Mental Health and Related Services Act 1998 Review

Consultation Report

NORTHERN TERRITORY GOVERNMENT

Contents

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We acknowledge the traditional owners of Country and recognise their continuing connection to land, waters, and culture. We respect Aboriginal Elders past, present, and support emerging leaders across the NT and Australia.

Acronyms

Acronyms	Full Form
ACT	Australian Capital Territory
AGD	Department of the Attorney-General and Justice
AJU	Aboriginal Justice Unit
AMSANT	Aboriginal Medical Services Alliance NT
ATF	Approved Treatment Facility
CALD	Culturally and Linguistically Diverse
CMO	Community Management Order
CVP	NT Community Visitor Program
DDHS	Danila Dilba Health Service
ECT	Electroconvulsive Therapy
FASD	Fetal Alcohol Spectrum Disorder
MHACA	Mental Health Association of Central Australia
MHDL	Mental Health Diversion List
MHRSA	*Northern Territory Mental Health and Related Services Act 1998*

NAAJA	North Australia Aboriginal Justice Agency
NDIS	National Disability Insurance Scheme
NT	Northern Territory
NTAJA	Northern Territory Aboriginal Justice Agreement
NTCAT	Northern Territory Civil and Administrative Tribunal
NT Health	Department of Health
NTLAC	Northern Territory Legal Aid Commission
NTLEN	Northern Territory Lived Experience Network
NTMHC	Northern Territory Mental Health Coalition
OCC	Office of the Children's Commissioner
OPG	Office of the Public Guardian
RCVMHS	Royal Commission into Victoria's Mental Health System
SFNT	Solicitor for the Northern Territory
CRPD	United Nations Convention on the Rights of Persons with Disabilities
WHO	World Health Organisation

Terminology

In this document, anyone experiencing mental ill health is referred to as 'people' or 'person'; anyone receiving care and treatment under the *Mental Health and Related Services Act 1998* (the **MHRSA**) in a hospital or secure facility is referred to as 'patient', and anyone accessing outpatient services is referred to as 'client'.

The term Aboriginal is used to refer to all people of Aboriginal and Torres Strait Islander descent who are living in the NT.

The Approved Treatment Facilities (ATFs) are currently Royal Darwin Hospital and Alice Springs Hospital.

The terms 'involuntary' and 'compulsory' are used interchangeably for mental health treatment mandated under mental health legislation.

The term 'children' is used to cover children and young people up to age 18 years.

Throughout submissions and consultations, the terminology of 'wishes and preferences' and 'wills and preferences' was used interchangeably. In alignment with contemporary NT legislation, NT Health uses 'wishes and preferences'.

Introduction

The Northern Territory Government (NTG), through the Department of Health (NT Health), is committed to modernising mental health legislation for the NT. The NTG recognises that people's mental health and wellbeing is shaped by a variety of factors and that good mental health is more than the mere absence of mental illness; it is about the ability to fully and effectively participate in society. The review of the MHRSA aims to ensure modern mental health legislation that aligns with contemporary principles and enables timely, high quality, safe and appropriate in-hospital and compulsory mental health care for Territorians.

On 4 December 2020, as part of the review process, NT Health released a discussion paper titled 'Discussion Paper for the *Mental Health and Related Services Act 1998* Review' (the discussion paper) for public consultation. The discussion paper was developed following feedback from stakeholders on key issues about the MHRSA and concepts that have been introduced in mental health legislation in other Australian jurisdictions.

Following the release of the discussion paper, NT Health held public face-to-face information sessions and tele-presence sessions about the MHRSA review. For more in-depth feedback, NT Health led targeted consultation sessions with a wide range of government and non-government organisations, health professionals, legal practitioners and people with lived experience under the MHRSA.

NT Health received 19 submissions in response to the discussion paper. The following organisations and individuals submitted submissions. Those marked with an asterisk are available via the organisation's website.

1. Aboriginal Medical Services Alliance Northern Territory (**AMSANT**)
2. NT Community Visitor Program (**CVP**)*
3. Danila Dilba Health Service (**DDHS**)*
4. Division of Emergency Medicine, Royal Darwin Palmerston Regional Hospital, Top End Health Service
5. Ignite Potential
6. Person with lived experience
7. Person with lived experience
8. Person with lived experience
9. Person with lived experience
10. Credentialled Mental Health Nurse
11. Mental Health Association of Central Australia (**MHACA**)*
12. North Australian Aboriginal Justice Agency (**NAAJA**)*
13. Northern Territory Police, Fire and Emergency Services (**NT Police**)
14. Northern Territory Legal Aid Commission (**NTLAC**)
15. Northern Territory Lived Experience Network (**NTLEN**)*
16. Northern Territory Mental Health Coalition (**NTMHC**)*
17. Office of the Children's Commissioner (**OCC**)*
18. Office of the Public Guardian (**OPG**)*
19. Solicitor for the Northern Territory (**SFNT**)

The purpose of this report is to summarise and consider feedback received from stakeholders in response to the discussion paper, both through submissions and consultation sessions. The report makes recommendations for legislative reform, for consideration by the Government.

It is noted that Victoria's Mental Health and Wellbeing Bill 2022 was recently introduced to parliament. Given the timing that Bill has not been referenced in this report other than its provision with regard to chemical restraint, however its provisions will be considered in development of new mental health legislation for the NT.

Summary

Stakeholders who provided feedback in response to the discussion paper expressed a range of views about what reform to the mental health legislation needs to achieve. These views were not always consistent. However, in relation to the proposal that reform of the MHRSA or new mental health legislation is necessary in the NT, stakeholders overwhelmingly agreed that the MHRSA is outdated and supported modernisation. Stakeholders interact with the MHRSA in different ways and general feedback highlighted that improvements are needed to make the legislation more accessible for persons with lived experience and health professionals through the use of simple laguage.

Some stakeholders provided feedback that the scope of mental health legislation should include community-based mental health services and the transition between mental health settings or other systems, for example the criminal justicesystem, the public health system and National Disability Insurance Scheme (NDIS). NT Health acknowledges this feedback. However the priority for reform, and therefore the scope of this review, remains in-hospital and compulsory mental health treatment.

Stakeholders also commented on the need for system reform to take place concurrently with legislative reform. NT Health will carefully consider feedback on broader system reform, to inform ongoing work on such reforms.

Consultation Process

Review of the MHRSA has been an ongoing process which commenced in 2014. The findings of this report build on the learnings in recent years and on consultation that occurred in 2020/21, informed by the discussion paper.

During 2020, NT Health met with stakeholders to hear what Territorians had to say about the current mental health legislation and identify the key issues for consultation. Research was also undertaken in relation to national and international trends in mental health legislation. This process resulted in the development of the discussion paper, and a summary discussion paper. The discussion paper was also informed by other key NTG agencies, to ensure appropriate input on the interface between mental health and other service systems.

On 04 December 2020, NT Health released the discussion paper and summary discussion paper to stakeholders across the Territory. The documents were also published on social media, NT Health website and printed hard copies were distributed through mental health and community networks and at public consultations.

The aim of the face-to-face consultations was to provide further opportunities for Territorians from diverse backgrounds and different experiences, connected to the operation of MHRSA, to provide feedback and input. A significant focus of consultations was to hear from persons with lived experience and their families. NT Health partnered with the NT Mental Health Coalition to conduct public consultations.

From December 2020 to August 2021 NT Health conducted 228 episodes of engagement with stakeholders across the Territory, which included:

- Face-to-face meetings
- Public consultations
- Written communication
- Phone calls
- Group sessions
- Clinician Forums
- Video conferences
- Open public events

A list of stakeholders included in pre-consultation and consultation phases is located at Appendix A.

Several submissions also presented feedback and findings from independently conducted consultations. For example, NTLEN conducted a Lived Experience Consultation in Palmerston in May 2021 where eight people attended, and an online survey containing topics derived from the discussion paper in which 115 Territorians participated. The NTLEN submission and online survey are publicly available on the NTLEN website.

COVID-19 travel restrictions affected NT Health's ability to carry out consultations in the regional and remote communities of the NT. Fortunately, NT Health was able to draw on the extensive consultations conducted by the Aboriginal Justice Unit (AJU) of the Department of Attorney-General and Justice (AGD) for the NT Aboriginal Justice Agreement. The community feedback collated by the AJU contained important mental health feedback and highlighted what is important to remote communities, relating to locally based and outreach mental health services and the interface between the criminal justice system and mental health. Further details on the AJU consultations and learnings for the mental health system are discussed in the 'Cultural security' section of this report.

At the same time as NT Health was conducting the review and public consultations, elsewhere in Australia relevant reports were released such as the 'Productivity Commission Inquiry Report – Mental Health' and the Royal Commission into Victoria's Mental Health System, Final Report February 2021 (RCVMHS). NT Health established a network for sharing recommendations and learnings with cross-jurisdictional stakeholders and, while the mental health system differences between jurisdictions are significant, the commonalities in lived experience hospital and compulsory treatment were considerable.

Lived Experience

Australian mental health legislation and system reform increasingly involves and draws on the extensive knowledge of people with lived experience. The national trend, also outlined in the RCVMHS recommendations, is towards increased and consistent involvement of people with lived experience in shaping the mental health system.[1] National recognition is being given to mental ill-health and carer lived experience to shape mental health reform and acknowledge the importance and benefit of involving people with lived experience at the centre of the process.[2]

Stakeholders expressed unanimous support for the strengthened inclusion of people with lived experience in the development of the reformed mental health legislation and its processes, and also in its implementation and operation. The public consultation in Alice Springs included a strong lived experience representation, who provided significant insight into involuntary and voluntary admission processes at Alice Springs Hospital. The commonalities of lived experience of acute mental health treatment and services were consistent throughout consultations and submissions. The lived experience in the NT mirrored the submissions presented to the RCVMHS.

