervised person's mental impairment, condition or disability containing details of the treatment, therapy or counselling that the supervised person has received, and the services that have been provided to the supervised person, since the supervision order was made or the last report was prepared (as the case may require); and details of any changes to the prognosis of the supervised person's mental impairment, condition or disability and to the plan for managing the mental impairment, condition or disability.<sup>34</sup>

These reports can lead the court to decide to undertake periodic reviews during the life of the order to determine whether the supervised person the subject of the report may be released from the supervision order. This is to occur after consideration by the court of a report submitted 'the appropriate person' under the Act. For the purposes of those subject to supervision orders due to being found not guilty by reason of mental illness or unfit to stand trial, the 'appropriate person' is the CEO of NT Health.<sup>35</sup>

In determining whether to make an order under Part IIA, the court must apply the principle that restrictions on a supervised person's freedom and personal autonomy are to be kept to the minimum that is consistent with maintaining and protecting the safety of the community.<sup>36</sup>

The Mental Health and Related Services Act (MHRSA) also has provisions that can impact on the outcome of a criminal charge. These are used only in the Magistrates Court, as the Supreme Court has the provisions of Part IIA of the Criminal Code available to it.<sup>37</sup>

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<sup>34</sup> s 43ZJ and s 43ZK.

<sup>35</sup> s 43ZH.

<sup>36</sup> s 43ZM.

<sup>37</sup> <http://ntlawhandbook.org/foswiki/NTLawHbk/MentalHealth> 2016. contributed by Hanley A, Clunies Ross A and Marshall T.

*'If a court believes that a person appearing before it is mentally ill or mentally disturbed, it can adjourn proceedings to enable the person to be psychiatrically assessed. The court orders the person to be assessed by an APP and a report prepared for the court. A court can also order the person be detained in a place for up to 72 hours for assessment if it thinks that they may benefit from treatment, and it receives a written confirmation from the Chief Health Officer (CHO) that a psychiatrist, mental health practitioner or treatment facility is available to provide the assessment. The assessment report is tendered to the court when the case reconvenes. The court can then:*

- *discharge the person; that is, order that the charges be dismissed*
- *proceed to hearing and determine the charge, where the person is considered not to have been mentally ill at the time of the offence*
- *make an order to admit the person to a treatment facility under section 75 of the MHRSA.'*<sup>38</sup>

*'If a person is charged with an offence and the court is of the opinion that they appear to be mentally ill or mentally disturbed, it can dismiss the charge if:*

- *the person is likely to be found not guilty because they lacked capacity when they committed the offence*
- *the circumstances are such that, if the person is found guilty, the court would, in accordance with the Sentencing Act dismiss the charge without recording a conviction.*

*A court can't dismiss a charge unless it has received a certificate from the CHO stating that they are satisfied, after receiving reports from two psychiatrists, that the person is mentally ill or mentally disturbed. A court can't dismiss a charge if the offence is a regulatory offence, such as a parking fine [MHRSA s. 77].'*<sup>39</sup>

*'Where the report from the CHO states that the person meets the criteria for involuntary admission on the grounds of mental illness or mental disturbance and that resources are available at the specified approved treatment facility to diagnose and treat the person, the*

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<sup>38</sup> Ibid.

<sup>39</sup> Ibid

*court may adjourn the proceedings for a period specified by the court. The court can also order that the person be detained in the approved treatment facility for examination and assessment and, if the person is admitted to the facility, diagnosis and treatment under the MHRSA.<sup>40</sup>*

The court may then adjourn the proceedings a period as recommended in the report or for 15 days, whichever is the shorter.

#### Northern Territory Health - Mental Health Services

The preceding section outlined a number of clinical responsibilities relating to those found not guilty by reason of mental illness or unfit to stand trial that are specified in the Criminal Code Act. Paramount amongst these is the requirement to develop a diagnosis, prognosis and treatment plan for the individual and report to the court on the progress of therapy.

These responsibilities ought however, to be viewed within the context of the availability of relevant treatment services being a pre-condition to a determination of the residential setting for the individual being specified in the order. That is, if there is no clinically appropriate bed in a secure or non-secure treatment facility then an order specifying a custodial setting is under the current system likely.

Clearly individuals respond to treatment at different rates and with different proclivities. An appropriate treatment system should provide stepped options for care that identify a clear pathway for progress towards a return to the community, and if appropriate the revocation of supervision. Such a stepped model requires specialised forensic mental health services interfacing with the general mental health teams within the Territory. As such reference needs to be made to the current model of care in both the forensic and general mental health teams as part of this review.

Northern Territory Health Services have three predominant arms. There is a central policy setting body, The Department of Health, and two operational arms, called 'Health Services',

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<sup>40</sup> Ibid.

with Chief Operating Officers that report to the Chief Executive of the Health Department. The two 'Health Services' cover specified geographic areas, these being the Top End Health Services (TEHS) for the north part of the Territory, and the Central Australia Health Service (CAHS) for the south part of the Territory. In general terms each health service is responsible for delivering care to the residents within their geographic boundary.

However, health care has had increasing sub-specialisation over recent years and this sometimes has required the aggregation of resources within one health 'entity' to cover the residents of multiple entities. This is common for services such as neonatal intensive care or complex cardiovascular surgery. Forensic mental health (FMH) services are often considered a similar type of sub-specialty service. In the Northern Territory the Top End Health Service takes accountability for the provision of FMH sub-specialty services for the Territory's entire geography. Practically, this means that CAHS has been provided with almost no specific budget for managing forensic mental health patients, other than the general mental health resources that are available to them.

The Department of Health operationalises its state-wide planning and government policy intentions through service agreements with the 'Health Services' as described below.

*'This Service Delivery Agreement (SDA) is a formal agreement between the Department of Health (the Department) as system manager and the Top End Health Service (TEHS) consistent with the requirements of the Northern Territory Health Services Act 2014 (the Act) and the National Health Reform Agreement. It outlines the responsibilities and accountabilities of the Minister for Health, the Department and TEHS in the delivery of the services to be purchased under this agreement.'*

*Key elements of this agreement are:*

- *the specification of services to be delivered by TEHS*
- *the funding to be provided for the delivery of these services*
- *the measures against which performance will be assessed*
- *the processes for the management of the agreement.*
- *ensure Northern Territory and Australian Government health priorities and strategies are implemented and the intended outcomes achieved*

- *promote accountability to the Northern Territory Government and the community*
- *articulate a performance management and accountability system for monitoring and assuring the achievement of effective and efficient service provision*
- *address the requirements of the National Health Reform Agreement (NHRA) and the Act in relation to the establishment of SDAs between the Department and TEHS.*<sup>41</sup>

The TEHS Service delivery agreement specifies the Departmental expectations of TEHS with regard to its territory-wide forensic mental health service in Schedule 1.2. It states the following:

### **Forensic Mental Health Services (FMHS)**

*FMHS is a Territory-wide specialist, tertiary level service within TEHS and CAHS mental health services. Prison Forensic Mental Health Services will be provided by TEHS and will cover TEHS and CAHS. The CAHS Forensic Team comprising two Forensic Nurses and an Aboriginal Health Practitioner will be professionally supported by the Prison Forensic Mental Health Service.*

- *FMHS will provide specialist assessment and treatment to patients involved in the criminal justice system as a result of major mental illness and whose risks necessitate intervention by a specialist tertiary mental health service.*
- *In the Top End, FMHS is a Darwin urban based service with limited ability to provide rural and remote services. FMHS works closely with TEHS and CAHS to provide service to these areas.*

*FMHS members will provide:*

- *treatment to clients with enduring major mental illness such as psychosis and major mood disorders; or clients subject to Part IIA Criminal Code supervision orders*
- *reports to Courts*
- *case-management or co-case management of Part IIA supervised persons.*

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<sup>41</sup> Top End Health Service Service Delivery Agreement 2017/18.

*Assessment and treatment of patients (who are either known to psychiatric services in the NT or as a result of referrals by the prison primary care service) in Darwin Correctional Centre (DCC) and Alice Springs Correctional Centre (ASCC). FMHS also carries out 'at-risk' assessments for patients in custodial settings.*

*FMHS considers requests from other secondary level services within TEHS and CAHS for specialist opinion or for co-case management of high-risk complex patients with enduring major mental illness. Consideration is given to patients who are subject to ongoing criminal justice orders.<sup>42</sup>*

The total NT Mental Health budget is approximately \$68.5m, or about 4.5% of the \$1.5 billion NT Health budget. The Top End Mental Health Service has a budget of \$40.5m in 2018/19, of which the amount allocated to forensic services is \$3.3m or 8% of their mental health budget. This budget does not pay for the forensic mental health staff based in Alice Springs, who are accountable corporately to CAHS for access to entitlements and infrastructure.

TEHS mental health services have 236 FTE staff and 36 inpatient beds. The beds include 8 adult acute beds, 18 adult subacute beds, 5 youth inpatient acute beds and 5 community supported accommodation beds. There are no step-down rehab beds or Psychiatric Intensive Care beds. There are 3 Aboriginal mental health workers on staff. The Forensic Mental Health Service has 14.5 positions with an approximate average vacancy rate of 20%. The service includes 2 consultant psychiatrists, 1 trainee registrar, a psychologist, 2 social workers, 4 nurses and 2 Aboriginal health workers. There is also a team leader and a court liaison co-ordinator.

The inpatient services in TEHS ran at approximately 86% annual bed occupancy in 2016/17, which is slightly above the NT Health designated minimum efficient occupancy of 85%. The services ran at below 85% occupancy in the three preceding financial years with a rate of only 68% occupancy in 2015/16. However, there are individual financial quarters of activity

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<sup>42</sup> Ibid. Please note the CAHS service agreement 2017/18 contains exactly the same text.

where the bed occupancy approaches 100%. The Joan Ridley Unit runs at the highest occupancy rate, regularly over 100% and sometimes as high as 163%, and the youth inpatient unit at the lowest.

TEHS provided community services to 4369 individuals in the 2016/17 financial year with 854 of these under the age of 18. There were 40,225 treatment days in that same year with an average of 7.7 treatment days per client. Community residential facilities run at less than 70% bed occupancy.

The Central Australian Mental Health Service has a budget of \$18m in 2018/19, of which the amount allocated to forensic services is \$542,000. CAHS mental health services have 18 community mental health staff across all service cohorts. There are 12 Acute Adult Inpatient beds, up to 3 of which can be used as High Dependency beds, although this is not a secure area and may not meet the Australasian Health facility Guidelines for high dependency beds. CAHS also run an 8 bed Subacute Facility, which is a step up/step down facility. Two of these beds are designated for longer term clients. There is no designated high dependency unit and no child and adolescent beds. There are three forensic mental health staff based at Alice Springs Correctional Centre and a court liaison position. The Forensic Mental Health Service operates within the structures of the overall mental health service. It has links to the general adult mental health system and utilises some of the general adult system resources to achieve its therapeutic aims and to provide access to the necessary service elements required to provide a comprehensive stepped care model. The staff line of reporting is however unclear.

The inpatient services in CAHS ran at approximately 83% annual bed occupancy in 2016/17, which is slightly below the NT Health designated minimum efficient occupancy of 85%. The services ran at below 85% occupancy in the three preceding financial years with a rate of only 69% occupancy in 2015/16. However, there are individual financial quarters of activity where the bed occupancy is as low as 60%.

CAHS provided community services to 1791 individuals in the 2016/17 financial year with 586 of these under the age of 18. There were 23,704 treatment days in that same year with

an average of 10.0 treatment days per client. Community residential facilities run at around 77% bed occupancy.

Under the auspices of the COAG Health framework work has been underway to describe the appropriate set of service elements for a state or territory wide forensic mental health service, and their required capacity. This has been via an extension of the National Mental Health Service Planning Framework (NMHSPF) targeting forensic services. The NMHSPF is an evidence based, population driven, clinically framed model for planning resource need. It was developed using a combination of epidemiology, academic literature review and senior clinical consensus. However, the first edition of the NMHSPF deferred resolution of a model for forensic services given the complexity of such work and only recently was this work initiated.