Lived experience consultations strongly advocated change to legislation that:

- Respects and protects our human rights
- Recognises the trauma of the person and ensures that trauma-informed care and treatment is a requirement under law
- Provides for better, and high quality, treatment in approved treatment facilities
- Provides better access to in-hospital mental health by clearly setting out treatment criteria
- Uses plain language

The primary recommendations contained in this report call for reformed mental health legislation in the NT that is human-rights based, person-centred and provides clarity about roles and responsibilities.

Recommendations

1. **That the *Mental Health and Related Services Act 1998* be repealed and replaced or amended to provide a contemporary mental health framework for the provision of compulsory and in-hospital mental health services in the Northern Territory.**

2. **That the main objective of the mental health act is the provision of the highest standard of care to persons with a mental illness, consistent with their human rights in such a way as to promote their recovery. Inclusion of a broad, non-exhaustive definition of recovery should be considered.**

3. **That the mental health act be underpinned by principles that reflect holistic, person-centred and culturally appropriate service delivery. These principles should include, but not be limited to:**
    a. **that human rights be recognised and taken into account;**
    b. **that decisions about treatment and care reflect a person's right to self-determination;**
    c. **that treatment and care take into account a person's cultural and linguistic background, including traditional beliefs and practices;**
    d. **that treatment and care be provided on a voluntary basis as far as possible and otherwise on the least restrictive basis;**
    e. **that Aboriginal people be provided with treatment, care and support in a way that recognises and is consistent with the person's cultural beliefs, practices and mores and is culturally appropriate and respectful; and**
    f. **that the provision of treatment and care take into account the person's age (for example a child or an older person), and gender, gender identity, sexuality or sexual orientation or identity.**

4. **In furtherance of the principles and objectives in Recommendations 2 and 3, the mental health act should:**
    a. **include a presumption that a person has full decision-making capacity unless the contrary is proved. Capacity to provide informed consent should be clearly defined and decision-specific. Objective criteria for determining unreasonable refusal to consent should be included;**
    b. **expressly provide that a person's wishes and preferences, whether made contemporaneously or through an advance statement or directive, must be taken into account when determining treatment or care;**
    c. **include provisions regarding the appointment, role and responsibilities of nominated support persons;**
    d. **include recognition of the role of traditional healers and a requirement to involve them in treatment, admission and discharge planning to the extent appropriate and practical; and**
    e. **Include a provision requiring all communication with a person under the act to be in a means and form that the person is likely to understand, including using an interpreter if necessary and practicable.**

5. **The mental health act should set out clearly the criteria and processes for admission to an Approved Treatment Facility and compulsory treatment, and strengthen oversight and accountability mechanisms reflecting the principles in Recommendation 3. Reforms should include:**
    a. **removing complex cognitive impairment as a ground for compulsory admission;**
    b. **clarifying and providing guidance about assessment of whether a person is in need of treatment under the act and recommendations for psychiatric examination;**
    c. **a legislative requirement for the Chief Psychiatrist to develop and publish a policy or guideline about the application of treatment criteria under the act;**
    d. **expressly providing that involuntary (compulsory) admission or treatment should only be used as a last resort; and**

e. **setting out the criteria and processes for a person transitioning from voluntary to involuntary inpatient status and between inpatient status and compulsory treatment in the community.**

6. **That the role, functions and powers of NTCAT be retained.**

7. **That provisions regarding the rights of patients clearly reflect the principles of the mental health act including the introduction of the role of nominated support persons.**

8. **That the mental health act should establish clear provisions that enable approved leave for an isolated instance of leave and/or regime of leave for persons on compulsory orders and define the requirements and any criteria to approve leave.**

9. **That the mental health act include clear provisions on the rights of leave for persons admitted to an approved treatment facility on a voluntary basis, and clarify any circumstances where those rights might be limited.**

10. **That, in addition to the general principle at Recommendation 3(f), the new Act should, at a minimum, include the following provisions in relation to children:**
    a. **the capacity of a child to consent to care or treatment is to be assessed on a case-by-case basis by a person authorised under the act in accordance with the principle in *Gillick v West Norfolk and Wisbech Area Health Authority & Anor* [1986] 1 AC 112;**
    b. **specific measures to be included to reduce the use of restrictive measures (additional to Recommendation 17);**
    c. **seclusion can only be used as measure of last resort;**
    d. **children should be treated and cared for separately from adult patients where possible;**
    e. **a discretion for information sharing for persons 14 years and over based on capacity and the best interest of the child; and**
    f. **specific provisions for children aged under 14 years for the sharing of information with the parent or guardian of the child.**

11. **That the new act provide, to the extent necessary, separate or modified assessment, admission and discharge processes for persons in custody or on a forensic order.**

12. **That powers of emergency apprehension be reframed and clarified to reflect the Co-Response Model of responding to a mental health crisis, including NT Health, St John Ambulance and NT Police, and raising the threshold for apprehension as a last resort.**

13. **The mental health act should allow for virtual provision of mental health services and assessments, wherever possible, to support rural and remote regions.**

14. **In addition to matters within the ambit of Part 12 Rights and patients and carers in the *Mental Health and Related Services Act 1998*, provisions should be included to:**
    a. **provide powers of search and seizure that are commensurate with identified risks, with least restrictive options for various circumstances that recognise the vulnerabilities of the person (including both patients and visitors) being searched, age, gender, sexuality and cultural background;**
    b. **search and seizure powers contain protections for the person subject to the search that align with the principles of the mental health act and international law; and**
    c. **expand Community Visitor Program monitoring powers to include monitoring of search and seizure powers.**

15. **That the mental health act establish the position of the Chief Psychiatrist. The powers and functions of the Chief Psychiatrist should include:**
    a. **overall responsibility for the oversight of mental health treatment and care under the act;**
    b. **developing and promoting a statement of rights for persons accessing mental health treatment under the act;**
    c. **administration of the act, including the development of forms, publication of guidelines, standards, and policies to support the operation of the act;**
    d. **monitoring compliance with the act, including defining and receiving notifiable incidents, conducting audits, and establishing regular data collection processes;**
    e. **establishing endorsement processes, including authorising treatment facilities and mental health practitioners to perform functions under the act;**
    f. **conducting investigations related to clinical events;**
    g. **oversight or authorisation of ECT, restrictive interventions, and the compulsory treatment of children;**
    h. **a role in monitoring the reduction and, where possible, the elimination of restrictive practices;**
    i. **a role in the operation of new forensic legislation including, but not limited to, provision of information to courts;**
    j. **reporting to the Minister and the CEO, including provision of an annual report to the Minister, to be tabled in the Legislative Assembly;**
    k. **a role in interstate transfers and oversight of mutual recognition of civil mental health orders under mental health legislation in other Australian jurisdictions; and**
    l. **subsuming the role of the Approved Procedures and Quality Assurance Committee (APQAC) and the power to establish advisory panels.**

16. **That the Community Visitor Program including the Principal Community Visitor be retained, and be expanded in relation to monitoring of search and seizure powers.**

17. **That provisions regarding the use of restrictive practices reflect the principle of least restriction and that they:**
    a. **be clarified, including by defining 'physical restraint';**
    b. **remove the concept of 'controlling' a person to transport the person to an Approved Treatment Facility;**
    c. **define and regulate the use of medication as a 'chemical' restraint;**
    d. **require the Chief Psychiatrist to develop a policy in relation to physical, mechanical and chemical restraint and seclusion.**

18. **That Electroconvulsive Therapy (ECT) provisions be strengthened to:**
    a. **require a record of all other reasonable treatment options that have been performed or explored prior to ECT;**
    b. **explicitly note that the ability to provide informed consent in relation to ECT is separate to other capacity determinations;**
    c. **provide a list of matters that NTCAT consider before making an order for ECT, having regard to guidelines made by the Chief Psychiatrist about the administration of ECT;**
    d. **set out clear processes to be followed if emergency ECT is administered, including informing NTCAT as soon as possible; and**
    e. **clearly provide that an application for ECT should not be accompanied by an application for further compulsory treatment, unless there are exceptional circumstances warranting the application.**

19. **That a new, standalone forensic mental health act be developed concurrently with the mental health act (refer Recommendation 1).**

20. That the forensic mental health act be developed jointly by the Department of the Attorney-General and Justice and the Department of Health in consultation with other relevant NT government agencies and targeted stakeholders, with the Attorney-General and Minister for Justice having primary portfolio responsibility.

21. That the forensic mental health act:
- **a. include contemporary definitions of mental illness, mental disturbance, mental impairment and cognitive impairment that are consistent with like definitions in other NT legislation, including the mental health legislation; and**
- **b. provide criminal procedures and dispositions, available in all NT courts exercising criminal jurisdiction, for defendants who have a mental health impairment or a cognitive impairment as defined.**

22. That information sharing, in compliance with the *Information Act 2002*, between government agencies, NTCAT, court clinicians, the courts, and non-government providers of health, mental health and ancillary services be facilitated through legislation or by a formal non-legislative means.

23. That the forensic mental health act provide that a court exercising summary jurisdiction may:
- **a. request and order an assessment from the Chief Psychiatrist and, if appropriate, make an admission order where it appears the defendant may require treatment under the mental health act;**
- **b. divert a defendant with a mental health impairment or cognitive impairment from the criminal justice system without determining criminal responsibility; and**
- **c. hear and determine whether a defence of mental impairment is established.**

24. That the forensic mental health act clarify and simplify the process where the defence of mental impairment is raised in a court exercising summary jurisdiction and provide that where the defence is established and the court is satisfied the evidence establishes that the defendant carried out the conduct that constituted the alleged offence the court may:
- **a. dismiss the charge unconditionally; and**
- **b. make a non-custodial supervision order for a specific period, no longer than 12 months.**

25. That the Department of Attorney-General and Justice, the Department of Health and the Department of Territory Families, Housing and Communities consult with stakeholders as to whether any modifications or safeguards are required for the application of Recommendations 22 and 23 to the Youth Justice Court, including whether any amendments are required to the *Youth Justice Act 2005*.

26. That the issue of empowering a court exercising summary jurisdiction to determine fitness to stand trial be deferred.

27. That Part IIA of the Criminal Code be repealed and re-enacted in the forensic act except that:
- **a. supervision orders made in the Supreme Court be of a limited term; and**
- **b. ancillary amendments to the provisions currently in Part IIA of the Criminal Code be made, as required.**

28. That the transfer of jurisdiction to NTCAT to have oversight of orders made under the forensic mental health act, including the power to make decisions about detention, treatment and release of supervised persons, be considered at a later time.

29. That, concurrently with the development of legislative reforms, the Department of Health continue work supporting the implementation of recommendations from the *Report on the review of forensic mental health and disability services within the Northern Territory* (McGrath Report).

Outcomes of consultation

Stakeholders unanimously supported new or amended mental health legislation, stating that the current mental health legislation is not fit for purpose, outdated, and not responding to the unique and diverse needs of Territorians. Submissions supported legislative reform to develop a streamlined and contemporary mental health framework which is practical, flexible, and culturally appropriate for the provision of mental health services in the NT.

The majority of submissions raised operational issues, advocating for system-wide reform. NT Health acknowledges that, during consultations, Territorians with lived experience highlighted deficiencies of the mental health system that require funding, and system-level reform that is separate and distinct from legislative reform. The submissions and content that relate to system-level issues have been collated internally and will inform system reform that is occurring adjacent to the legislative review. The scope of the review and the recommendations contained in this report target legislative reform only.

Recommendation 1:

That the *Mental Health and Related Services Act 1998* be repealed and replaced or amended to provide a contemporary mental health framework for the provision of compulsory and in-hospital mental health services in the Northern Territory.

1. Part One: Principles and rights of the patient

In 2008, Australia ratified the United Nations Convention on the Rights of Persons with Disabilities (CRPD), which includes persons with mental ill-health. The mental health legislation in all Australian states and the Australian Capital Territory (ACT) has been reviewed and modernised to align with the international human-rights commitment made by Australia in ratifying the CRPD. Reviewing the MHRSA gives the NT the opportunity to do the same.

Stakeholders stressed that legislative objectives and principles in the reformed legislation must align with Australia's human rights commitments under the CRPD. Feedback received from people with lived experience conveyed that human rights, including those listed in the CRPD, had frequently not been upheld during their care and treatment under the MHRSA.

Stakeholders expressed the need to see rights, values and interests protected in the new mental health legislation and supported the inclusion of clear principles. AMSANT highlighted that many NTG policies already incorporated and reflected contemporary principles, such as trauma-informed care, and called for their inclusion in the Act to provide a broader authorising environment, and to support action to embed these principles into practice.

1.1 Recovery

Contemporary international human rights, national legislative frameworks, and practices across the mental health sector continue to shift towards holistic and person-centred service delivery. This shift recognises that mental health services extend beyond clinical care and need to be underpinned by principles of trauma-informed care, self-determination and recovery to ensure that the individual is at the centre of mental health services.

Will incorporating the concept of 'recovery' into the legislation change how treatment and care is administered under the legislation? Why do you think so?

The majority of stakeholders supported the inclusion of the concept of recovery in the new mental health legislation, noting that this will embed the administration of treatment and care in recovery-oriented practices, in alignment with contemporary practices and principles. It will promote person-centred principles, such as self-determination and working in partnership with a person, recognising that they are 'experts in their own lives'.[3] It will acknowledge the choices of individuals and the importance of the people supporting

them in their unique recovery, while also providing guidance and direction for mental health service providers. A person with lived experience consulted in Alice Springs summed up what stakeholders unanimously expressed in relation to recovery - 'People need to be partners in their own recovery' (MHACA submission, p. 2).

Mental health providers and clinicians confirmed the need for legislative clarity to feel protected and assured in the provision of services under the mental health legislation. Stakeholders unanimously noted that service delivery has become increasingly risk averse, with mental health professionals and also police experiencing a lack of clarity about the ambit of the MHRSA beyond hospital-based involuntary admission and the administration of medication. Clinicians shared experiences of risk averse service provision with hospital-based and biomedical therapies dominating the acute mental health system response. The MHRSA lacks clarity about other clinical pathways.

Acute mental health treatment and care will be strengthened by clear legislative pathways founded in the concept of recovery. This, in turn, will provide protection and support to service providers and counter the trend of risk aversion.

Do you have any suggestions for how the legislation can be changed to include the concept of recovery?

The majority of stakeholders encouraged the incorporation of the concept of 'recovery' in the new mental health legislation to provide a strong legislative framework that will underpin operational policies and service delivery. Most stakeholders supported the inclusion of a broad, non-exhaustive definition of recovery, arguing that this would provide practical guidance on the application of the legislation while also ensuring flexibility to respond to unique circumstances and emerging best-practices and values. Some stakeholders, however, expressed concerns about defining 'recovery'. For example, NAAJA stressed the 'subjective nature of its interpretation and difficulties associated with applying broad terms in the context of understanding another person's situation' (NAAJA submission, p. 6).

Regardless of legislating a definition, introducing the concept of recovery will influence the entire legislation. Consequently, phrases such as 'wherever practical' which can serve to undermine adherence to the principle of recovery, need to be replaced with terminology that promotes the principle of recovery.

NTLEN suggested including a rights-based framework for recovery in the reformed legislation, as recommended by the World Health Organisation (WHO), to further support a person's recovery journey by involving people with lived experience. The involvement of people with lived experience of mental illness to support others with mental illness in their recovery is supported by the Productivity Commission Report and several stakeholders.[4] The system reform towards recovery-centred treatment, care and support, and the strengthening of a person's personal recovery is also a major theme promoted by the RCVMHS.[5] The strengthening of a person-centred approach and an individualised service delivery framed through the inclusion of the concept of recovery also aligns with the NT Mental Health Strategic Plan 2019-2025.[6]

Recommendation 2:

That the main objective of the mental health act is the provision of the highest standard of care to persons with a mental illness, consistent with their human rights in such a way as to promote their recovery. Inclusion of a broad, non-exhaustive definition of recovery should be considered.

Recommendation 3:

That the mental health act be underpinned by principles that reflect holistic, person-centred and culturally appropriate service delivery. These principles should include, but not be limited to:

- **a. that human rights be recognised and taken into account;**
- **b. that decisions about treatment and care reflect a person's right to self-determination;**

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c. that treatment and care take into account a person's cultural and linguistic background, including traditional beliefs and practices;
d. that treatment and care be provided on a voluntary basis as far as possible and otherwise on the least restrictive basis;
e. that Aboriginal people be provided with treatment, care and support in a way that recognises and is consistent with the person's cultural beliefs, practices and mores and is culturally appropriate and respectful; and
f. that the provision of treatment and care take into account the person's age (for example a child or an older person), and gender, gender identity, sexuality or sexual orientation or identity.

1.2 Capacity and informed consent

1.2.1 Capacity

The CRPD requires State Parties to 'recognise that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life'[7] and to 'take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity'.[8]

Do you think the legislation considers the right criteria when determining if someone has capacity?

The stakeholders who provided a response to this question were unanimous that reformed mental health legislation include a presumption that a person has full decision-making capacity, unless the contrary is proved, and a clear definition of capacity to provide informed consent. Submissions in relation to lived experience of mental ill-health highlighted a routine lack of autonomy in decision making about treatment and care.

While several provisions in the MHRSA refer to a person being 'not capable of informed consent', [9] there is no statutory definition of capacity. There is also no statutory presumption of capacity. Section 7 of the MHRSA sidesteps the threshold question of capacity and sets out stautory preconditions that must be met before a person can give 'informed consent'. It does not reflect presumed capacity.

The absence of clarity around the fundamental concept of capacity is inconsistent with principles of autonomy and recovery. The absence of a statutory presumption of capacity is inconsistent with Article 12 of the CRPD. These concepts are expressly stated in mental health legislation in other Australian jurisdictions[10] and in other intersecting NT legislation, namely the *Advanced Personal Planning Act 2013* and the *Guardianship of Adults Act 2016*. The OPG noted the importance of consistent definitions of capacity and impaired capacity in NT legislation, where possible, to provide 'a consistent approach to the human rights of individuals in the NT and the point at which an interference with these rights is authorised' (OPG submission, p. 4.).

Stakeholders pointed, with approval, to provisions regarding capacity in the mental health legislation of other Australian jurisdictions, in particular the ACT.[11] Submissions varied on how prescriptive a definition should be but, in general, the following are the minimum legislative requirements:

- capacity requires understanding, retention/appreciation of information, reasoning and communication;
- capacity and consent are decision-specific;
- capacity can fluctuate; and
- a person has capacity if they can make a decision with practical and appropriate support.

1.2.2 Informed consent

Does the legislation need to include any other steps to make sure that a person has given informed consent? Do any steps need to be removed?

The main issue raised by stakeholders was the need for a definition and statutory presumption of capacity. Some stakeholders considered that the criteria for determining informed consent were too onerous or prescriptive. Generally, a detailed checklist of requirements as in section 7 of the MHRSA does not feature in the mental health legislation of other Australian jurisdictions. The extent, if any, to which factors evidencing consent should be included in the legislation will be considered during the process of drafting a bill for new legislation. With the focus shifting to a clear definition and presumption of capacity, it is anticipated that much of the content of section 7 of the MHRSA will be unnecessary.