The first draft of the Forensic extension was made available to the review panel during the review. The jurisdictional experts have agreed that there are four programmes that constitute core components of a FMHS. These are;

- Secure Inpatient Services
- Community Forensic Outreach Services
- Prison Mental Health Services
- Court Liaison Services

Secure inpatient services provide inpatient assessment and treatment planning services for people in custody experiencing or suspected to be experiencing severe episodes of mental illness complicated by alleged or proven offending and who require further assessment in a secure setting. The core business is to provide multidisciplinary specialised assessment, evidence based, collaborative treatment planning, and initial interventions in a safe, therapeutic environment. Those in acute secure inpatient settings pose a significant risk of harm to others and require a higher level of physical, relational and procedural security than can be provided in mainstream mental health services. Secure services can also be sub-acute or non-acute.<sup>43</sup>

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<sup>43</sup> Drawn from the NMHSPF Forensic Service Elements – Provisional Definitions

Community forensic outreach services provide high quality mental health assessment, treatment and care to assist individuals with a significant risk of harm to others. The purpose is to help individuals function effectively within the community and to manage the transition into and out of the community from institutional settings. Community Forensic Mental Health Services are central to a mental health system's capacity to provide continuity of care from community or mainstream mental health services, to institutional care (e.g. criminal justice service or a secure hospital setting) and back to community or mainstream mental health services.<sup>44</sup>

Prison Mental Health Services (PMHS) are delivered by multidisciplinary teams who provide services to people affected by mental health problems who are incarcerated in an Australian prison.

PMHS engage in

- reception screening for the presence of mental illness;
- early identification of mental illness in prisoners;
- high quality mental health assessment, treatment and care;
- transfer of patients to hospital if necessary.

PMHS facilitate access to mental health services on release from custody and prepare individuals with complex mental health needs to integrate back into community. PMHS can be accessed by any person detained in a prison or a detention centre.

Prisoners with mental health issues may require assistance to access finances, accommodation, support networks and access to services. PMHS promote re-integration. PMHS will generally be an element of a Forensic Mental Health Service, with the capacity to provide continuity of care from community or mainstream mental health services, usually via the criminal justice system, to prison or a secure hospital setting, and return to the care of community or mainstream mental health services.<sup>45</sup>

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<sup>44</sup> Ibid. (definition for Clinical Community Treatment Team – Community Forensic Mental Health Service)

<sup>45</sup> Ibid. (definition for Clinical Community Treatment Team – Forensic Prison Mental Health Service)

Court Liaison services provide mental health advice, assessments, referral and diversion for people who have been charged with an offence. These services intervene early in the criminal justice process at the post- arrest and pre-sentence stages.

Court liaison services:

- Conduct mental health assessments and may intervene to link individuals to mental health service providers.
- Provide or facilitate specialised advice to the court regarding the impact of a person’s mental health or intellectual capacity on their offending behaviour and ability to take part in legal proceedings.
- Provide advice to individuals before the court, their relatives/carers, service providers or legal representatives about issues related to mental health and relevant legislation. <sup>46</sup>

Not all of these elements are available in the Northern Territory and not all of those that are available are provided by the FMH service, or even by Health Services.

The acute mental health bed-based service elements in the NT are provided either inside the correctional system, contrary to best practice, or in the general adult acute units predominantly using high dependency unit beds. Technically on a policy basis those requiring clinical acute care are transferred to the hospital acute units in Darwin or Alice Springs, however, there were numerous examples provided during the course of the review of acutely unwell individuals being managed inside the prison system by either corrections or the health team responsible for primary care service delivery in the prison environment supported by FMHS. If a correctional facility is the location for the provision of this acute management it may occur in high security cells or within the purpose built complex behavioural unit (CBU) in Darwin. This is contrary to the National Principles for Forensic Mental Health Services and also the Convention on the Rights of Persons with Disabilities. There is no purpose built unit inside the Alice Springs correctional facility and there is no longer a designated ‘complex behavioural’ support area.

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<sup>46</sup> Ibid. (definition for Consultation Liaison – Forensic (Court Liaison))

Sub-acute mental health care for the forensic population is generally provided inside the correctional system. The CBU in Darwin provides a location for sub-acute care although it is staffed by corrections officers rather than health staff. There is a sub-acute ward on the Darwin Hospital campus (as part of 'The Cowdy' Unit) however it is not secure, and custodial patients rarely utilise it. There is no sub-acute facility in Alice Springs for forensic mental health patients however there is a secure care facility for forensic disability patients that can be utilised by those with a dual mental health/disability diagnosis. This is a purpose built facility for sub-acute disability care, staffed by Health staff, and is located approximately 200 metres from the prison. There are also sub-acute mental health beds in the Alice Springs General Hospital.

There is very limited non-acute mental health forensic community rehabilitation service provision either in designated units or in secure community supported accommodation. The TEHS has funded five co-located secure supported accommodation beds in the community at significant expense through a non-government provider. There are no similar beds in Alice Springs. There are secure supported accommodation arrangements in both regions for those forensic patients with a disability, and these can be used by those with a co-occurring mental health diagnosis.

The NMHSPF has identified two key roles for a community forensic mental health service (CFMHS). The first relates to those who are NGMI or unfit to stand trial (Part IIA patients). This patient cohort is identified as a key focus for CFMHS and services are either delivered through direct case management or co-case management with general mental health services. The second key role of CFMHS is consultation liaison for patients that are considered high risk of offending or who require interventions for problem behaviours (eg. stalking, fire setting, sexual offending). The NMHSPF also identifies a key role for FMHSs in the assessment and management of people with mental illness in prisons. The TEHS provides community based forensic services from its location in Darwin and provides outreach to the Alice Springs community. The outreach service to Alice Springs is however severely curtailed due to limited resources. There is very limited access to community forensic MH supports outside of the NT's two main residential centres with remote communities getting almost no access.

There is in-reach to the prison setting via community based forensic mental health staff in both correctional centres. These staff almost exclusively service those individuals on Part IIA orders or those deemed 'at risk' by primary care or corrections. There are three staff in Alice Springs, two of them nurses and one a designated aboriginal mental health worker position.

The forensic mental health service also provides a court liaison service to the courts in both main residential centres and provides reports to the courts consistent with the Department of Health statutory accountabilities.

### General Prison Population (Correctional Patients)

#### Legislation

*'In the NT the main legislation governing prison matters is the Correctional Services Act 2014 NT (CSA) and Correctional Services Regulations 2014 (CSR).<sup>47</sup>*

*The NT Department of Health and the Commissioner are responsible for providing appropriate health care to prisoners [CSA ss.82, 88(2)]. Prisoners must have access to healthcare that is of a standard available to the general public [CSA s.93]. If a prisoner is concerned they are not receiving adequate public health care, they can talk to a lawyer or representative.*

*The law says that health care can be administered without consent if prison management or a health practitioner believes that failure to accept the treatment is likely to cause serious harm to the prisoner or others [CSA ss.92, 93]. If required, correctional officers may use reasonable force to assist the medical practitioner in administering medication [CSAs.93(4)].*

*If the health practitioner believes that the prison is not able to provide the necessary health care or specialist treatment is required, they will recommend that prison management make arrangements to transport a prisoner to an appropriate facility [CSAss.85, 86]. Royal Darwin*

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<sup>47</sup> Rawnsley J, Dutailis S and Burke C (2016) .Prisoners. Accessed @ <http://ntlawhandbook.org/fo/wiki/NTLawHbk/Prisoners> on November 5, 2018.

*Hospital and Alice Springs Hospital have outpatient clinics where prisoners are treated. If a prisoner requires observation overnight, they will be admitted to hospital and placed under 24-hour guard by prison officers. In some circumstances a prisoner's custody may be assigned to hospital authorities.*

*Prison management may request that the Department of Health provide current health information about a prisoner [CSA s.89(1)]. This is information that might be needed for administering appropriate care, managing the prisoner and preventing deterioration of medical conditions [CSA s.89(4)]. Information that the Commissioner can request includes health conditions and risks, the likelihood of significant health problems, symptoms associated with conditions and any documented treatment plans [CSA s.89(4)].'<sup>48</sup>*

Part 11 of the NT Mental Health and Related Services Act (MHRSA) deals with prisoners. This part provides for the assessment of prisoners by designated mental health professionals or psychiatrists for the purposes of determining the appropriateness of an involuntary admission, voluntary admission or community treatment order. If the practitioner determines that the prisoner meets the criteria for an involuntary admission and the prisoner is not already at an approved treatment facility, the Commissioner of Correctional Services must permit the transfer of the prisoner to an approved treatment facility for examination, assessment and admission. A prisoner admitted to an approved treatment facility as a voluntary patient or involuntary patient is taken to be in lawful custody while the prisoner remains in the facility. The period spent in the facility is taken to be a period of imprisonment under the sentence imposed on the prisoner.<sup>49</sup>

#### Health Services

The inpatient mental health facilities at both Darwin and Alice Springs accept admissions from their respective correctional centres of general prison population patients. The Alice Springs mental health unit received nine transfers in the first nine months of 2018. These are for acute management of serious mental health concerns. Patients can also be

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<sup>48</sup> Ibid.

<sup>49</sup> Mental Health and Related Services Act. Part 11.

transferred from the general prison population to the CBU for management of their mental health concerns, however the majority of CBU admissions are on Part IIA orders.

The prison primary care service, run by Health, shoulders much of the load in managing the health needs of the general prison population and their health needs. This includes a major role in meeting the statutory requirements for health screening and assessment on admission, including screening for mental health problems. There is an established referral pathway for individuals assessed to require a mental health consultation, however it was indicated to the panel that resource constraints meant that this mechanism was not timely or reliable as the FMH service prioritises Part IIA patients and often is unable to meet the demand for general prison population consultations. FMH services provide outpatient consultation services within the primary care clinic setting at Darwin Correctional Facility and have a limited capacity to do so within the Alice Springs facility, although lack the personnel to do so.

The FMH service does provide consultations in the CBU within Darwin Correctional Facility irrespective of the designation of the resident.

### Those Not Guilty by reason of Mental Impairment (NGMI) or Unfit to Stand Trial (Forensic Disability Patients)

#### Legislation

Individuals with an intellectual disability or cognitive impairment are subject to largely the same provisions of Part IIA of the Criminal Code as those listed earlier for those with a mental illness, with the definition of mental impairment in the Criminal Code stating 'In this Code: **mental impairment** includes senility, intellectual disability, mental illness, brain damage and severe personality disorder.'<sup>50</sup>

The Criminal Code interfaces with the Disability Service Act<sup>51</sup> for those with an intellectual disability in the same way that it interfaces with the MHRSA for those with a mental illness.

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<sup>50</sup> Criminal Code Act NT. Section 7.3 (8)

<sup>51</sup> NT Disability Services Act. [http://www8.austlii.edu.au/cgi-bin/viewdb/au/legis/nt/consol\\_act/dsa213/](http://www8.austlii.edu.au/cgi-bin/viewdb/au/legis/nt/consol_act/dsa213/)

The Disability Services Act has provision for allowing orders for involuntary treatment and care, the development of behaviour support plans and for allowing restrictive interventions. Application of the DSA by services is also subject to external oversight by the Community Visitors Program. Placement in the cottage accommodation in Darwin is based on the application of the Disability Services Act.

#### Health Services

The panel only intends to detail the services utilised by those on forensic orders but notes that the Office of Disability within NT Health funds non-government service providers to provide support to those with a disability, as well as co-ordinating the transition to NDIS services in the Territory. The budget for secure care within the Office of Disability in the Northern Territory is \$10.5m in the 2018/19 financial year. The majority of this budget relates to personnel costs for service provision.

As noted earlier in this report those on Part IIA orders with an intellectual disability are able to be placed in the Complex Behaviour Unit at Darwin Correctional Centre, along with community cottage accommodation co-located with the correctional facility but outside the facility perimeter. There are up to four community cottage beds. The Community cottage facility is not purpose built but rather is converted from accommodation for relatives of inmates from outside of Darwin who required an overnight bed. It has recreational facilities and individual units with en-suite bathroom, bedroom and a small lounge area.

The cottages are not exclusively a 'step-down' from the Darwin Correctional Centre. They are a facility where specialist disability services can be undertaken for eligible Office of Disability clients who need a higher level of support in relation to high risk behaviours. The cottages are staffed by disability support workers trained to support clients with disabilities and administered under the Disability Services Act.<sup>52</sup>

The Complex Behaviour Unit is run by Corrections and is inside the perimeter fence. The exact capacity of the CBU is not clear. It appears to generally house approximately ten

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<sup>52</sup> <https://nt.gov.au/wellbeing/hospitals-health-services/secure-care>

inmates, however it is designed with capacity to house at least 24, although some reports suggest it could be as high as 36 beds.<sup>53</sup> The panel was advised that the current budget does not allow more than 14 inmates to be housed there at a maximum. The cohort resident there includes those with a disability or a mental illness on Part IIA orders as well as general inmates.

There is also a secure care facility next to the Alice Springs Correctional Centre. This is currently an 8 bed facility although it was originally designed with a second wing of equal size which has been repurposed for drug and alcohol care. The facility provides direct care services to high risk, complex clients who are subject to custodial and non-custodial supervision orders under the Criminal Code, as well as clients with dual diagnosis and exceptional needs. The service provides 24/7 residential care, intensive therapeutic interventions and person-centred support to enable clients to:

- improve health and wellbeing and maximise their quality of life
- reduce risk behaviours
- increase opportunities for community integration.