A number of stakeholders raised whether incapacity to give informed consent should be the sole gateway to the imposition of involuntary admission or treatment. The MHRSA currently authorises involuntary admission or treatment (where other thresholds are met) on the bases of incapacity to give informed consent or 'the person has unreasonably refused to consent to treatment'. [12]

NTLAC recommended the repeal of this criterion. AMSANT cautioned against its removal and DDHS noted that, despite its inconsistency with the concept of autonomy, it can play a necessary role in safeguarding patients, families and communities and its removal could 'also undermine effective treatment and ethical practice in certain circumstances' (DDHS submission, p. 7). DDHS and CVP submitted that there should be greater legislative clarity about what does and does not constitute unreasonable refusal. DDHS pointed to the objective criteria in the ACT legislation[13] as a suitable model. Clarifying the concept of capacity may also lead to decreased use of the unreasonable refusal criterion.

Recommendation 4(a):

In furtherance of the principles and objectives in Recommendations 2 and 3, the mental health act should include a presumption that a person has full decision-making capacity unless the contrary is proved. Capacity to provide informed consent should be clearly defined and decision-specific. Objective criteria for determining unreasonable refusal to consent should be included.

2. Part Two: Person-centred approach

The promotion of a person-centred approach is a NT Health priority, as committed to in the NT Mental Health Strategic Plan 2019-2025.[14] Stakeholders unanimously supported this and highlighted the extensive legislative and wide-reaching system reform required for a shift to successfully take place. The person-centred approach is about empowering people. Adopting this approach is multi-faceted, as outlined by national reports and highlighted by mental health legislation reviews across Australia. It translates into legislative and system reform to ensure that the individual is involved and at the centre of planning and decision-making regarding their treatment. A person-centred approach includes the provision of services which are appropriate, timely, effective and seamless. This requires the effective sharing of information between service providers to ensure a person has access to required and appropriate services at the time of need.[15]

2.1 Will and preferences

What is your opinion about introducing the concept of investigating the 'will and preferences' of someone to help make decisions about mental health treatment and care? What steps should be taken to find out someone's will and preferences?

The concept of will and preferences corresponds with the concept of recovery, which acknowledges the uniqueness of every person's situation and journey and the role they play in it. Stakeholders supported including the concept of will and preferences in legislation.[16] Inclusion of this concept is directed at empowering persons throughout their journey towards recovery and ensuring their involvement in decision making relating to their care and treatment, as much as possible. Its successful implementation will rely on integrated support services across the system and effective accountability mechanisms.

Submissions also raised the issue of planning for future relapse and admission, to ensure that a person's autonomy and participation in decision making are maintained. Independently led consultations and surveys revealed that the majority of persons with lived experience had not heard or been informed about Advanced Care Directives to support their mental health care.

NTLAC shared the story of a person with lived experience who had expressed their concern over the treating team's handling of their personal information while involuntarily admitted. They had in a previous admission agreed for the treating team to talk to their parents about their treatment and care. However, their wishes and preferences had changed and this was no longer what they wanted. The treating team's continued reliance on their wishes from a past admission left them feeling that their wishes and preferences had not been considered. and their privacy not protected nor respected.

In contrast, MHACA provided a story shared by a person with lived experience who had been supported by a psychologist in the development of their care plan for the event of a relapse. This allowed the person to feel 'better prepared and more confident', knowing that their needs were available to health professionals even when they had lost capacity.

Submissions strongly supported the promotion of the use of recovery focused Advanced Care Directives including advance consent decisions and care statements, made while persons have planning capacity, for care and treatment during periods when their capacity may be impaired. NTMHC supported the suggestion of rebranding the Advanced Care Directives to 'Advanced Health and Recovery Directive' to mirror their role and purpose.

Recommendation 4(b):

In furtherance of the principles and objectives in Recommendations 2 and 3, the mental health act should expressly provide that a person's wishes and preferences, whether made contemporaneously or through an advance statement or directive, must be taken into account when determining treatment or care.

2.2 Nominated support person

The inclusion of nominated support persons upholds a person-centred approach and preserves the person's autonomy and participation throughout their treatment and care, even in the event of compromised capacity. It enables a person to involve someone of their choice to support them in their recovery. A flexible nominated support person model safeguards a person's wishes and preferences. Flexibility will allow a person to determine the level of support required and wanted from their nominated support person, ranging from receiving information to substituted decision making.

Should the Northern Territory introduce a 'nominated support person' into the mental health legislation?

Submissions supported introducing a clear but flexible model of a nominated support person into the mental health legislation. Most stakeholders suggested the nomination of a support person be non-mandatory or an 'opt-in' process and apply to both voluntarily and involuntarily admitted persons. Some stakeholders including NTLEN and OPG, however, advocated for an 'opt-out' model. They raised concerns about inequality and disadvantage when a person was unable to nominate a support person, for example, because of not having an appropriate support person within proximity, or because of a lack of capacity to nominate.

NTLEN submitted that a Nominated Support Service should be legislated and have a focus on rights and a recovery orientation. A Nominated Support Service would ensure equitable access to support was automatically available to all who wished to use it. NTLEN further proposed that such a service should have a lived experience workforce as an enabler to recovery. This concept was overwhelmingly supported at NT LEN's lived experiencing consultation and in the online survey.

On balance, an 'opt-in' model would reflect more strongly a person's wishes and preferences, taking into account that a person may not have capacity to 'opt-out' at the point of their admission.

Submissions generally supported that a person could nominate anyone as a support person regardless of age, as long as the nominated support person was willing and able to fulfil the functions and responsibilities of their role. Most stakeholders supported availability of the model to any person, regardless of having been admitted voluntarily or involuntarily; either explicitly or by not differentiating between the different admission statuses. Stakeholders unanimously called for not confining support persons to a certain cohort of people, such as relatives or partners, recognising different cultural networks such as Aboriginal cultures and their kinship relationships. They also expressed that a person should be free to nominate a person to support them and the nomination should not rely on the judgement of, for example, the person's psychiatrist, unless it pertains to sensitive matters such as information sharing.

To ensure independent support and advocacy NAAJA submitted that, for Aboriginal People, the nominated support person model should be complemented with an Aboriginal support service system which could also function as an oversight mechanism.

Nominated support persons will need to be integrated into the framework of existing services. The NTMHC highlighted the complexity of the role of nominated support persons, sharing feedback from support people who said they had been unaware of their rights as well as of the rights of the people they were supporting. This complexity is compounded by possible cultural and language barriers. Given the complexity of their role, these persons will require support to successfully navigate the system and effectively support the person who nominated them.

What kind of role should the nominated support person have?

The majority of submissions supported clear legislative provisions setting out the rights, role, and advocacy options of nominated support persons. NTLAC stressed that the role of nominated support persons will need to comply and correspond with other relevant NT legislation, such as *Guardianship of Adults Act 2016* and the *Advance Personal Planning Act 2013*. Stakeholders unanimously supported the role of nominated support persons being broad and flexible to ensure that the interests and choices of the client are safeguarded and upheld throughout their treatment and care.

How many nominated support persons should an involuntary patient have?

The majority of submissions supported the ability to nominate more than one support person. To prevent any conflict, a person could nominate a primary and a secondary support person. Legislation will need to clearly define roles, responsibilities and level of involvement of each nominated support person.

Recommendation 4(c):

In furtherance of the principles and objectives in Recommendations 2 and 3, the mental health act should include provisions regarding the appointment, role and responsibilities of nominated support persons.

2.3 Cultural security

Consultations across the NT emphasised the connection between mental health and cultural and spiritual wellbeing, in particular for Aboriginal people. As highlighted in the discussion paper there is an over-representation of Aboriginal people on involuntary treatment orders. The over-representation is also globally observed for people with culturally diverse and marginalised backgrounds,[17] and international analysis indicates that people from economically disadvantaged circumstances are more likely to be on compulsory/involuntary treatment orders.[18]

Stakeholders suggested legislative mechanisms to support connection to culture, strengthen cultural security and ensure oversight and accountability. This section provides an overview of the legislative reform proposed by stakeholders to improve and protect cultural security for persons receiving mental health treatment and care under the mental health legislation.

Stakeholders also submitted a variety of cultural security measures for system reform. These will be subject to further consideration by NT Health. An example for system reform, submitted by AMSANT, is to increase the Aboriginal workforce and expand mental health services in remote communities.

In addition to the consultations undertaken as part of this review, NT Health collaborated with the AJU to understand the mental health feedback gathered from communities as part of the NT Aboriginal Justice Agreement (NTAJA) consultations. From 2017-2020, the AJU conducted 160 consultations across the NT, consulting some communities more than once to gain deeper insights into local concerns. The feedback from Aboriginal communities contained consistent overarching themes in relation to mental health including:

- High prevalence of intergenerational trauma;
- Youth and adult diversion or alternatives to custody need to include trauma support, including mental health services;
- No or not enough counselling, psychologists or psychiatrists visiting services in community;
- Lack of cultural safety when accessing health services, including mental health services;
- Not enough youth mental health services;
- Lack of recognition of Ngangkari Healers;
- Lack of access to interpreters;
- More support to reduce the high prevalence of suicide;
- Privacy issues when accessing mental health services in the community; and
- Fly-in-fly-out issues when accessing mental health services.