The aim of the 24/7 intensive therapeutic disability residential care is to increase client capacity to enable them to step down to a less restrictive care setting as quickly and as safely as possible.<sup>54</sup>

The existence of a supervision order for a client does not make a client automatically eligible or ineligible for the service. Clients will be assessed individually by the Office of Disability against eligibility criteria. Clients subject to a supervision order under Part IIA of the Criminal Code must be assessed and approved for admission procedures and are subject to the eligibility criteria under section 5 of the Disability Services Act. Clients subject to an order are prioritised.<sup>55</sup>

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<sup>53</sup> Senate Standing Committee on Community Affairs. Report on the Inquiry into 'Indefinite Detention of People with Cognitive and Psychiatric Impairment in Australia.' Chapter 2.

<sup>54</sup> <https://nt.gov.au/wellbeing/hospitals-health-services/secure-care>

<sup>55</sup> <https://nt.gov.au/wellbeing/hospitals-health-services/secure-care>

The Office of Disability also provides secure supported accommodation in the community for appropriate clients including those on Part IIA orders. These facilities exist in both Alice Springs and Darwin. There are currently 2 supported accommodation arrangements in Darwin and 4 in Alice Springs. There are also a further four clients who are on the non-custodial supervision orders within the NDIS.

## Youth Justice Facility Patients

### Legislation

The legislation that provides authority for youth detention in the Northern Territory is the Youth Justice Act (YJA) with the detention responsibilities of the Act administered by Territory Families. Section 4 of the YJA outlines the principles to apply in the exercise of the Act including that a youth should only be kept in custody for an offence (whether on arrest, in remand or under sentence) as a last resort and for the shortest appropriate period of time.

Part 10 of the YJA spells out the provisions relating to medical treatment for detainees. The superintendent of a detention centre must ensure that a detainee is given access to a medical practitioner, for the purpose of medical consultation and treatment, on request<sup>56</sup>. The superintendent of a detention centre must comply with the direction of a medical practitioner in relation to the health of a detainee at the centre.<sup>57</sup> A detainee may be required to be examined or treated.<sup>58</sup> The superintendent of a detention centre must move a detainee from the detention centre to a hospital, in the event of illness of the detainee, on the order of the CEO; a medical practitioner; or the Court.<sup>59</sup>

The Youth Justice Regulations require the superintendent '*to ensure*' a comprehensive medical and health assessment be carried out by a medical practitioner on each detainee within 24 hours of admission, or if a medical practitioner is not available, as soon as possible

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<sup>56</sup> Youth Justice Act (NT) s173.

<sup>57</sup> YJA (NT) s174.

<sup>58</sup> YJA (NT) s176.

<sup>59</sup> YJA (NT) s178.

following an interim assessment by a registered nurse.<sup>60</sup> A detainee must be provided with the medical attention, treatment and medicine that, in the opinion of a medical practitioner, is necessary for the preservation of the health of the detainee and, if applicable, other detainees and members of staff.<sup>61</sup>

A member of staff who notices that a detainee appears to be physically or mentally ill must bring the matter to the attention of the Superintendent without delay. The Superintendent must ensure appropriate medical attention is provided to the detainee. In an emergency requiring that medical attention be provided to a detainee, the members of staff responsible for supervising the detainee must take action that is reasonable in the circumstances and likely to ensure that medical attention is provided to the detainee as soon as practicable.<sup>62</sup>

If the Court endorses a warrant with a note that the youth is at risk of self-harm, when admitted to the detention centre the youth must immediately be referred to a medical practitioner. If a member of staff considers a detainee may be at risk of self-harm, the member must ensure the detainee is in view of a member of staff or a health professional at all times until and emergency response or an individual management plan for the particular detainee is implemented; and notify the Superintendent or other person in charge of the detention centre at the time. The Superintendent or person in charge must immediately refer the detainee to a medical practitioner; and implement the Emergency Management Protocol or, if an individual management plan has been formulated for the particular detainee, that plan.<sup>63</sup>

The responsibility for ensuring the provision of health services lies with the Superintendent of the Detention Facility, however the provision of those services is by NT Health. It is unclear if there is an extant MOU for this relationship, however no senior officers were able to produce one on request.

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<sup>60</sup> YJ Regulation 57.

<sup>61</sup> YJ Regulation 58.

<sup>62</sup> YJ Regulation 59 and 60.

<sup>63</sup> YJ Regulation. Division 3.

## Health Services

NT Health provides a primary care clinic within the Don Dale detention facility, staffed by a medical practitioner on a part-time basis, a full-time nurse and a part-time psychologist. There are also primary care services available at the Alice Springs Youth detention facility.

The primary care team undertakes all screening and referral within the youth detention facilities. Despite the fact that the available Australian evidence suggest a high proportion of youth in detention have mental health problems, there is very limited in-reach by mental health services unless there is a young person in detention who is suicidal. The latter only occurs as the relevant regulations described above are activated. In most cases it is the adult forensic mental health team that deals with these acutely unwell individuals. This is not standard practice in other jurisdictions who would provide child youth mental health services to youth in detention. There is capacity for transfer of a young person to an inpatient facility if that is deemed clinically appropriate.

The specialist child and adolescent mental health team does not attend the Don Dale facility. The Royal Commission report into young people in detention notes that the Forensic Mental Health team do not provide general mental health treatment other than for acute mental illness. This was confirmed by both the primary care team and the forensic team on interview. The Child and Adolescent Mental Health team indicate that they do not have specialist forensic skills and therefore do not provide general mental health care either. This means that the majority of 'specialist' mental health care within the facility is undertaken by the primary care team, and by the behavioural management staff provided by Territory Families.

In Alice Springs in 2016 there was one FTE child psychiatrist, a Child & Adolescent MH team leader and five clinical positions. There is also one clinical position in Tennant Creek. Each clinical case manager manages around 20-30 children.<sup>64</sup> There is a substantial caseload overlap with youth justice clients<sup>65</sup>. The CAMHS (CYMHS) team in Alice Springs will see

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<sup>64</sup> Dr Megan Chambers, Dr Sally Cleworth and Dr Marcus Tabbart. "Submission to the Royal Commission" October 2016. Provided to the panel by Dr Tabbart.

<sup>65</sup> Ibid.

children in detention if they are existing clients if they are transported into the offices of the team. This does not allow however for a case management approach.<sup>66</sup>

### Current Planning Objectives

The current Northern Territory Mental Health Plan runs from 2015-2021 and states as its vision 'to promote, protect and enhance the health of all Territorians across all stages of life'<sup>67</sup>. The Mental Health Plan does not articulate the current resource base for mental health in any detail, nor does it reference any particular initiatives related to forensic mental health service provision. It does however describe six principles that underpin current strategy: person centred holistic care; care that is culturally safe and appropriate; partnering with consumers and carers; a recovery paradigm; high quality safe services; and equity sustainability and a stepped care approach. It is anticipated that the Government intends to apply these principles equally to forensic mental health care as to other parts of the mental health system.

There is no territory wide mental health clinical services plan. The panel was advised that the Health Services did their own clinical services planning, and that as part of the Fifth National Mental Health Plan implementation that this clinical services planning will be led by Primary Health Networks. It is not clear on what basis therefore that NT Health disperses budget to the Health Services for mental health service provision.

The panel was unable to locate an extant NT Disability Services Plan. This is likely due to the substantial impact that the NDIS is expected to have on Disability Service Provision. It would appear however that the Office of Disability will retain service delivery responsibility for Part IIA patients after the NDIS has achieved full rollout. The relationship between the NDIS and access for Forensic patients on Part IIA orders is unclear to the panel at this time.

The outcomes of the Royal Commission into Youth Detention in the Northern Territory will drive strategic planning in the NT for Youth Justice services for the foreseeable future. A

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<sup>66</sup> Ibid.

<sup>67</sup> Northern Territory Health. Mental Health Service Strategic Plan 2015.

new facility to replace the current Don Dale facility has been announced and is currently in the planning phase. The Government has committed to fund more than 200 recommendations from the Royal Commission.

## Description of the Forensic Population in the Northern Territory

### Those on Part IIA Orders

The prevalence of forensic mental health orders in the NT is higher than in some other jurisdictions.<sup>68</sup> NT Health advised the panel that at the time of requesting data for the review process there was 45 individuals on part IIA orders, with 17 of these being custodial and 28 being non-custodial. Approximately 90% of these individuals are Aboriginal or Torres Strait Islanders and almost all of them are male, although complete data has not been provided by NT Health.

The Senate Community Affairs inquiry into Indefinite Detention indicates that in 2016 there were 16 individuals put onto Part IIA orders during that year bringing the total at that time in the Northern Territory to 36. It does not indicate how many came off orders in that year or what the usual rate of progression is through the system. The Senate report does indicate that of the sixty separate people to have had their cases reviewed by the court between 2002 and 2016, 20 people have been released unconditionally at some point (five of whom were released unconditionally prior to any custodial order).<sup>69</sup>

NT Health were able to provide data on 22 of their Part IIA clients from the last five years, however they indicated that this did not cover the whole cohort, with the number not available unspecified. Of those 22 where data was provided, four had orders revoked and two had passed away by the start of 2019. Age and gender information was not available.

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<sup>68</sup> [https://www.alrc.gov.au/sites/default/files/subs/118.\\_nt\\_government.pdf](https://www.alrc.gov.au/sites/default/files/subs/118._nt_government.pdf)

<sup>69</sup> Senate Standing Committee on Community Affairs. Report on the Inquiry into 'Indefinite Detention of People with Cognitive and Psychiatric Impairment in Australia.' Chapter 2.

## Those in Youth Detention

At the time of the panel visit to Don Dale Youth Detention facility there were 24 resident young people of whom 23 were male. All 24 residents were Aboriginal or Torres Strait Islander. The age range was between 14 and 17 years.<sup>70</sup>

According to advice from Territory Families staff, all other options are tested before incarceration at Don Dale. Many of the young people present during the panel visit had been in Don Dale on more than one occasion and the majority of residents had multiple offences prior to being placed in the facility.<sup>71</sup> The most common offences for youths received into detention during 2015-16 were 'acts intended to cause injury' (39% of all receptions) and 'unlawful entry with intent/burglary, break and enter' (29% of all receptions). There was a 60% increase in the number of youths received into detention for 'dangerous or negligent driving' (from 15 offences in 2014-15 to 24 offences in 2015-16).<sup>72</sup>

## General Prison Population

As of April 2018, Darwin Correctional Centre had 1087 prisoners of all classifications and genders. At the same time Alice Springs Correctional Centre had 642 prisoners across all classifications and genders. The adult imprisonment rate in the Northern Territory (921 per 100,000) is the highest in Australia and three times higher than the next closest rate (WA with 292 per 100,000)<sup>73</sup>. In the last five years (from June quarter 2013 to June quarter 2018), the number of persons in custody has increased by 39% (12,043 persons). (see Table 1) In short, it is an extreme outlier.

As at 2 August 2017, 1,156 Aboriginal adult males were imprisoned, which represented 85 per cent of the total adult male prison population in the NT. As at 2 August 2017, 90 Aboriginal adult females were imprisoned, which represented 83 per cent of the total adult female prison population in the NT. In the NT in 2016, 84 per cent of the total prisoner

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<sup>70</sup> Advice provided by Senior Don Dale facility staff during the panel visit.

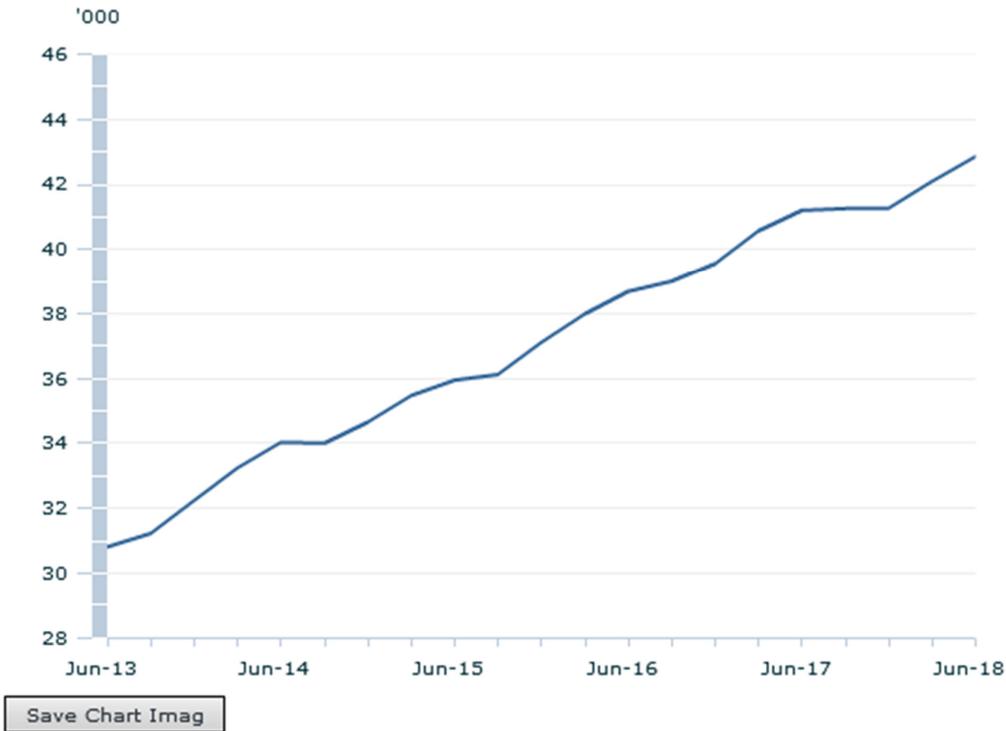
<sup>71</sup> Ibid.

<sup>72</sup> [https://justice.nt.gov.au/\\_\\_data/assets/pdf\\_file/0009/430110/2015-16-NTCS-Annual-Statistics.pdf](https://justice.nt.gov.au/__data/assets/pdf_file/0009/430110/2015-16-NTCS-Annual-Statistics.pdf)

<sup>73</sup> [https://justice.nt.gov.au/\\_\\_data/assets/pdf\\_file/0009/430110/2015-16-NTCS-Annual-Statistics.pdf](https://justice.nt.gov.au/__data/assets/pdf_file/0009/430110/2015-16-NTCS-Annual-Statistics.pdf)

population identified as Aboriginal. In the March Quarter 2016, Aboriginal people comprised 76.1 per cent of people in community-based corrections in the NT. This is almost four times the national proportion of 19.6 per cent.<sup>74</sup>

**PERSONS IN FULL-TIME CUSTODY(a), Jun 2013 to Jun 2018**



Australian Bureau of Statistics  
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## Review Findings

This review was a system and policy review and not a clinical case file review. While the panel observed both custodial activity and clinical care during site visits, these will be described in general terms, rather than as specific case outcomes. Individual cases raised with the panel may be referenced where the details are already in the public domain, but only as illustrations of policy and systems issues already identified.

The findings of the review panel detailed below are based on the views of the panel with regard to best practice and appropriate policy responses in contemporary comparable

<sup>74</sup> [https://www.alrc.gov.au/sites/default/files/subs/118.\\_nt\\_government.pdf](https://www.alrc.gov.au/sites/default/files/subs/118._nt_government.pdf)

systems. There are some references to responses that would be ideal rather than simply the most pragmatic, as the panel believes that all governments should retain the aspiration to deliver that which is best for their community. However, there are also recommendations that recognise the competing tensions in government service provision. As such the situation in the Northern Territory with regard to the capacity for revenue generation for government services and the competing priorities of global budgets has not been a substantive consideration for the panel. This is not to say that financial considerations have been ignored in this report but rather that the panel has determined that it is for government to decide what actions it will prioritise and how it will raise the funds to implement them.

The findings below are aggregated into relevant themes that align to the TORs provided to the panel.

### Resourcing

This review makes a number of recommendations to improve service delivery within the forensic mental health and disability program and improve compliance with human rights obligations. However, in the absence of additional resources, and particularly staffing resources, the gains made will be minimal. The overall level of resourcing for forensic mental health services, and mental health services generally, in the NT requires revision and adjustment. There appears to be a lower proportion of health expenditure on forensic mental health in the NT compared to other jurisdictions, and the NT is the only Australian jurisdiction with no dedicated inpatient facility for this cohort.<sup>75</sup> There may be valid reasons for this, however it is an issue central to many concerns expressed to the panel thus far.

While commentary is made about the model of care and service components at a later point in this report it is important to state that capital expenditure is not the primary priority. The Territory could benefit from some targeted new facilities but it also has a number of relatively new assets that are operating well below their physical capacity due to lack of

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<sup>75</sup> Submission from the RANZCP to this review

staff. It is important to communicate that additional clinical and disability support staff are required to improve practice and outcomes.

The RANZCP submission to this review was critical of the current alignment of resources and responsibilities for the two forensic mental health teams in Darwin and Alice Springs. Informants from these two services similarly expressed frustration at the relationship between service expectations and concomitant resourcing. The table and break out box below summarises the resourcing and workload as documented in the RANZCP submission to this review. The panel corroborated this information with other informants to the review process.

<b><i>Forensic Mental Health Team (Darwin)<sup>76</sup></i></b>	<b><i>ASCC Forensic Mental Health Team</i></b>
1 team manager (administrative role) 2 consultant forensic psychiatrists 2 trainee psychiatrists 2 Court clinicians (court liaison role) 1 Court coordinator (administrative role) 1 Aboriginal Mental Health Worker and occasional access to an Indigenous advisor 3 Registered Mental Health Nurses 1 social worker 1 psychologist 0.5 admin support (administrative role)	1 team leader (administrative and clinical role) 1 Court clinician (Court liaison in Alice Springs Court) 2 Registered Mental Health Nurses

To illustrate the workload, the Darwin-based team is responsible for delivering all the services listed below<sup>77</sup>:

- a. Assessment and treatment of patients who are referred by the prison primary care team and not yet under the care of TEMHS.

<sup>76</sup> Submission from the RANZCP to this review

<sup>77</sup> Submission from the RANZCP to this review

- b. Assessment and treatment of patients who are under the care of TEMHS and received into custody.
- c. Assessment and consultation for patients placed 'at risk' by the Courts and prisons. Approximate average 3–5 assessments per working day.
- d. Assessment of 'at risk' youth in Don Dale Youth Detention Centre.
- e. Managing a caseload of Part IIA supervised persons (not guilty by reason of mental impairment individuals) in prison in addition to doing their Part IIA reports.
- f. Managing a caseload of Part IIA supervised persons in the community in addition to doing their Part IIA reports.
- g. Providing one consultant plus two registrar clinics per month at ASCC in addition to providing email, video link and telephone supervision to the ASCC Forensic Mental Health Team for all their patients.
- h. Providing section 77, 74 (mental health related disposition) reports to Local Courts.
- i. Providing Part IIA (e.g. fitness to plead, mental impairment defence, supervision order related mental health care plan, periodic mental health review and Supreme Court major reviews) reports to the Supreme Court.

Alice Springs Team:

- j. Assessing and managing Forensic Mental Health Team patients who are admitted to the local civil psychiatric closed ward in Royal Darwin Hospital. On average, 1–2 patients.
- k. The ASCC Forensic Mental Health Team delivers services a, b, c, d (for youth detained in the ASCC), e and h above. The general adult psychiatrists of Central Australia Mental Health Service are responsible for the periodic reviews of Part IIA patients on Non-Custodial Supervision Orders.
- l. In addition to the above, both teams are required to do case-review meetings, formulate HCR-20 risk assessments, undertake professional development and contribute to clinical and operational governance requirements.

The most recent AIHW report comparing expenditure across jurisdictions on mental health covered the financial year 2015/16. In that report there was no forensic expenditure recorded for the NT<sup>78</sup>, which may have been a data submission error, or perhaps reflected the resource groupings at that time. NT Health advises that in 2018/19 the total NT Health forensic mental health budget is approximately \$4m or 6% of the total \$68.5m mental health budget.

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<sup>78</sup> AIHW. Mental Health Services in Australia 2018. <https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/expenditure-on-mental-health-related-services>

The AIHW report for 2015/16 did demonstrate that the NT is comparable to the national average on per capita expenditure for mental health<sup>79</sup>. The NT was behind WA and the ACT, level with SA and ahead of the larger jurisdictions and Tasmania. However, given the NTs small population and very low population density, and the impact of scale on per capita calculations, it would be expected that the NT should be at, or very near to, the top of the per capita comparisons. This is not the case.

In 2018/19 mental health makes up approximately 4.5% of the total NT Health budget, and the forensic budget makes up 6% of the mental health budget. While comparisons with other jurisdictions are only a “broad brushstroke” assessment of need they do provide a useful reference point.

There are currently national efforts to agree on resource modelling frameworks for both mainstream MH and forensic MH services. The panel has been provided with the epidemiology that underpins this work and the taxonomy of services but not the resource outputs. These should be used as templates for comparison for resourcing questions. Notwithstanding this it is also clear that there are underutilised resources in the NT that could be better harnessed for Forensic mental health and disability care.

The Northern Territory has the highest incarceration rate per head of population in the country, three times higher than the next closest jurisdiction. The NT is therefore an extreme outlier in provision of mental health and disability services to those involved in the criminal justice system. As a general rule therefore the NT forensic mental health resource base should be at least three times higher than that of other states and territories. The submission to this review by the RANZCP recommends 11FTE specialist mental health staff per 550 male prisoners based on work done in the UK, which would be an approximate doubling of the existing forensic staffing resources in the NT. While the panel does not necessarily endorse this figure, and would prefer to rely on the final outputs from the forensic component of the NMHSPF when available, the recommendations below do foresee a substantial resourcing increase as necessary.

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<sup>79</sup> Ibid.

### **Recommendation 1**

**The Northern Territory Government needs to immediately increase the resource base for forensic mental health service provision in the Northern Territory by:**

- a. Repurposing the Complex Behaviour Unit at Holtz to a health run forensic inpatient facility catering for both mental health and disability presentations and dual diagnosis.**
- b. Allowing a broader diagnostic category to utilise the secure care facility at Alice Springs and the cottages in Darwin with both forensic disability and forensic mental health clients being eligible.**
- c. Increasing the availability of community based mental health supports, in collaboration and partnership with Aboriginal CCHS to allow relevant Part IIA clients to return to their community and/or country.**
- d. Increase the availability of specialist forensic psychiatry positions by at least doubling current positions to assist with meeting the existing functions prescribed to the forensic service in Darwin.**
- e. Allocate resources to specialist forensic positions in Alice Springs, including a dedicated forensic psychiatry position.**
- f. Ensure that there is appropriate access to Aboriginal mental health workers with forensic skills in the forensic teams.**
- g. Improved availability of forensic psychology services**
- h. Improved availability of secure supported accommodation in the community in both Darwin and Alice Springs.**

A significant number of Part IIA patients have cognitive impairment. They are primarily serviced through the Specialist Support and Forensic Disability Unit within NT Health.<sup>80</sup>

While this review advocates for the creation of a single forensic health program in the NT with two operational arms, the resource requirements for those with an intellectual disability or cognitive impairment similarly need enhancement. The demand for secure

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<sup>80</sup> Submission from the RANZCP to this review

supported accommodation exceeds supply and there are similar statutory requirements to those that pertain to the mental health service

for court reports and assessments. The NSW Corrections State-wide Disability Service provides a reference point for both functional and staffing needs that can be mapped to expected service demand.<sup>81</sup>

## Recommendation 2

**The Northern Territory Government model the resource needs for responses to clients with cognitive impairment based on projections of future demand volume aligned to a reference model provided by the NSW Corrections State-wide Disability Service for the enhancement of multidisciplinary resources for this group. It should be noted that it is expected that there will be economies available through the sharing of resources across the two forensic specialties and more effective management of those with dual diagnoses who are estimated to be up to 50% of the Part IIA cohort.**

## Forensic Services Model of Care

There is no evidence of a comprehensive Forensic Mental Health Services and Forensic Disability Services model of care consistent with the aims of the AHMAC national principles for forensic care, the position statement of the RANZCP, the aims of the Forensic components of the NMHSPF and the intent of policy direction 5 of the National Disability Strategy. *There is a prevailing need for a clear clinical pathway of care with a stepped resource model for individuals subject to Part IIA orders and others in contact with the criminal justice system who require forensic mental health or disability services.* This model should reflect the service elements described in the forensic documentation associated with the NMHSPF.

The fundamental premise underpinning a NGMI or unfit to stand trial decision is that the individual is 'not guilty' of the offence, and concurrently, that 'the state' has an obligation to

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<sup>81</sup> Details available in Dowse, L., Rowe, S., McGillivray, J., & Newtown, D. (2017). *Education, Training and Employment for Prisoners with Cognitive Disabilities: A Case Study*. Sydney: UNSW Sydney. <http://doi.org/10.4225/53/59f1236338e46>. Section 3.

provide appropriate treatment or support for their underlying condition. Simply, they do not warrant a prison sentence and they do require a treatment or care setting.

The second premise is that the ideal objective of a forensic order is that the individual can receive treatment or support for their condition that balances patient and public welfare and helps maximise opportunities for recovery and community reintegration. There ought to be a properly resourced pathway, with settings involving graduated supervision and levels of security, to achieve that aim. Individuals will move along the pathway at different rates, and some may not reach the end of that pathway, but the pathway must be available.