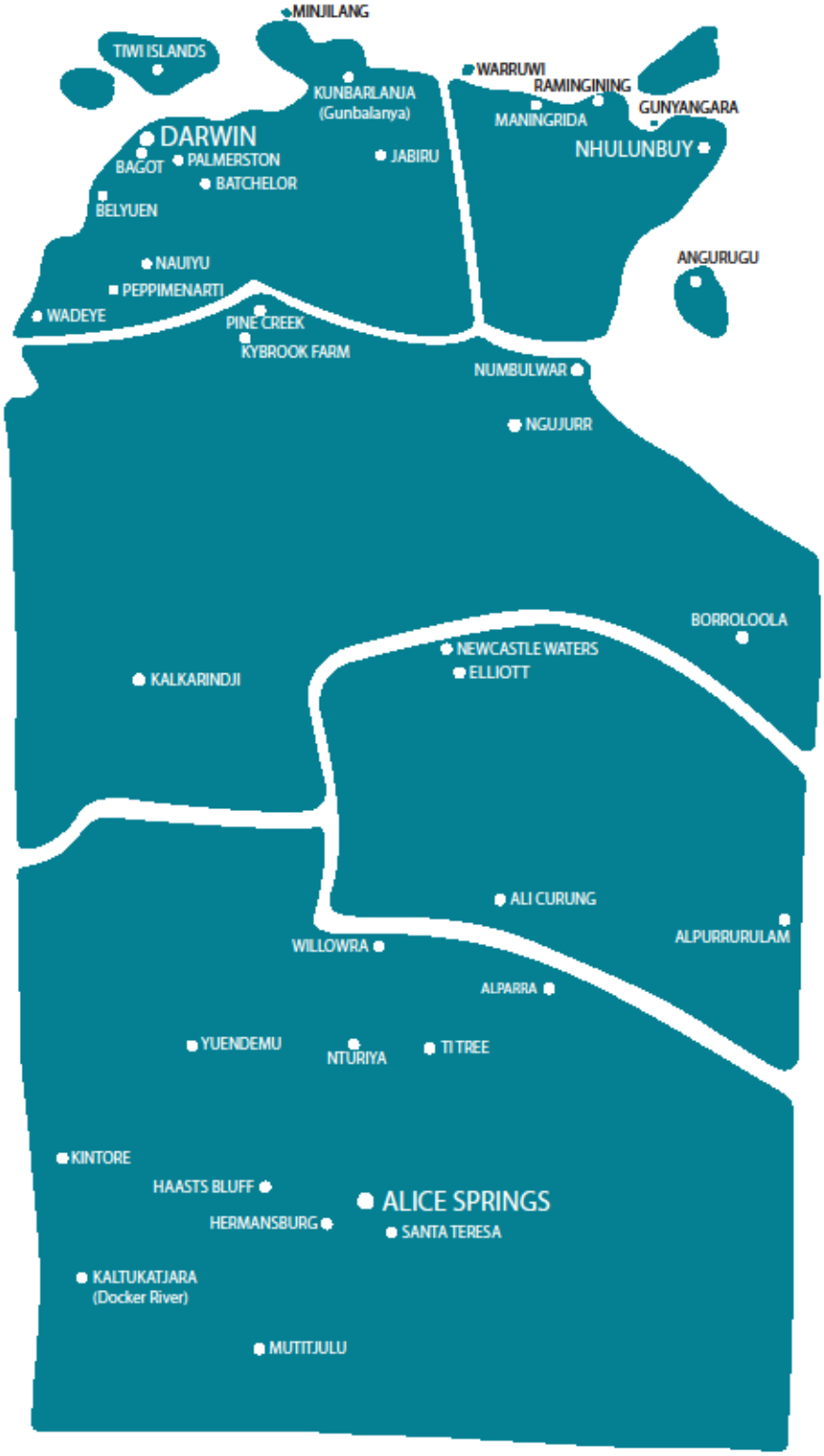

Image 1: Map of NTAJA community consultations

Recommendation 3(c):

That the new act be underpinned by principles including that treatment and care take into account a person's cultural and linguistic background, including traditional beliefs and practices.

2.3.1 Traditional healers

'Traditional healers'[19] is a broad term used to describe the traditional 'bush' medicine, energetic therapies, ceremonies, physical / hand on therapies and healing traditions that have evolved over thousands of years in Aboriginal culture. Traditional healers, also known as Ngangkari healers in the region of Central Australia, currently access the Alice Springs Hospital Approved Treatment Facility (ATF) to work with admitted persons and provide traditional medicine. The importance of access to Ngangkari healers was raised throughout consultation with Aboriginal people, for example at the Alice Springs Community Forum by an Aboriginal lived experience participant who shared their experience of leaving their community to travel to Darwin. They told their story of becoming unwell during their travels due to dark spirits and eventually seeking help from an Ngangkari healer in the ATF. This helped them feel much better. They felt very strongly that traditional healers and traditional counselling were an important part of looking after their mental health as well as being in touch with country.

> Traditional healers and traditional counselling are important part of looking after mental health and as well as being in touch with country.
> (Alice Springs Community Consultations – 17 March 2021)

At the AMSANT Social and Emotional Wellbeing Forum in Alice Springs, local Ngangkari healers provided a demonstration of the preparation of bush medicine and spoke with the NT Health representatives about how the process of making bush medicine is part of the healing process. Traditional healing practices share commonalities with modern mental health therapies,[20] for example counselling and 'touch' or tactile therapy. The key issue raised by Ngangkari healers is the lack of appropriate recognition of their level of skill, knowledge, training and abilities when working in hospital settings. The lack of recognition is a longstanding issue between traditional medicine and the modern science-based biomedical model.[21]

DDHS raised in its submission the 'diagnosis' of mental illness, stressing the need to recognise 'culture bound syndromes' such as being 'sung' and 'sorry time' behaviours. The Palmerston Indigenous Network also provided examples of young people who were 'sung' and subsequently admitted involuntarily to an ATF without any appropriate cultural support and input. According to DDHS, these [culture bound] syndromes are often misdiagnosed as psychoses, as the symptoms share similar traits to those in the DSM-V.

Other jurisdictions that recognise traditional healers in their mental health legislation include South Australia and Western Australia, which share cross-border Aboriginal communities with the NT. A lived experience participant at the consultations in Alice Springs described the concept of traditional healing as relevant to other cultures, not only Aboriginal communities. The need for the recognition of cultural healing practices was also raised in consultation with Ignite Potential, an organisation that supports people from culturally and linguistically diverse backgrounds who often have only recently arrived in Australia. The national trend, as set out by the Productivity Commission Report, is towards establishing partnerships between mainstream mental health services and traditional healers.[22]

The recommendation regarding recognition of traditional healers is also relevant to Culturally and Linguistically Diverse (**CALD**) communities as many different cultures practice healing customs; however, any new provisions and definitions need to remain distinct for Aboriginal and CALD communities. Aboriginal people, as First Nations people, have experiences and connection to country that are unique to their culture. New legislation should acknowledge this difference between Aboriginal and CALD communities.

Recommendation 4(d):

In furtherance of the principles and objectives in Recommendations 2 and 3, the mental health act should include recognition of the role of traditional healers and a requirement to involve them in treatment, admission and discharge planning to the extent appropriate and practical.

2.3.2 Use of interpreters

Stakeholders emphasised the importance of using interpreters consistently, at all stages of service provision under mental health legislation. As raised by NTLAC, it is fundamental that the use of an interpreter is offered to everyone, including people with mental disturbance and/or complex cognitive impairment.

Sharing operational insight, clinicians highlighted that language and cultural barriers lead to increased risk of involuntary admissions. CVP and AMSANT also expressed the need to include Australian Sign Language (Auslan) interpreting services in the discussion around the use of interpreters.

What do you think about the current provisions relating to the use of interpreters?

OPG stated in its submission, 'the use of interpreters and/or other communication aids for Aboriginal people or people from CALD backgrounds is essential to ensure the opportunity for real participation and engagement by the person [...the use of an interpreter...] does not always occur in practice due to the limited availability of an interpreter in the person's language and other resource constraints within mental health services, including personnel resources.' (Submission from OPG, p. 7).

Stakeholders unanimously supported the use of interpreters in mental health settings and highlighted the importance of using qualified interpreters given the 'complex and technical' medical terminology used and the impact a mental health condition may have on the brain and a person's understanding of the information. However some stakeholders went further, submitting that the provision of interpreters should be mandatory in specific situations, for example during a diagnosis /admission process and other significant communication gaining informed consent. DDHS submitted that the use of interpreters is 'particularly important during the stage of assessment for involuntary admission, and so recommends the strengthening of legislative requirements for a qualified interpreter during client assessment.' (DDHS submission, p. 12) NTLAC supported this, recommending that the mental health legislation place a positive obligation on health professionals to ensure the use of interpreters during medical examinations. NTLAC also submitted specific legislative changes to clarify NTCAT's responsibility to provide interpreters for hearings and stressed the importance of NTCAT developing clear interpreter protocols for NTCAT hearings to clarify the role of interpreters and to highlight the importance of their use in hearings.

NTMHC recommended that interpreters be available to patients and nominated support persons at all times and stages, and especially during admission. People with lived experience raised concerns that without the use of interpreters at all stages, many people had little understanding of their care and treatment. CVP submitted that vague phrases like 'as far as practicable' should be removed when referring to requirements for the use of interpreters.

Aboriginal Health Practitioners provided feedback on the mandatory use of an interpreter during the admission and assessment process. Their view was that an interpreter would not necessarily guarantee culturally safety upon admission, for example if the person being assessed needs time and treatment to de-escalate. Rather, they stressed the importance of timing and how evaluating the person's readiness for an interpreter would improve the effectiveness of interpreter service and staff safety.

Stakeholders supported the use of an accredited in-person interpreter as their preferred option of providing interpreting services. The use of interpreters through other means of communication (for example via the telephone, video or through information recorded in language) received less support from stakeholders who raised concerns that these methods further place Aboriginal and CALD people at a disadvantage as use of in-person and accredited interpreters is best practice.

NT Health supports the use of interpreters where there is an identified need. However, legislation that mandates the use of only 'qualified' interpreters or specifying they must be used during admission is not supported. Including a statutory requirement that interpreters be accredited will likely limit the availability of interpreters, in particular for some Aboriginal language groups which are not nationally accredited. Additionally, mandating interpreters for specific processes would require 24-hour availability. There are not enough interpreters in the NT for this to be feasible. However, NT Health strongly supports that health

professionals must make every effort to obtain an interpreter where there is an identified need and, where an interpreter cannot be obtained, to record the reasons why not and what efforts were made to obtain one.