The current forensic system appears to have limited options for movement out of the correctional environment while maintaining forensic orders and appropriate care and support. The starting point for the majority of people placed on custodial orders is either with the general prison population or specialist accommodation within the prison. This is also often the ongoing arrangement with people kept in prison as a consequence of their disability rather than their offending behaviour.<sup>82</sup> There is no secure health- run facility for this cohort. As there is a requirement for NT Health to endorse the availability of an ‘appropriate place’ for the placement of an individual on a custodial order, and Health does not have secure accommodation for the total cohort on custodial orders, or for addressing their differentiated needs, the only option is a corrections managed environment.<sup>83</sup> This is despite the legislation clearly indicating the intention of parliament that gaol be a last resort for placement. This can mean that individuals on Part IIA orders can spend a far greater time in a correctional centre than their original offence would have mandated if they were found guilty. This was described by many informants as a common outcome, and an unacceptable one. It is also contrary to national and international frameworks that articulate the rights of individuals with a disability in the criminal justice system.

There is a need to model a forensic clinical pathway that allows patients to move through a least restrictive care paradigm and progress toward community placement. This is a fundamental objective of any forensic care system. There is also an apparent deficiency of

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<sup>82</sup> NAAJA Submission to this inquiry.

<sup>83</sup> Dr Peter Norrie. Report on the Independent Review into Part IIA orders. April 2018. p2.

community accommodation and secure non-acute care facilities for forensic clients<sup>84</sup>, and this diminishes movement through the system.

NT Health operates a secure facility for forensic patients with a disability in Alice Springs and community cottages for this population at the Darwin (Holtz) Correctional precinct. At the time of the review each of these facilities housed only one client. The panel was advised that the bed occupancy of the Alice Springs facility is around 40% and the community cottages in Darwin around 60%. Less than half of the available beds in the CBU were open.

### **Recommendation 3**

#### **The Northern Territory Government:**

- a. Develops as a matter of urgency, a territory wide services plan for clients of forensic mental health and forensic disability services that incorporates secure inpatient or residential care, secure supported accommodation and access to community based forensic supports at a minimum. The role and responsibility of, and interface with, the National Disability Insurance Scheme should be made clear in the plan.**
- b. Should prepare this plan immediately however it should be updated to utilise the outputs from the Forensic component of the National Mental Health Services Planning Framework to determine service resource need for the mental health component when that tool becomes available.**
- c. Develops a resourcing strategy to fund the components of that plan acknowledging there is underutilised capacity already within the system that could be repurposed through the provision of additional staffing resources.**

The Complex Behavioural Unit (CBU) at Darwin Correctional Centre is a purpose built facility for the management of individuals on Part IIA orders, however it is under the operational authority of Corrections, and is run to correctional centre operational protocols. This is inconsistent with the intention of the NT legislation, the national statement of forensic principles, the position statement of the RANZCP, and the provisions of the Convention on

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<sup>84</sup> Dr Peter Norrie. Report on the Independent Review into Part IIA orders. April 2018; NAAJA submission to this inquiry.

the Rights of People with Disabilities. *The operational authority for the Complex Behavioural Unit (CBU) at the Darwin Correctional Facility should be moved to NT Health and the facility regazetted as a health facility.* The unit is underutilised with only half its bed capacity operational. A transfer of operational authority to Health and a regazetting of the unit as a health facility would provide a more appropriate start point on the forensic pathway. The Joan Ridley Unit is not an appropriate treatment environment for these patients with its mixture of male and female clients, forensic and civil clients and occasionally young people under the age of 18. Resources should be sourced to ensure that the empty bed base in the CBU can be utilised and particularly to ensure that no Part IIA clients are resident inside the general prison and that the JRU is required only in extreme circumstances.

The panel wishes to acknowledge the efforts of the existing correctional staff inside the CBU. There was genuine endeavour to manage the unit within a recovery framework and to adjust and reframe their custodial training. These staff are to be commended for their efforts, with the recommendations below based on global best practice and an acknowledgement of the particular clinical skills required with this cohort, rather than any negative assessment of the current CBU staff efforts.

#### **Recommendation 4**

- a. **The Northern Territory Government shifts operational authority for the Complex Behavioural Unit at the Darwin (Holtz) Correctional Complex to NT Health, and degazettes the facility as a correctional unit in favour of changing the legal status to a health facility, approved as a treatment facility within the meaning of the Mental Health and Related Services Act. Appropriate changes to the existing security arrangements, staffing and physical asset should be made to allow this change to occur.**
- b. **Additional resources should be allocated to enable care to be delivered by NT Health. In addition, funding should be allocated to utilise the unused bed capacity at the CBU consistent with the designated functionality of the unit identified by the services plan from Recommendation 1. It is likely that this will involve high acuity, sub-acute and potentially non-acute mental health wings,**

**at least one dedicated wing for those with a cognitive impairment and could also provide dedicated areas for women and young people from youth detention facilities.**

There are clear resource differences in forensic mental health service provision between the Top End Health Service and Central Australian Health Service.<sup>85</sup> These differences are causing challenges for practitioners and administrators, causing unpredictable service pathways for patients and external partner agencies, and are causing concern for senior clinical staff with the amount of clinical risk they are carrying<sup>86</sup>. The staff based in the Alice Springs Correctional Centre feel isolated and are unclear of their advocacy and governance pathways given the division of responsibilities between the two health services for determining and monitoring their activity. The current unclear arrangements whereby the staff are corporately and professionally accountable to CAHS and yet are potentially clinically accountable to TEMHS are untenable.

There were numerous examples provided to the panel, with different perspectives regarding cause, of contradictory or countermanding directives with regard to forensic patients by clinical staff from the TEHS FMHS and the local CAHS mental health staff, particularly with regard to transfers from the prison to the hospital mental health ward. This leads to frustrations for all concerned but for Corrective Services staff in particular. A driver of this is the interplay between clinical decision making in the prison environment and its associated thresholds, and clinical decision making in the hospital environment, with its resource management component and associated thresholds. With the current service relationships between FMHS and CAHS there is no shared accountability for these decisions across settings.

#### **Recommendation 5**

- a. The Northern Territory Government should improve the resourcing of the forensic mental health team onsite in the CAHS to improve local relationships**

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<sup>85</sup> Dr Peter Norrie. Report on the Independent Review into Part IIA orders. April 2018.

<sup>86</sup> Root cause analysis into Naomi Smith as quoted in the “Inquest into the death of Naomi Smith [2018] NTLC 017”.

- and service arrangements. This includes the establishment of appropriate senior medical positions in forensic psychiatry.**
- b. In alignment with later recommendations regarding the future arrangements with Forensic Disability Services, the forensic CAHS staff should be involved in the operation of the secure care facility adjacent to the Alice Springs Correctional precinct and be part of a Territory wide Forensic Service.**
  - c. An operational protocol should be developed by the two health services and endorsed by the Department of Health that provides the mechanism for movement between specialist forensic facilities across the TEHS and CAHS.**

Improvements are necessary in the provision of specialist mental health services to correctional inmates. The forensic mental health teams at both the Alice Springs and Darwin facilities have nominal accountability for specialist service provision to correctional inmates in addition to their responsibilities with Part IIA patients. There is evidence to suggest however that the majority of resources go to forensic clients and that there is a dearth of specialist provision to correctional patients with primary care services carrying this accountability. There is also limited evidence of routine specialist MH screening on admission to the correctional facilities with primary care again having predominant responsibility for this. The panel is concerned to ensure that appropriate specialist skills are being made available and that resources and processes are appropriate to make this happen.

The service agreements with TEHS and CAHS places caveats on their responsibilities with correctional inmates. It indicates that treatment is limited to clients with enduring major mental illness such as psychosis and major mood disorders and assessment and treatment of patients who are either known to psychiatric services in the NT or as a result of referrals by the prison primary care service. FMHS also carries out 'at-risk' assessments for patients in custodial settings. There is no documented accountability for the FMHS for screening and given the documented thresholds in the service agreement, it appears there is a default service option of the primary care team. The NMHSPF forensic component incorporates consultation liaison and 'community' care in the general prison environment within the responsibilities of FMHS. It is a specialist skill to manage mental health concerns in this

environment and one for which primary care teams are not specifically trained. Further the specialist resource of secure mental health care is part of the mental health service spectrum.

#### **Recommendation 6**

**The Northern Territory Government should resource forensic mental health services to provide comprehensive suicide and self-harm assessment in the prison environment and ensure that these resources are adequate to allow for effective, equivalent 'community based' specialist mental health care to the general prison population. In the absence of additional resourcing the forensic mental health team cannot fulfil this task.**

It is evident that a substantial proportion of individuals on Part IIA orders identify as Aboriginal or Torres Strait Islanders. It is equally evident that effective service delivery to the Part IIA group requires culturally appropriate services, co-designed with Indigenous leadership

The panel acknowledges that the vast majority of individuals subject to this review are male however it was clear that there is a lack of clear service pathways that recognise the needs of women and girls. In fact, it is likely that the substantial gender bias in the cohort has reduced the prioritisation of determining an appropriate service model for women and girls. This is creating a substantial clinical risk. The JRU is clearly not an appropriate service setting for vulnerable women and girls with evidence provided of past adverse events relating to co-location of males and females in this setting. The management of the only young woman in the Don Dale facility during the panel visit is unsatisfactory and a clear breach of most of Australia's international agreements on human rights. There is little evidence to date of specific service settings or care pathways designed for women. It is acknowledged that targeted services planning will be required to establish the most effective models for female forensic patients.

#### **Recommendation 7**

**The Northern Territory Government should incorporate into its clinical services planning a specific set of responses for women and girls in the criminal and youth justice systems.**

**This may require the establishment of, or repurposing of, physical assets. At a minimum it requires the development of a sexual safety policy for secure facilities. In undertaking this work specific consultation should be held with Aboriginal and Torres Strait Islander people to ensure that the specific needs of Aboriginal and Torres Strait Islander women are met.**

#### The alignment of Forensic Mental Health and Disability services

*There are strong arguments for a closer relationship between forensic mental health services and forensic disability services within NT Health.* There are obvious similarities of process, and clinical overlaps between the two forensic teams within NT Health with the shared cohort amongst the Part IIA clients of around 50%<sup>87</sup>. There are also resources available, particularly residential resources, that are underutilised as they are reserved for a single diagnostic grouping, either mental health diagnoses or disability diagnoses. There are clinical and efficiency benefits to developing a single team Forensic Health team with responsibility for all those individuals on Part IIA orders and with an aggregation of the existing resources for both sets of diagnostic groupings. This would require a multidisciplinary workforce with specialist skills in both sets of diagnostic groupings.

Examples were provided to the panel of opposing views being expressed by the two teams around clinical treatment planning and also in external communication to the justice system which has the potential to cause reputational damage to Health as an agency. A single team may assist in resolving threshold and resource management issues that lead to these opposing views. The panel is concerned however to ensure that specialist skills in both disciplines are available in residential settings and that the physical resources are designed appropriately for the patients who will be utilising them.

#### **Recommendation 8**

**The Northern Territory Health Department should merge the operational responsibilities of the Office for Disability with regard to Part IIA clients and the Forensic mental health teams in TEHS and CAHS to create a single Forensic Health Service. The secure care facilities available to both services should be designed and staffed, with appropriate**

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<sup>87</sup> Interview evidence provided to panel members from staff of the Office of Disability.

**interdisciplinary training, to manage both cohorts based on consumer need rather than diagnostic grouping.**

The National Disability Insurance Scheme will completely change the support landscape for people with a disability once it has arrived at full scheme, with individualised funding, and enhanced resources. Ensuring a robust market of providers in the NT however, is crucial. The bilateral arrangements with government are still being finalised however it is important that those on forensic orders are eligible for the scheme both during the life of the order and after its expiration. As such the involvement of the NDIS in the ongoing care of forensic disability clients must be resolved with the Commonwealth and be incorporated into the bilateral arrangements. There is currently lack of clarity regarding the capacity for forensic disability patients to access the NDIS either on Part IIA orders or after discharge. An appropriate care pathway requires identification of resourcing of appropriate community supports as part of the NDIS bilateral arrangements.