NT Health supports strengthening the Chief Psychiatrist's legislative powers to monitor and report on the use of interpreters and to set policies in relation to access to interpreters.

Recommendation 4(e):

In furtherance of the principles and objectives in Recommendations 2 and 3, the mental health act should include a provision requiring all communication with a person under the act to be in a means and form that the person is likely to understand, including using an interpreter if necessary and practicable.

3. Part Three: Admission and treatment

Mental health legislation in Australia, generally regulates compulsory and in-hospital mental health services. For in-hospital mental health services, a person may be admitted either on a voluntary or an involuntary basis. Different criteria and processes apply to each. Involuntary treatment may also be provided in the community. Under the MHRSA this is through a Community Management Order (CMO). Legislative criteria and processes apply to regulate the making of a CMO.

Stakeholders' responses to questions in Part 3 of the discussion paper addressed not only legislative criteria, processes, oversight and accountability but also wider systemic issues. All submissions expressed the need for legislative clarity about the criteria for admission and the admission process. Stakeholders submitted that the legislation must provide protection to persons being assessed for admission, irrespective of location. In relation to remote locations, some submissions also addressed the opportunity to assist timely decision making during the admission process through collaboration via telehealth with a person authorised under the act.

The overwhelming feedback received from stakeholders highlighted that seeking assistance when experiencing mental ill-health had been an experience of disempowerment, (re-)traumatisation, and challenge. Stakeholders shared experiences of people who had sought help and had been left feeling disconnected, misunderstood and disbelieved. A person with lived experience summed up their experience, one shared and supported by many stakeholders, as 'you do not feel believed in your pain or story.' (MHACA submission, p. 4)

The experience of feeling disempowered and left alone was linked by many stakeholders to the lack of available services for early prevention and intervention to prevent deterioration into acute mental health crises, particularly for people in remote and regional areas where service provision is limited or irregular.

3.1 Involuntary admission

What do you think about the current process of assessment and examination for involuntary admission?

People with lived experience under the MHRSA stated that a lack of understanding of assessment and processes by both health professionals and themselves worked against their interests.

The MHRSA provisions broadly set out requirements for involuntary admission from initial contact with a person through to examination processes at an ATF, the key steps include:

- **initial concerns** for a person raised by someone with a genuine interest;
- **assessments** by a suitably qualified health practitioners;

- **examination** on admission and **ongoing examination** during the period of involuntary admission by authorised psychiatric practitioners.

3.1.1 Assessment

A key area of confusion, raised during consultation at both community and health professional forums, was how the assessment provisions in the MHRSA and the power under section 34, to make a recommendation for a psychiatric examination, apply. Section 34 requires a medical practitioner, an authorised psychiatric practitioner, or designated mental health practitioner to recommend a psychiatric examination where the practitioner is satisfied that the person fulfils the criteria for involuntary admission on the grounds of mental illness or mental disturbance. The feedback highlighted that medical practitioners, for example GPs, who request a psychiatric examination often lack an understanding of the grounds for involuntary admission and apply this section to persons who do not satisfy the criteria. This can often result in a person not being admitted for in-hospital mental health treatment. In addition, the rights of the person and the application of the MHRSA once the request for a psychiatric examination has been made are not clear.

The feedback from people with lived experience who did not meet the admission criteria or who were perceived as not being unwell enough to access in-hospital services was that this created a lot of confusion and distress. People with lived experience and their families did not understand how the person in crisis did not meet the admission criteria. People with lived experience also provided system feedback on the intake process and assessment teams, pointing out the need for trauma-informed responsiveness and referral processes.

The issue of persons being recommended for a psychiatric examination without satisfying the involuntary admission requirements is both a system and a legislative issue.

The legislative issue relates, in part, to there being very little guidance on how a medical practitioner may be satisfied that a person meets the criteria for involuntary admission on the grounds of mental illness or mental disturbance. This issue is compounded by the mandatory language of section 34. The medical practitioner must make a recommendation for psychiatric assessment if satisfied the criteria for involuntary admission are met, i.e. there is no discretion. This contrasts, for example, with section 39 of the *Mental Health Act 2014* (QLD) which provides that a doctor or authorised medical health practitioner *may* make a recommendation for assessment if satisfied that the treatment criteria may apply to the person and 'there appear to be no less restrictive way for the person to receive treatment and care for the person's mental illness.'[23]

Section 34 of the MHRSA also provides broad powers to 'control' a person to take the person to an ATF for a psychiatric examination. For people travelling from remote communities, admission often includes leaving or being taken away from their local community and support network. Upon arrival in the urban centres of Darwin or Alice Springs, they then often hear that they do not 'fit the criteria, then returned to community with no support' (NTMHC submission, p. 23). While the legislation needs to provide a clear power for what would otherwise be a deprivation of liberty, the language of 'control' is too broad and outdated. The legislation needs to clearly detail the authority to transport a person to an ATF for a psychiatric assessment, including the requirements for use of any restraint. Chapter 11, Part 6 Division 5 of the *Mental Health Act 2016* (QLD) may be a useful model.

The feedback shows the current provisions in the MHRSA regarding assessment to determine the need for treatment require greater clarification and guidance. However, legislative amendment alone will not address systemic issues. The establishment of a statutory Chief Psychiatrist position with improved lines of accountability and system-wide guidelines will support GPs in decision making under new mental health legislation.

3.1.2 Admission

Health professionals and other stakeholders highlighted that a 'reviewed admission' or ongoing examination process would reduce admissions and / or shorten their duration. This is because involuntary admission is connected to other issues, including the use of interpreters and the questions of capacity and informed consent. Capacity and informed consent can fluctuate and require regular review during the admission process. If, for example, a person is found to have capacity during the process this can lead to an avoidance of an involuntary admission.

To reduce any preventable prolongation of involuntary status, health professionals from the Emergency Department at the Royal Darwin and Palmerston Regional Hospital submitted that the examination process for involuntarily admitted persons would be improved by requiring a review not less than once every 48 hours. The current requirement is 72 hours.[24]

The admission process needs to be reviewed to align with contemporary best practice to ensure suitably qualified persons have powers to authorise and oversee the assessment and admission process. The Chief Psychiatrist's powers and responsibilities could include the oversight and monitoring of the admission process and associated policies, which should be publicly available.[25] The current Approved Procedures under the MHRSA on admission and treatment are publicly available on the agency website. However, while NT Health is committed to the publication of this information it is not currently legally required. The Health Complaints Commissioner recently recommended that the Approved Procedures should be 'up-to-date, that their currency is clear, and that they are accessible to the public.'[26]

3.1.3 Criteria

One of the criteria for involuntary admission and treatment under the MHRSA[27] is that without treatment and care the person 'is likely to cause serious harm to himself or herself or to someone else'. The assessment of risk of harm to self or others is completed as part of the comprehensive mental health assessment completed by the authorised practitioner. Within 14 days the decision that a person needs treatment and care must be reviewed by NTCAT.[28]

NAAJA and NTLAC submitted that, in the NTCAT review and decision process, satisfying the likelihood of causing serious harm often relied on 'historical incidents with limited (if any) probative value' (NAAJA submission, p. 16) and that evidence provided to NTCAT by the treating team 'often relies on unclear, untested or out of date evidence, [...] taken at face value' (NTLAC submission, p. 8). To ensure the consideration of relevant criteria and to 'strongly emphasise the temporality of the enquiry at hand', NAAJA suggested that the likelihood of causing serious harm must be 'in their present condition' or 'immediately' (NAAJA submission, p. 16). This would raise the threshold for involuntary admission.

In Queensland, the threshold criteria for involuntary or compulsory orders includes reference to the 'immediacy' of the risk of serious harm as follows:

> 'because of the person's illness, the absence of involuntary treatment, or the absence of continued involuntary treatment, is likely to result in **imminent serious harm** to the person or others [...]'.[29] [Emphasis added]

In Victoria, the need for involuntary admission is determined by a registered medical practitioner or mental health practitioner, the test in section 5 of the *Mental Health Act 2014* (VIC) being:

> '... (b) because the person has mental illness, the person needs **immediate** treatment to prevent...
> (ii) **serious harm** to the person or to another person'.[30] [Emphasis added]

The Victorian treatment criterion provides a focus on the immediate necessity of the treatment to prevent serious harm as opposed to the immediacy of the risk of harm. Some health professionals expressed the

requirement to evaluate the risk of future serious harm to self or others as being problematic in cases where the underlying causes of the person's presentation are unknown. The Queensland focus on establishing the risk of serious harm being imminent would add complexity to the assessment for treatment. The Victorian treatment criterion maintains a focus on the person's present condition and the appropriateness of immediate treatment, which can be evidenced by the clinical judgement of medical professionals. The Victorian criterion is supported by NT Health as it provides a high threshold, being the risk of serious harm to self or others, but places an emphasis on evidencing the need for immediate treatment.

Compulsory treatment and care must be used as the last resort. This is supported by the national trend toward reducing involuntary treatment and care as it denies a person their human rights including 'liberty, autonomy … and a home and family life'.[31] The reformed legislation should uphold this rights-based approach and provide clear parameters in relation to the risk of harm and the criteria for compulsory treatment.