#### **Recommendation 9**

**The Northern Territory Government should resolve the involvement of Part IIA patients in the NDIS and have their eligibility documented in the appropriate intergovernmental agreements. An individual found not guilty by reason of mental illness or unfit to plead, and therefore with no criminal conviction, who is managed by the health system and resident in a health facility, should be eligible for the NDIS.**

#### [Legal Process and Oversight of Part IIA Patients](#)

In the NT forensic orders are both established and monitored by the Supreme Court. In most other jurisdictions subsequent to establishment of an order by the Supreme Court, the MH Review Tribunal (or equivalent) in that jurisdiction takes on responsibility for monitoring and adjusting the care conditions on the patient and making decisions about detention, treatment and release.<sup>88</sup> This is with appropriate safeguards and appeal mechanisms

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<sup>88</sup> Senate Standing Committee on Community Affairs. Report on the Inquiry into 'Indefinite Detention of People with Cognitive and Psychiatric Impairment in Australia.' Chapter 2.

available, such as appropriate judicial seniority of presiding tribunal members and appeal to the Supreme Court available.

In NSW for example the *Mental Health (Forensic Provisions) Act 1990* deals with the care, treatment, control and release of forensic patients and patients transferred from correctional centres, and with the functions of the Mental Health Review Tribunal. In 2009 there was a change to the Act providing the transfer to the Tribunal of decision-making responsibility over forensic patients. The Tribunal is now able to make orders for the detention, care and treatment of forensic patients, including orders for release.<sup>89</sup>

The NSW Tribunal must consider the protection and safety of both the patient and members of the public when making decisions on forensic patient release, placement and leave. The Tribunal can order back to detention conditionally released patients who breach the terms of their release or leave orders.<sup>90</sup> The amended Act creates a new category of patients called **correctional patients**. These patients are inmates serving a sentence in a correctional centre or on remand who are transferred to a mental health facility to treat their mental illness or mental condition. The Commissioner of Corrective Services may allow a correctional patient to be absent on leave from a mental health facility for a period of time and subject to terms and conditions set by the Commissioner. The Tribunal can recommend the granting of such leave.<sup>91</sup>

In NSW the Tribunal has the power to make non-custodial (community) treatment orders in relation to forensic and correctional patients and inmates who are detained in a correctional centre, as well as forensic patients who have been released conditionally.<sup>92</sup>

The Tribunal must review persons who are subject to community treatment orders and who are detained in correctional centres. The Act requires the Tribunal to review forensic and correctional patients at least once every 6 months. The Tribunal forensic reviews are conducted by the Tribunal President or Deputy President; a member who is a psychiatrist, a

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<sup>89</sup> <https://www.health.nsw.gov.au/mentalhealth/Factsheets/Pages/patients-carers.aspx>

<sup>90</sup> <https://www.health.nsw.gov.au/mentalhealth/Factsheets/Pages/patients-carers.aspx>

<sup>91</sup> <https://www.health.nsw.gov.au/mentalhealth/Factsheets/Pages/patients-carers.aspx>

<sup>92</sup> <https://www.health.nsw.gov.au/mentalhealth/Factsheets/Pages/patients-carers.aspx>

registered psychologist or other suitable expert in relation to a mental condition; and a member who has other suitable qualifications or experience.<sup>93</sup> The President and Deputy President must be individuals who have served as a Supreme Court or District Court judge or be individuals eligible to be so appointed.

Forensic patients and correctional patients can apply to the Supreme Court to appeal against decisions of the Tribunal. The Minister for Health may also appeal to the Supreme Court against Tribunal decisions and the Attorney General may appeal to the Court of Appeal on a question of law in a release matter. The Minister for Health and the Attorney General may appear before, or make submissions at Tribunal forensic patient reviews in relation to release or grant of leave of absence. A range of officials, including the Minister for Health, Attorney General, Director-General of Health, and the medical superintendent of a mental health facility can request that the Tribunal review the case of a forensic or correctional patient.<sup>94</sup>

Finally, a victim of a forensic patient, or an immediate family member, may apply to the Tribunal for an order to impose or vary certain conditions on patient release or leave orders that the patient not associate with victims or members of their family or visit certain places. Registered victims can apply to the Supreme Court to appeal against Tribunal determinations in relation to their applications for non-contact or place restriction conditions.<sup>95</sup>

There are similar provisions in Queensland where The Tribunal reviews forensic orders every 6 months. When a review is undertaken, the Tribunal may continue or revoke the order. A forensic order cannot be revoked during any non-revocation period set by the Court or if the patient remains temporarily unfit for trial. If the Tribunal continues the order, the Tribunal may decide the category of the order, limited community treatment and any conditions on the order in the same way as the Court decides these matters. In addition, the Tribunal may revoke a forensic order and make a treatment support order.<sup>96</sup> Similarly the

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<sup>93</sup> <https://www.health.nsw.gov.au/mentalhealth/Factsheets/Pages/patients-carers.aspx>

<sup>94</sup> <https://www.health.nsw.gov.au/mentalhealth/Factsheets/Pages/patients-carers.aspx>

<sup>95</sup> <https://www.health.nsw.gov.au/mentalhealth/Factsheets/Pages/patients-carers.aspx>

<sup>96</sup> [https://www.health.qld.gov.au/\\_data/assets/pdf\\_file/0035/635498/forensic-order-fs.pdf](https://www.health.qld.gov.au/_data/assets/pdf_file/0035/635498/forensic-order-fs.pdf)

Victorian Mental Health Tribunal (VMHT) reviews all 'involuntary' mental health patients. Most states provide for a Mental Health Tribunal or equivalent to review forensic orders on a regular basis.<sup>97</sup>

The panel sees merit in a greater role for the NT Mental Health Review Tribunal in the oversight of forensic patients although with a number of important caveats. First that the Tribunal would need to be appropriately resourced for this task, including through identification of appropriately skilled senior judicial members, or ex-judicial members, to take on the additional workload. Second, that the stepped model of care described in recommendation 1 is implemented with additional resourcing to allow the tribunal the capacity to make appropriate orders with the sort of flexibility necessary to get the best outcomes for individuals.

#### **Recommendation 10**

##### **The Northern Territory Government should:**

- a. 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.**
- b. Provide the MHRT with the necessary financial and human resources to take on this additional responsibility.**

A substantial amount of clinical time is being consumed by the provision of reports to the court system for the purposes of criminal responsibility determinations and ongoing review of forensic orders. This is a statutory responsibility and one that is necessary for the appropriate operation of the criminal justice system. It is possible however that the thresholds for these reports could be adjusted in consultation with justice agencies, so as to ensure the needs of judicial officers are met, and also to reduce the burden on clinical staff. Some of the informants interviewed indicated that it was possible that some reports were ordered as a method of ensuring that NT Health progressed treatment plans with forensic

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<sup>97</sup> Senate Standing Committee on Community Affairs. Report on the Inquiry into 'Indefinite Detention of People with Cognitive and Psychiatric Impairment in Australia.' Chapter 2.

patients, as the demand for a court report seemed to ‘spur activity’ within the Health system. Additional resources for the Health system as described in later recommendations may mitigate this incentive, if indeed it is reflective of judicial or legal officer concerns.

There is also merit in considering a budget transfer on a per case basis from the Attorney-General’s Department to NT Health for the provision of reports so as to send a price signal associated with the business process and in recognition of the need to maintain clinical resources for patient care. It may be possible to increase awareness in the courts and legal system through the development of a ‘benchbook’ to address the use of orders that may not be needed that builds confidence that people can come off orders successfully and to address the historical pattern in which orders are used to ‘ensure there would be a service’ provided to a defendant.

The NT Law Reform Committee released Report No 42 on ‘the Interaction between people with Mental Health Issues and the Criminal Justice System in May 2016. The recommendations to this report featured heavily the concept of a Mental Health Court or Diversion List to divert people from the regular criminal justice system who have mental health concerns, particularly those with more minor offences. The report focused on the use of powers under the MHRSA in this court rather than Part IIA of the Criminal Code. A similar court operates in Queensland although as the panel understands it, this court does also consider issues related to fitness to plead and the defence of mental illness. The panel does not feel suitably qualified to make a recommendation on the creation of such a court with local court jurisdiction, only to note that there was substantial support for such a model amongst a number of informants to the evidence gathering process of this review.<sup>98</sup>

### **Recommendation 11**

**The Northern Territory Government should:**

- a. **consider the development of a ‘benchbook’ related to mental health and disability service delivery and its interface with the criminal justice system.**

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<sup>98</sup> NAAJA submission to this inquiry. Interview evidence provided by a number of senior judicial interviewees.

- b. negotiate an interagency protocol between NT Attorney-General's Department and NT Health that:**
  - i. recognises the resource impost of court reports on NT Health, and creates a volume based price signal in the form of a budget transfer from Attorney-Generals to Health that balances the legitimate requirement for judicial information with clinical care.**
  - ii. Defines the different types of reports necessary, their purpose and the required authority and qualifications of the signatory parties.**
  - iii. Provides for standardised templates for routine reports.**

The panel notes the recent Law Council report, 'The Justice Project'<sup>99</sup> and its recommendations regarding access to justice for vulnerable populations in Australia.

Specifically, we note the recommendations below:

*In circumstances where there is a determination that a person is unfit to stand trial, state and territory laws should provide for:*

- (a) limits on the period of detention that can be imposed;*
- (b) regular and independent periodic review of detention orders, including reviews of the reasonableness and necessity of ongoing detention;*
- (c) access to judicial review for all decisions relating to the detention of people with cognitive impairment, without charge or conviction; and*
- (d) alternative non-custodial accommodation options that are sustainable, stable, secure, individualised and culturally responsive.*

☐ *State and territory governments should invest in the continued development of alternative accommodation options that are sustainable, stable, secure, rehabilitative and individualised for people who have been found unfit to stand trial.*

☐ *Governments and the broader justice sector should work together to address the intersectional needs of Aboriginal and Torres Strait Islander people experiencing disability by developing informed and culturally competent responses throughout the criminal justice system. This includes:*

- (a) developing strategies to enable better identification of disability;*
- (b) enabling better access to disability support services, including in RRR communities, as part of a preventative and early intervention*

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<sup>99</sup> Law Council of Australia. The Justice Project. Final Report. August 2018.

- approach and to rehabilitate those within the criminal justice system;  
and*
- (c) *addressing concerns regarding existing unfitness to stand trial laws, and the lack of alternative accommodation for those deemed unfit to stand trial.*

☐ *Where it has not occurred already, state and territory governments should implement a Disability Justice Plan or Strategy. People with disability and other relevant lived experience should be involved in the development and implementation of any Disability Justice Plan.*

Many of the above recommendations have been captured in the body of this report as they relate to current activity in the Northern Territory. The panel would support the NT Government applying these principles in their approach to relevant clients within their system.

One specific recommendation the panel would make with regard to legislative reform pertains to the capacity within the current legislation under s43I to remand an individual into custody who has been found NGMI or Unfit to Stand Trial. This seems at odds with the fundamental premise underpinning an NGMI or 'Unfit to stand trial' finding. The panel would recommend that this be reframed to recognise the importance of placement in an appropriate treatment or support facility as the default option.

### Health Services in Youth Detention

*There is lack of clarity over delegated authority within Health for the provision of services to youth justice detention facilities.* There does not appear to be a statutory responsibility for health to provide services at Youth Detention facilities run by Territory Families. There is a statutory responsibility for Territory Families to ensure that certain health related services are provided, including 'at risk' assessments and mandatory screening on arrival, and to date health have provided these services on behalf of Territory Families. As such health services have largely built their service delivery to this cohort on evolving 'custom and practice' grounds over time rather than on a statutory framework.

This has led to a role delineation issue between specialist Child & Adolescent MH services and specialist forensic MH services about who is best placed to service youth justice facilities in providing mental health care. Each service is concerned that they lack the relevant expertise for the task, and that they have not been provided with the requisite resources, and the result is management by Primary Health care services. This leads to the potential for risk avoidance and under servicing of the clientele and leaves the health staff with the least amount of specialised mental health training, the primary care team, holding the default responsibility.

Earlier recommendations in this document have opened up the possibility of the CBU being redesignated a health facility and potentially increasing the range of cohorts that could be serviced in its separate wings. It is possible that a youth inpatient service could be established there, with links to youth detention clients who are 'at risk'. If so, this provides the opportunity to build a small critical mass of super-specialised expertise in child and adolescent mental health within a forensic paradigm at that facility. Sufficient resourcing would allow that service to provide the in-reach to Don Dale, and potentially provide consultation support to the proposed forensic team in Alice Springs to service the youth facility there. It is recognised that this is further additional resourcing, and a highly skilled workforce that may be difficult to source, however the panel can only acknowledge in the strongest possible terms that the availability of care at the Don Dale facility currently is inadequate and substandard. The management of a 'at risk' young female patient, currently in 24 hour isolation, would be much better handled in a health facility with trained specialty child and adolescent staff.

Most jurisdictions have a specialist forensic service for adolescents, however it is acknowledged that the model above may be operationally challenging to establish in the Territory. In the absence of a dedicated resource the forensic team and child and adolescent team must establish a joint protocol for responding to the needs of these clients. The current arrangements of drawing clinical thresholds which exclude the provision of necessary services is not appropriate in the context of Australian community norms. The panel is strongly in favour of enhanced resourcing, but even with that a documented joint protocol for activity will be required.

## Recommendation 12

- a) **The Northern Territory Government should, in the context of the recommendations regarding enhanced resourcing and operational responsibility for the CBU, seek to establish an inpatient specialty service for children and young persons in the youth justice system. This service should be built on best practice principles and be designed with the relevant expertise provided by Child and Youth MH specialists. Noting the potential operational challenges of establishing such a service, in the interim a joint protocol for service delivery involving the FMHS and CAMHS service should be established as a matter of urgency.**
- b) **The Northern Territory Government should resources the Child and Youth MHS to provide FMHS, with further review of the overall model of care undertaken by a Child and Youth MH specialist.**
- c) **As a matter of urgency Territory Families and NT Health should agree a joint policy on the management of suicide and self-harm in youth detention facilities and a policy on the appropriate clinical management of segregation of young persons in the facilities.**

## System Management and Clinical Governance

Under the health reforms implemented nationally earlier this decade, a clearer division of responsibilities has been formed between the central agencies of health systems, usually a Department or Ministry, and the operational arms of health systems, usually a health service, network or district. This has left service delivery structures and models up to the operational arms, and the system management issues of policy, funding and performance management up to the central body.

This change has required improvements in local planning capacities for health services and a change in skill sets and processes for central agencies. It has inherently implied a less 'hands on' involvement by central bodies in day to day service delivery.

However, this concept of less involvement by central agencies in service delivery does not mean an intention to step out of clinical services planning completely. A state or territory wide clinical services plan is a necessary framework for making funding and performance decisions in service agreements, and for providing the basis of budget bids to treasury and advice for the Minister to provide to Cabinet. While detailed clinical services plans should be the purview of health services, it is easy to see that without a state-wide framework, these plans could differ from government policy intentions, and could lead to conflict between individual health services who delineate different service parameters.

There is currently no territory-wide Mental Health clinical services plan evident. While nomenclature varies, the sort of plan expected is one that describes the various elements of the MH service system in the NT, what their accountabilities are and to which cohorts, and the resourcing models that match to this. Service gaps and priorities for budget bids can then be identified. The NMHSPF was designed to serve this purpose and reference to the WA Mental Health Commission Mental Health Services Plan will assist in identifying the methodology. This plan then forms the basis of service purchasing in service agreements. While the service agreements make some effort to describe services and roles, the descriptions are very limited. The panel is concerned to ensure that the NT health department has the necessary documentary infrastructure to fulfil its role as system manager.

### **Recommendation 13**

**Northern Territory Health should as a matter of priority develop a MH ‘services plan’ that articulates the expected componentry of the service system in broad terms, their anticipated delivery settings and functions and on what basis the Department provides funds to services for these components. Identifying gaps and priorities in service elements should form a part of this planning process and the NMHSPF can be used for this purpose. It should identify territory wide specialty services and the inter-regional protocol for accessing these services. It should also identify the expected role relationships between forensic services and the other parts of the mental health treatment system, the disability service system including the NDIS, access to community mental health services and**

**disability support services in remote communities and primary care services in the corrections environment.**

**Similarly, NT Health must ensure that an equivalent services plan exists and is maintained as current, for the disability service system. This plan should identify the links within that system to forensic clients and to the general mental health system.**

There are challenges in attracting and retaining suitably qualified staff with a willingness to stay in their roles in highly specialised services in the Northern Territory. It is not uncommon for Fly In Fly Out (FIFO) medical and specialist disability professional staff to be used for high priority service delivery. Many people interviewed as part of this review had been in their jobs less than six months or had English as a second language. There are problems filling vacancies and substantial use of privately contracted clinicians to augment service need and use of FIFO medical staff and telepsychiatry services for specialist report writing and assessment.

The panel acknowledges the unique problems of the NT in terms of scale, population distribution, the geographic location of major centres relative to the rest of Australia, and overall critical mass of clinical expertise to support new entrants. These are all challenges for Territory planning. Notwithstanding this, there was little evidence of a quantitative workforce plan for either mental health or disability services which identified how many staff of each discipline may be required in five years time, what super specialist training may be necessary and where they could be sourced from. Problems with recruitment to positions, which are genuine, were always framed retrospectively and not prospectively, ie. “No one applied”, or “Those who applied didn’t have the skills.” It is because of the unique challenges of the Territory that a quantitative, prospective recruitment plan is required. If two new Child & Adolescent psychiatrists are required in 2022, and one will need forensic skills, efforts to source those individuals should begin now by identifying where suitable applicants might be in their training pathway, building the necessary relationships with senior colleagues and working to build the necessary support infrastructure around the roles. The Territory cannot afford to identify a need on a given day and then advertise and hope to attract a good candidate.

#### **Recommendation 14**

**Northern Territory Health should use the outputs from the NMHSPF and its forensic adjunct to identify quantitatively future mental health workforce needs and develop a structured plan to attract and retain that workforce. A similar approach should be adopted with regard to using the outputs from Recommendation 11 above to identify workforce needs and responses for Disability services.**

A crucial role of a central health agency is to establish formal structures with other government departments and managing relationships with those departments. However, the panel was concerned that there was general lack of clarity as to whether formal MOUs were in place between Health and Territory Families or Health and Corrections with regard to services to be provided at detention facilities. Senior staff from all agencies involved indicated that they were unaware whether MOUs were in place and certainly none were made available to the panel to review. It was indicated to the panel that the TEHS may have been negotiating an MOU with Corrective Services for mental health service delivery however the staff at the Department of Health could not confirm this with certainty. Notwithstanding this it seems a dangerous governance precedent to establish an operational MOU between two government services without reference to a policy MOU between the two relevant department heads.

It is noted that the Coronial inquest into the death of Naomi Smith made recommendations for the establishment of an interagency forum to resolve challenging presentations that have multiple agencies involved in an individual's care<sup>100</sup>. The abovementioned MOUs should provide a framework for the creation and operation of such interagency forums including an escalation framework from local services to central agencies for problem resolution.

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<sup>100</sup> Inquest into the death of Naomi Smith [2018] NTLC 017".

### **Recommendation 15**

**The Northern Territory Government should ensure that there are appropriate Interdepartmental MOUs in place between NT Health and the Department of Attorney-General and Justice, and NT Health and Territory Families that reflect the statutory responsibilities of each agency and describe the basic frameworks for how these will be operationalised. These MOUs should form the basis of operational protocols between local services and provide for the establishment and operation of interagency forums for managing challenging cases.**

Mental Health legislation differs between jurisdictions in many key ways. While many of the fundamental principles of detention and care apply, there are differences in statutory process, timeframes and authorised persons. Importantly, mental health legislation, like all legislation is jurisdiction dependent for its authority, or by corollary has no authority outside of its jurisdiction. As such when individuals subject to orders move outside of the state or territory where that order was made, the order cannot be enforced without the assistance of the state or territory where the individual is now situated. In order to achieve this assistance jurisdictions can enter into cross-border agreements that allow for the enforcement of orders within the legislative power of the host jurisdiction. These are called cross border agreements. There are generally two types of cross border agreements, those for patients subject to mental health legislation and agreements related to orders for forensic patients.

AHMAC is currently working to establish some uniformity in cross border agreements between Australian jurisdictions. It should be noted however that AHMAC and its subsidiary structures have been working on this for some time as it was a priority under the Fourth National Mental Health Plan in 2009.

The NT interstate arrangements are set out in the NT MHRSA Act and NT Regulations, which provides for both civil and forensic patients. The provisions allow for corresponding laws to be prescribed by the NT Regulations, which declares the mental health laws of all other

States to be corresponding laws. The provisions allow for 'intergovernmental agreements' to be made.<sup>101</sup>

There are currently eight civil mental health interstate agreements entered into between five States. None of these agreements involve the Northern Territory. The NT, Tasmania and WA have not entered into any agreements that are operational. The NT did, at one time, draft an agreement with South Australia but it was not given effect.<sup>102</sup>

The resolution of these matters are complex and involve national collaboration. The panel would encourage the Northern Territory Government to work within the AHMAC structures to resolve interstate agreements that allow for the voluntary movement of both civil and forensic patients in clinically appropriate circumstances consistent with human rights instruments and also to allow for the return of patients who leave the jurisdiction without leave.

Effective clinical governance is central to an effective treatment system. It is characterised by scrutiny, measurement and reflection on practice, effective senior support structures, well understood oversight arrangements and rapid and committed responses to adverse events that improve practitioner learning and the systems that support them. Good clinical governance requires senior leadership and a cultural acceptance that practice can always be improved.

Clinical governance arrangements can be improved in the Northern Territory. There is a general agreement amongst informants to this review that the leadership functions of the Chief Psychiatrist role are unclear, and that the statutory authority of the position is negligible. There is agreement that a more obvious leadership role is needed although those interviewed did not have unanimous views on what this role should be. It is clear that a fundamental function would be to lead on territory wide clinical governance structures and to ensure that the systems that flow from those structures at the local level are effective. It

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<sup>101</sup> Government of Western Australia. 2018. Research into Interstate Arrangements for the *Mental Health Act 2014 (WA)*

<sup>102</sup> Ibid.

would also seem that a role in leading on the development of the high level territory-wide services plan was warranted.

There is evidence of a division of opinion on the specifics of the role amongst senior practitioners. There was insufficient opportunity for the panel to identify the specifics of these differences within the time frame of this review. As such the panel recommends that a suitable senior psychiatrist from another jurisdiction be engaged to negotiate the specific functions of the role on behalf of NT Health. At a minimum this should include clear leadership functions with regard to clinical governance and clinical system design. Building and maintaining a culture of continuous quality improvement is also important. There may be merit in incorporating functions and processes visible in similar roles in other jurisdictions such as resolving interregional clinical disagreements particularly regarding access to super-specialty inpatient resources, and functions associated with the provision of high level advice to the Mental Health Review Tribunal should it take on responsibility for Part IIA clients. Policy setting and monitoring of statewide practice with regard to the use of restrictive practices should also be a part of this function.

#### **Recommendation 16**

**Northern Territory Health should engage a suitably senior psychiatrist or other senior mental health policy expert from another jurisdiction to identify a role framework and any associated legislative arrangements for an enhanced role for the Chief Psychiatrist in the Northern Territory. At a minimum this should include developing a territory wide clinical governance framework and leading on clinical system services plans.**

The Northern Territory Department of Health retains minimal data on patients involved in the forensic health system. While the Department was able to identify the numbers on Part IIA orders in the most recent completed year, 2017, it could not provide data on earlier years, or on the movement of patients through the forensic system, or on those who have had their orders rescinded or terminated. The panel was advised that this information could be sourced via manual file reviews in health services but was not held centrally.

In those jurisdictions where a Mental Health Review Tribunal provides oversight of forensic patients, data is published annually on the movement of patients through the forensic system. This is consistent with the oversight responsibilities of the Tribunal. The panel believes that data that describes the number on Part IIA orders, the duration of orders, the transitions through the system and the cessation of supervision should be publicly available. Data on the numbers held in the custodial system and those held in locations inconsistent with Tribunal orders (generally on grounds of lack of available resources) should also be published.

### **Recommendation 17**

**The Northern Territory Government establish a statutory annual reporting requirement to publish data on forensic patients that captures the numbers entered into the system, those exited, those continuing, the average duration of orders, those held in custodial services, and those unable to be found placements in the locations preferred by the overseeing body (be it Supreme Court or MHRT).**

### [Appropriate responses to Aboriginal and Torres Strait Islander clients](#)

There can be no discussion about the care of forensic patients in the Northern Territory without acknowledgement of the predominant Aboriginal and Torres Strait Islander constitution of the cohort. They are predominantly individuals from indigenous communities, often from remote centres, and often immediately disconnected from their families and culture at the time of their index offence.

There were very strong opinions expressed to the panel about the approach of government agencies to the cultural needs of indigenous people in the correctional system. One informant described this effect as “wilful cultural blindness” and another “fiscal racism”. Despite 100% of the youth detention clients and around 90% of the Part 11A clients being Aboriginal Australians there is limited use of interpreters or targeted cultural interventions that map to a client’s own community. There is a dearth of Aboriginal mental health workers and very little community based mental health support in remote communities. The forensic mental health care provided, and mental health care more generally, is

metropolitan centric. For example, it was noted that despite Katherine being a catchment town for around 25,000 people including those from outlying communities up to 3 hours drive away, there is very little mental health care available in the town and no forensic mental health supports. Even where supports exist there is a dearth of culturally competent staff and Aboriginal specialist health workers.