Recommendation 5:

The mental health act should set out clearly the criteria and processes for admission to an Approved Treatment Facility and compulsory treatment, and strengthen oversight and accountability mechanisms reflecting the principles in Recommendation 3. Reforms should include:

a. **removing complex cognitive impairment as a ground for compulsory admission;**
b. **clarifying and providing guidance about assessment of whether a person is in need of treatment under the act and recommendations for psychiatric examination;**
c. **a legislative requirement for the Chief Psychiatrist to develop and publish a policy or guideline about the application of treatment criteria under the act;**
d. **expressly providing that involuntary (compulsory) admission or treatment should only be used as a last resort; and**
e. **setting out the criteria and processes for a person transitioning from voluntary to involuntary inpatient status and between inpatient status and compulsory treatment in the community.**

Recommendation 6:

That the role, functions and powers of NTCAT be retained.

What are your thoughts about the process to involuntarily admit somebody on the grounds of mental illness or mental disturbance or complex cognitive impairment?

Many responses to this question focused on the inappropriateness of involuntary admission for complex cognitive impairment being included in mental health legislation. The mental health legislation of all Australian jurisdictions limits admission to the basis of mental ill-health (or equivalent term). The NT is the only jurisdiction in Australia that has a distinct ground of admission based on complex cognitive impairment.[32]

NTLAC submitted that the involuntary admission on the grounds of complex cognitive impairment results in the detention of people because of aggressive or irresponsible behaviour and DDHS argued that involuntary admission on the grounds of complex cognitive impairment (and mental disturbance) addressed behavioural issues instead of therapeutic issues.

Health professionals from a NT Approved Treatment Facility reported that the grounds for involuntary admission for complex cognitive impairment are outdated and rarely used. Only one historic admission was cited during the clinicians' forums, pre-dating the introduction of the NDIS.

While the overwhelming consensus is that complex cognitive impairment is not an appropriate basis for admission or treatment under mental health legislation, nothing should limit the admission or treatment of persons with both mental ill-health and complex cognitive impairment.

Stakeholders also recognised the need for appropriate services being available to people with complex cognitive impairment, such as Fetal Alcohol Spectrum Disorder (FASD), to cover any gaps between the services provided under the MHRSA and *Disability Services Act 1993* and NDIS.

Recommendation 5(a):

Reforms should include removing complex cognitive impairment as a ground for involuntary admission.

3.2 Voluntary to involuntary admission

Submissions highlighted the lack of transparency and understanding about the difference between involuntary and voluntary admission, and how the MHRSA is applied to determine admission status. Section 30 allows a medical practitioner or nurse to detain a voluntary patient for up to six hours if they believe the person may fulfil the criteria for involuntary admission. This provision also allows for use of force, mechanical restraint and seclusion while detaining the person. Some people with lived experience as voluntary patients under the MHRSA felt that admission status is sometimes used as a way to control their behaviour.

CVP submitted that the legislation needs to be strengthened around when a person must be informed about their rights, supporting a requirement for informing a person of their rights at the time of involuntary admission.

A person with lived experience expressed concerns around risk-aversion of health professionals and how this trend has resulted in an increase of involuntary admissions,[33] a concern raised repeatedly by stakeholders in consultations and also by the RCVMHS which recommended a legislative requirement that compulsory treatment be used only as a last resort.[34] OPG recommended that, to align with the principle of least restrictive practices, involuntary admission needs to be a last resort with strong legislative safeguards. NTLAC recommended inclusion of an explicit provision that each of the criteria for involuntary admission be presumed not to apply, and to place the onus on the treating team to establish that each of the criteria does apply. NTLAC also recommended inclusion of a positive requirement for an authorised psychiatric practitioner to take reasonable steps to find out if there is a less restrictive way for the person to receive treatment or care.

To uphold a rights-based approach, legislative provisions will need to safeguard a person's rights. To protect persons from unwarranted involuntary admission, the reformed mental health legislation must be clear on the formal processes that apply when a voluntary patient is deteriorating and must have strong oversight and monitoring mechanisms in place. Part of clarifying processes will be the use of unambiguous, contemporary terminology such as replacing 'involuntary order' with 'compulsory order' to better reflect the circumstances of a treatment being ordered by an authorised medical practitioner. Clear and simple admission processes and the consistent provision of information on the rights of the person with every change in circumstances will protect persons from the inappropriate use of involuntary admission and treatment.

3.3 Community Management Orders (CMOs)

In their responses about involuntary admission, many stakeholders discussed the use of CMOs. CMOs are integral to the provision of person-centred treatment in line with the principle of providing treatment as close to home as possible.[35] The CMO provisions support a whole-of-system mental health reform that is underpinned by community-based treatment and support instead of hospital admission at an Approved Treatment Facility. Stakeholders supported the greater use of CMOs ~~instead of involuntary admission, as CMOs offer a less restrictive option. As submitted by~~ NTMHC, CMOs can prevent people from being

'traumatically evacuated' (NTMHC submission, p. 23) when transported away from their community to either Darwin or Alice Springs.

Some stakeholders supported strengthened legislative provisions, including new forms to highlight that a CMO offers a less restrictive alternative to a person being admitted to an ATF. OPG submitted that clear legislation could increase the use of CMOs and prevent admission to ATFs.

Feedback from health professionals referred to the MHRSA as confusing and not fit for purpose, in particular provisions on when a person's CMO is suspended and when it is reinstated during admission to an ATF. The stakeholders who referenced CMO provisions mainly offered systems recommendations, but also supported improved information sharing between services to support seamless care. The need for seamless care provision was further highlighted by the feedback received from people with lived experience under the MHRSA, namely that services which can offer support to a person while on a CMO need to be accessible, connected and better coordinated to assist persons, for example, to access supported accommodation.[36]

Recommendations 5(d) and (e):

d. **That the new act expressly provide that involuntary (compulsory) admission or treatment should only be used as a last resort.**

e. **That the new act set out the criteria and processes for a person transitioning from voluntary to involuntary inpatient status and also between inpatient status and compulsory treatment in the community.**

3.4 Voluntary admission

Do you have any feedback on the current voluntary admission process?

Stakeholders unanimously called for clear legislative provisions requiring a statement of the rights of persons who are voluntarily admitted be given to the person and that the rights must align with international law and principles.

Legislation should explicitly provide that a person admitted voluntarily has full decision-making capacity. NTLEN detailed experiences shared by people who had been voluntarily admitted in an ATF, but never informed about their rights and in particular the right to leave the facility. Another common experience, raised during the Alice Springs public consultations was that persons with lived experience did not feel confident complaining about treatment or conditions in an ATF, believing it could result in their admission status being changed to an involuntary admission or adversely impact their care and treatment.

Legislation on voluntary admission and treatment should also regulate the involvement of any guardian or other decision-maker, for example, nominated support persons. NTMHC submitted the need to offer support services to persons trying to be voluntarily admitted, but not meeting the criteria, such as developing a 'care/safety plan' (NTMHS submission, p. 25) responding to their needs. NTHMC also highlighted substance (ab)use as a barrier to admission.

Recommendation 7:

That provisions regarding the rights of patients clearly reflect the principles of the mental health act including the introduction of the role of nominated support persons.

3.5 Leave

3.5.1 Involuntary admission leave

What do you think about the current approach under the MHRSA that grants leave to involuntary patients?

Leave supports 'having access to the outside world' (MHACA submission, p. 6) which is important in a person's treatment and recovery.

Leave generally falls into two types:

- Short leave, which allows time outside an ATF on nearby surrounds. Conditions, such as the length of leave and whether it is supervised or not, may apply.
- Extended leave of absence that permits a person to leave the ATF for an extended period. This may involve residing in the community with relatives, friends or a support person. Conditions of leave are generally set and may be revoked on specific grounds.

Leave for persons admitted on an involuntary basis is regulated by section 166 of the MHRSA.[37] There is no differentiation between types of leave and the only guidance for approval is that section '[leave] must not be granted except in accordance with approved procedures' (see 166(3)(a)).

Submissions supported the granting of leave to persons involuntarily admitted, ranging from 'smoking leave' through to leave to visit community, and stressed its significance in a person's recovery, highlighting the benefits. For example, as highlighted by NAAJA, for Aboriginal people leave can ensure a therapeutic environment and the opportunity to connect to Country.

Feedback from health professionals included that denying involuntarily admitted persons leave can lead to more restrictive practices as it links to increases in agitation, specifically when smoking leave is not provided, which can result in extreme behaviour.

However, submissions acknowledged the uniqueness of every person's situation and the need for a suitably qualified psychiatric practitioner to assess a person and their situation in accordance with the risks and benefits.

Stakeholders noted the lack of legislative guidance in the MHRSA regarding leave. For example, health professionals noted the lack of clarity about giving approval in advance for a schedule of leave, such as daily leave for a specific of period of time.

In contrast, provisions in the mental health legislation of some other Australian jurisdictions offer clearer guidance to both health professionals and mental health service consumers and promote a person's autonomy and path to recovery. For example, section 64 of the *Mental Health Act 2014* (VIC) may offer a useful model. Section 64(3) explicitly directs the authorised psychiatrist who is considering whether to grant leave to have regard (to the extent reasonable in the circumstances) to:

a) the person's views and preferences about the leave of absence and the reasons for those views and preferences, including the recovery outcomes that the person would like to achieve
b) the views and preferences of the person expressed in his or her advance statement
c) the views of the person's nominated person
d) the views of a guardian of the person
e) the views of the person's carer, if the authorised psychiatrist is satisfied that the decision will directly affect the carer and the care relationship
f) the views of a parent of the person if the person is under the age of 16 years
g) the views of the Secretary, if the person is the subject of a family reunification order or a care by Secretary order.

Recommendation 8:

That the mental health act should establish clear provisions that enable approved leave for an isolated instance of leave and/or regime of leave for persons on compulsory orders and define the requirements and any criteria to approve leave.

3.5.2 Voluntary admission leave

Section 29 of the MHRSA provides for the 'Discharge of voluntary patients'. Section 29(2) provides that, 'A person must be informed of his or her right to leave the approved treatment facility on being admitted as a voluntary patient.' Usage of the term 'leave' within this provision in relation to discharge of a voluntary patient is confusing. Stakeholders called for a clear legislative provisions for person admitted voluntarily to leave the ATF and discharge from an ATF, with records kept to satisfy occupational health and safety requirements.