There is also evidence that carer advocacy models for Indigenous clients need to be augmented given the culturally unique approach to this task. The traditional European model of carer advocacy as an adjunct to a health care experience does not map to Indigenous community approaches. This can further reduce the agency of participants in the health care system, particularly if the individual has a cognitive impairment or language difficulties.

The maintenance of cultural identity does not appear to be a significant component of treatment plans and the impact of this on health outcomes does not seem to be understood.<sup>103</sup> The panel does not intend to prosecute all the available arguments associated with Indigenous policy either nationally or in the Northern Territory as part of this review. We will note though that Indigenous health policy must overlap with forensic mental health and disability reform, and that successful system improvement can only occur through partnerships with Aboriginal communities. The Aboriginal Community Controlled Health sector provides a clear infrastructure and framework for access to Indigenous communities and community based mental health solutions must involve systematic arrangements with these organisations.

### **Recommendation 18**

**Northern Territory Health should establish a formal forensic health service partnership with the Aboriginal Community Controlled Health sector to build on their skill sets with Aboriginal communities and to provide the capacity for individuals on Part IIA orders to return to their communities when clinically appropriate. This partnership should involve**

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<sup>103</sup> NAAJA Submission to this inquiry.

**the design of culturally appropriate service models for both mental health and disability in these communities.**

**Recommendation 19**

**Northern Territory Health should take active steps to support culturally appropriate services for forensic clients including access to interpreters, service design initiatives, and models of care. NT Health should establish a Forensic Consumer and Carer Liaison Panel, with appropriate representation of Indigenous people, to provide input to policy directions and service design initiatives.**

Human Rights and International Obligations

As detailed earlier in this report Australia has made a number of international commitments to the application of human rights instruments in our mental health approaches that are detailed in the Fifth National Mental Health Plan. A central commitment amongst these is to address mental health concerns in the group in contact with the criminal justice system as a health problem and not predominantly a custodial one. In the Northern Territory the basic architecture of the current forensic system is in breach of these agreements. This is similarly reflected in the commitments of Australian Governments to the UNCRPD in the National Disability Strategy and there are issues of equity of access to disability services for clients in contact with the justice system.

There is a heavy operational emphasis on security concerns for forensic patients. This is partly due to the considerable role that Corrections staff have in their management in comparison to other jurisdictions, and partly out of concern for media scrutiny associated with absconding and subsequent events.

However, a forensic order is predicated on the absence of effective mental health or disability care having a contributing element to an index offence, and the conceptualisation that effective care may allow for community reintegration. Forensic patients in a complying treatment regime are far less likely to offend again than correctional patients and are less likely to offend than many other risk groups in the community. Managing a narrative effectively and proactively with the NT community that describes the intent and policy

framework of a forensic care program will be central to changing an inherent custodial culture and building an effective forensic system.

*There is evidence of potential breaches of the Convention on the Rights of People with Disabilities (CRPD) and the UN Principles for the Protection of Persons with Mental Illness.*

There has been evidence provided that treatment decisions have been made that do not allow for the use of the least restrictive care environment for an individual due to resource constraints or an absence of suitable support. This was particularly evident in our visit to the Don Dale facility but was equally visible in the Joan Ridley Unit and within the Correctional Centres. The fact that so many of the Part IIA clients are resident in the correctional centres is, of itself, a breach of the Convention, along with the national policies that flow from it.

The Fifth National Mental Health Plan includes a commitment to implement within Australian jurisdictions a specific training package developed by the World Health Organisation to improve understanding of the CRPD and improve application of the Convention in mental health laws, programs and practice<sup>104</sup>. This training package is known as Quality Rights<sup>105</sup> and comes in both e-learning and face to face modalities. The Territory would benefit in establishing use of this package to establish a core understanding of the principles and practices promoted by the Convention and to build momentum for change amongst community-based organisations. The training is designed to be discipline neutral and therefore is equally applicable to staff from Territory Families and Corrective Services.

## **Recommendation 20**

**The Northern Territory Government liaise with staff at the World Health Organisation to gain access to the 'Quality Rights Training' package for staff of NT Health and other relevant agencies and organisations, consistent with national commitments made in the Fifth National Mental Health Plan.**

An effective reform response requires a clear implementation governance structure.

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<sup>104</sup><http://www.coaghealthcouncil.gov.au/Portals/0/Fifth%20National%20Mental%20Health%20and%20Suicide%20Prevention%20Plan.pdf> Action 27.

<sup>105</sup> [https://www.who.int/mental\\_health/policy/quality\\_rights/guidance\\_training\\_tools/en/](https://www.who.int/mental_health/policy/quality_rights/guidance_training_tools/en/)

### **Recommendation 21**

**Oversight of the implementation of the recommendations in this report should be undertaken by an Implementation Oversight Panel auspiced by the Office of the Chief Minister. The panel should include the Office of the Public Guardian, the NT Community Visitor Program, the Aboriginal Community Controlled Health Services sector, the Northern Australia Aboriginal Justice Agency (NAAJA) and appropriate senior representation from NT Health, Territory Families, the Attorney-Generals Department and NT Corrections. The panel should also be informed by appropriate consumer and carer inputs, with appropriate proportional representation of Aboriginal and Torres Strait Islander persons, with those inputs sourced in a way that allows genuine participation.**

### Concluding Remarks

There are clearly a large number of committed professional staff working hard to provide positive outcomes from health services to those involved in the criminal justice system. This review acknowledges their work and the circumstances they are operating under. It can be difficult for governments to take action when there is equivocation about the appropriate directions for reform and a risk of action being divisive rather than effective. This does not reflect the panels experience during the consultation for this review. There was near universal agreement on the need for action, significant and shared frustration at the current service failings, and a real desire for a clear circuit breaker on system conflicts. The recommendations contained in this report will find substantial support in achieving the desired reform.

Decisions to spend government funds ideally should be policy sound, politically achievable and morally appropriate. The outcomes of this review can meet those criteria. As a result, the resource enhancements advocated here make a good investment case.

The Northern Territory is a long way from a contemporary system design for its forensic services despite abundant good will and endeavour amongst staff and a genuine desire

across agencies to improve outcomes. It is the sincere hope of this panel that concerted action and genuine partnership can improve the outcomes in the forensic mental health and disability system and for the vulnerable group of individuals it serves.

## Appendix A – The Terms of Reference and Review Panel

The Northern Territory Government provided the following Terms of Reference to the Expert Panel for the conduct of the review. The expected timeframe for delivery of the review findings was three months from the initiation of the review. The panel however was granted leave by the NT Government to extend this time to ensure the reviews objectives were met.

### **FORENSIC SERVICES IN THE NORTHERN TERRITORY –THE NEED FOR SERVICE REFORM**

#### **PURPOSE**

To commission a Service Reform Project for the evaluation of the systems, processes, service delivery models and legal provisions required to meet the clinical needs of clients who require the specialist expertise of a Forensic Mental Health and Disability Services in the Northern Territory. Such services are currently provided through the Forensic Mental Health Team and the Office of Disability.

The Service Reform Project will consider the needs of

- Clients who are subject to Part IIA of the Criminal Code (including both Custodial and Non-Custodial Supervision Orders)
- Clients detained by Correctional Services who have mental illness or mental disturbance
- Community based clients who require ongoing support of a specialist forensic nature (including those with disability)
- Other clients who may require the specialist input of such services not covered by the above.

The Service Reform Project (the Project) will be carried out a by a Service Reform Team [Panel]<sup>106</sup>, and will provide recommendations about strategic developments required to deliver a comprehensive, contemporary and evidence based service model.

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<sup>106</sup> During the review process the reviewers were more commonly described as an expert panel with different roles undertaken by individual members. The word panel will be used throughout the main body of the document.

## OBJECTIVES

The objectives of the Service Reform Project are:

1. To develop contemporary models of care and associated policies for all clients using forensic health services, including those with disability. This will include a review of:
  - a. The organizational structure of the services, including specialist mental health wards, specialist service providers for people with disability, and youth detention facilities
  - b. Eligibility of clients to access these services
2. To review the organisation and capacity of the specialist forensic services to meet the needs of those clients in custodial and community based settings (including mental health wards), juvenile detention centres, and in the community. This will include the capacity of the services to provide reports and recommendation to the legal system in a timely manner.
3. To consider and reform as necessary the arrangements by which clients charged with serious offences and where there are concerns about incapacity due to mental illness or impairment are progressed through the legal and health care systems, including ongoing clinical care and reporting requirements.
4. This will include a consideration of the adequacy of systems and processes to assess and manage risk, and the development and implementation of risk management strategies for mentally disturbed or cognitively impaired clients.
5. To review and advise on the current and future accommodation provisions in NT for clients under supervision orders, including that it is culturally safe and recovery focused, whilst also addressing security needs.
6. To develop and implement appropriate clinical governance frameworks for the programs working within these specialist areas.

The Team [Panel] will consider the above with regard to the Mental Health and Related Services Act, and The Criminal Code of the Northern Territory, as well as other contemporary relevant legislation and will:

1. Make recommendations in relation to the above including if indicated, improvements to systems and processes
2. Advise on the development of a contemporary integrated model of service provision for those clients with very complex needs
3. Examine any issues that may impact on the implementation of any required/recommended system or process improvements or alterations outlined above, including any factors that may negatively impact on implementation
4. Report upon requirements for models of resourcing to ensure correct future allocation of funding including:
  - a. Adequate resourcing to enable the service to undertake all functions required in order to have safe and effective care for all clients
  - b. Adequate resourcing of all residential/custodial facilities (including juvenile facilities)
  - c. Adequate resourcing for the provision of supported accommodation beds for clients subject to non-custodial.

### **The Panel**

**David McGrath. B Sc (Psychol) Hons, MBA, JD.** has extensive experience in facilitating consultations with service providers, community leaders and consumers through projects undertaken by David McGrath Consulting and through his prior role as the Executive Director of Mental Health and Drug & Alcohol Programs for the NSW Government. David previously held the position of Chair of the Intergovernmental Committee on Drugs, and Chair of the Mental Health Standing Committee within the COAG framework, including executive lead for the development of the National Drug Strategy 2010-15, and implementation of the Fourth National Mental Health Plan. David McGrath was also lead for the development of the National Mental Health Service Planning Framework (NMHSPF) population based planning model for the COAG Standing Council on Health. David is currently on the Board of Odyssey House and has previously held board positions at the National Drug and Alcohol Research Centre (UNSW), the NSW Institute of Psychiatry, and the NSW Psychologists Registration Board.

David McGrath Consulting has undertaken projects with significant consultation and facilitation components including development of the Fifth National Mental Health Plan,

and assessments of the impact of the NDIS on psychosocial service provision in mental health. David is currently an advisor to the World Health Organisation on the application of human rights principles in mental health legislation and programs.

**Dr Owen Samuels FRCPsych FRANZCP**; Forensic Psychiatrist and Clinical Director, NSW Health. Dr Samuels has extensive experience in both the UK and Australia. He has previously been involved in the commissioning of a new secure mental health service in ACT, including a model of care for community and in-patient facilities. He has extensive experience in the delivery of contemporary mental health services.

**Ms Dannielle Nagle**, Director of Forensic Mental Health Services, ACT Health. Ms Nagle trained as a mental health nurse. She has extensive experience working in forensic mental health. She has been involved in the commissioning of the secure mental health service in ACT and the model of care that supports the service. She has extensive day to day experience of leading a service in delivering contemporary mental health services for the wide range of clients presenting in ACT.

**Professor Leanne Dowse** is Professor of Disability Studies and Chair in Intellectual Disability Behaviour Support at UNSW where she has been a researcher since 1995 and an academic since 2008. Leanne's research and publications apply models of critical inquiry to the study of disability and in particular, intellectual or cognitive disability. Her work utilises a multidisciplinary approach to investigate social justice issues for people with complex needs. In particular her work addresses the intersections of disability with mental illness, acquired brain injury, homelessness, social isolation, early life disadvantage, experience of out of home care, substance misuse and violence. Her work is particularly concerned with the ways these intersect for Indigenous Australians with intellectual disability, for women with disabilities, those in the criminal justice system, and people with complex behaviour support needs.

**Dr Ed Heffernan** is the Director of Queensland Forensic Mental Health Services and an Associate Professor in Psychiatry at the University of Queensland. He has had a key leadership role in Forensic Mental Health Services in Queensland including the development and establishment of mental health programs to support those with mental health problems in contact with police, courts, watch houses and prisons.

He has been the principal investigator for a number of significant mental health and criminal justice research projects. As a clinician he has worked in general adult and forensic psychiatry in both public and private sector settings.

As a service leader he has had key roles within the Queensland mental health system including being a delegate of the Director of Mental Health and the Queensland representative on the national mental health Safety Quality Partnership Steering Committee.