A new mental health act also needs to include specific provisions in relation to any circumstances where leave can be refused and powers for the Chief Psychiatrist to monitor leave.

Recommendation 9:

That the mental health act include clear provisions on the rights of leave for persons admitted to an authorised treatment facility on a voluntary basis, and clarify any circumstances where those rights might be limited.

3.6 Admission and treatment of children

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

All submissions supported the inclusion of specific criteria and principles to strengthen the rights of children who are voluntarily or involuntarily admitted under the MHRSA, as the current admission provisions lack reference to age. The United Nations Convention on the Rights of the Child provides, in Article 3, 'In all actions concerning children … the best interests of the child are a primary consideration'. As the OCC submitted:

> *The MHRSA must give due weight to children's rights in order to be a tool that effectively recognises the importance of early prevention and detection of mental illness in children and supports individualised and therapeutic healing*. (OCC submission, p. 2)

Issues about children are closely linked to the question of capacity and informed consent. Section 25(1) of the MHRSA provides for voluntary admission of a person aged 14 years and over. There is no specific provision for establishing consent of a child and as noted above at item 1.1 (Capacity and informed consent) there is no presumption of capacity in the MHRSA at all.

Some stakeholders supported that instead of defining clear age brackets, the principle enunciated in *Gillick v West Norfolk and Wisbeach Area Health Authority & Anor* [1986] 1 AC 112 (Gillick competency) should be legislated to take into account the level of maturity and comprehension of an individual on a case-by-case basis. NAAJA supported the presumption of decision-making capacity for any young person from age 14 years,[38] and the presumption that persons under the age of 14 years do not have decision-making capacity unless proven otherwise.[39]

An issue raised by health professionals is that a parent or guardian can, under section 25(2) of the MHRSA, apply to have a child under 18 voluntarily admitted. The voluntary status of the young person is difficult to reconcile when the young person does not support the admission. Furthermore all the provisions of the

MHRSA that apply to voluntary patients, for example leave and discharge, are not appropriate for a young person admitted by a parent or guardian.

The OCC submission highlighted the gap in the holistic approach to prevent mental ill-health, as specialist services across the NT leave young people unsupported with no access to early intervention, community service providers or therapeutic programs, and no access to support post discharge. Many stakeholders emphasised the need for secure, therapeutic facilities and special wards to provide a safe and secure specialist youth environment. Submissions shared experiences of young people feeling unsafe. Although ATFs in both Alice Springs and Darwin have additional processes / considerations in relation to 'paediatric' involuntary admissions to ensure they are the only viable option for treatment, the MHRSA allows a young person to be involuntarily admitted and does not prohibit a child residing alongside adults in an ATF.

The complexity of working with young people and their families and/or adult guardians was highlighted by NTLEN in the feedback received through their online survey, and was confirmed by health professionals.

3.6.1 Information sharing for children

Information sharing, specifically the information of a child, was not separately raised in the discussion paper, but was raised in consultations and submissions. Stakeholders shared experiences of young people feeling disempowered and misunderstood, with information shared against their wishes and preferences. Mindful of the impact information sharing can have, the OCC called for consideration including specific legislative provisions to protect children who have nominated a support person(s).

Consultations with health professionals highlighted the issues and complexities around strictly defined age brackets. Mental health professionals working in Central Australia raised concern around an increasing number of young people under the age of 10 accessing youth centres. Consultations with remote communities, conducted by the Aboriginal Justice Unit of AGD, further noted the need for youth support services accessible to young people in regional and remote areas. Regularly, young people between 15-17 years old requested that 'their parents are not to know' something, particularly relating to gender-specific issues such as reproductive and sexual health. It is regular practice clinicians will make a judgment whether 'the child is believed to be reasonably competent and making the right decision and if so, the clinicians will follow the child's lead' (Consultation 13 April 2021, Minutes p. 2). At other times clinicians will break the confidentiality requested by the child, their patient, to inform the parents – this can significantly affect the therapeutic relationship established between clinicians and young people. Health professionals called for clear provisions so that the requirements around breaking confidentiality are unambiguous.

Recommendation 10:

That, in addition to the general principle at Recommendation 3(f), the new Act should, at a minimum, include the following provisions in relation to children:

a. **the capacity of a child to consent to care or treatment is to be assessed on a case-by-case basis by a person authorised under the act in accordance with the principle in *Gillick v West Norfolk and Wisbech Area Health Authority & Anor* [1986] 1 AC 112;**
b. **specific measures to be included to reduce the use of restrictive measures (additional to Recommendation 17);**
c. **seclusion can only be used as measure of last resort;**
d. **children should be treated and cared for separately from adult patients where possible;**
e. **a discretion for information sharing for persons 14 years and over based on capacity and the best interest of the child; and**
f. **specific provisions for children aged under 14 years for the sharing of information with the parent or guardian of the child.**

3.7 Other specific admission requirements

In addition to specific admission requirements for children, stakeholders also highlighted the need for specific admission processes for other cohorts including youth detainees, prisoners and persons on forensic orders.

NTLAC expressed concern that the admission options for people in prison are misunderstood by staff who feel uncertain about their ability 'to treat prisoners at an Approved Treatment Facility as voluntary patients' (NTLAC submission, p. 8).

Feedback from forensic health professionals was that the admission process for youth detainees needs to be different to that of a prisoner as youth detention is the responsibility of the Department of Territory Families, Housing and Communities not AGD correctional services.

Recommendation 11:

That the new act provide, to the extent necessary, separate or modified assessment, admission and discharge processes for persons in custody or on a forensic order.

3.8 Apprehension by Police

The Co-Response Model and its multi-disciplinary approach was supported by the majority of submissions when considering the role of police. In 2020, NT Health and NT Police developed a Co-Response Model to better address and meet the needs of persons experiencing a mental health emergency. The Co-Response Model supports persons to access mental health treatment and remain in their community setting. The model supports an integrated system of governance and coordination arrangement for the activation and response functions of the Co-Response Team. Roles and responsibilities are shared between the Top End Mental Health and Alcohol and Other Drug Service, St John Ambulance Australia and the NT Police under this model.

The Co-Response Team includes a Designated Mental Health Practitioner (DMHP), paramedic and police officer. Together they assist in the triage and treatment of mental health patients within the Greater Darwin Area. This model corresponds with current national trend to better support police when responding to mental health related incidents, such as the Productivity Commission Report and RCVMHS Recommendation 10.[40] In 2020, the Co-Response Model was trialled in the NT and the success of the initial trial resulted in an extension of the trial until 2022. The NT Police submission also highlighted the success of the Co-Response Model and queried whether legislative amendment was necessary to further support the model.

The majority of stakeholders supported the trial of the Co-Response Model and its interagency collaboration and called for the development and rollout of the co-response model to cover more of the Territory, with special consideration given to regional and remote communities.

The need for accessible mental health services in remote communities was also highlighted in submissions about police apprehension in remote regions. Compared to urban centres of the NT, remote regions have limited resources to respond to an acute mental health crisis and the initial response is often led by police and primary health. Some submissions noted that, on occasions where responses are led by police, the focus is often on risk management and community safety. Stakeholders suggested mental health training for police within primary health care settings. Stakeholders suggest greater access to specialised mental health professionals for remote communities. While these comments and suggestions are largely system-based,

consideration will be given to any legislative requirements needed to support the Co-Response Model and the parameters of virtual mental health services under the new act.

What do you think about the current power of police to apprehend a person in order to take them to be assessed?

The power of police to apprehend a person is currently regulated under section 32A of the MHRSA. The legal threshold for apprehension by police is determined in subsection 32A(1)(b) that states 'the person is **likely** to cause serious harm to himself or herself or someone else **unless apprehended immediately'** [emphasis added].

Under the Criminal Code[41] 'serious harm' means any harm (including the cumulative effect of more than one harm):

(a) that endangers, or is likely to endanger, a person's life; or
(b) that is or is likely to be significant and longstanding.

NT Police submitted that the threshold of 'serious harm' often results in the inability of police to act until the likelihood of serious harm is satisfied, which prevents earlier intervention. A lower threshold such as 'risk to the public or public safety' (NT Police submission) may mitigate the risk of escalating behaviour.

Stakeholders acknowledged the pivotal role of police in providing timely responses to mental health crises, particularly in regional and remote communities when other services are unavailable. However, most stakeholders supported raising, not lowering, the threshold for apprehension by police. NTLAC, for example, recommended the threshold for apprehension by police to resemble the South Australian provisions that require a 'significant' risk of serious harm. The rationale for increasing the threshold for apprehension by police is to ensure these powers are only exercised as a last resort.

NTLAC and NAAJA emphasised the risks attached to persons deteriorating during a mental health crisis, referencing deaths in custody, and submitted that legislative measures should be in place to 'minimise risk that an apprehension will lead to a tragic outcome' (NTLAC submission, p. 12). Submissions also highlighted the practice of using police vehicles as 'unnecessarily humiliating and anti-therapeutic [...]' stating that this can also 'precipitate an episode of violence' (NTLAC submission, p. 13). MHACA submitted feedback from people with lived experience who described the shame associated with being apprehended by police and how this method of apprehension has often led to persons being reluctant to engage in subsequent treatment. Submissions stressed the stigma attached to apprehension by police.

All submissions supported police being accompanied and/or supported by a person with mental health expertise and training when attending mental health crises, for example the Co-Response Model. NAAJA also referred to systemic factors, including past trauma and negative experiences with police, and black deaths in custody to support a combined clinical and Aboriginal-led co-response approach. In addition to mental health professionals, paramedics and police, the model should include an Aboriginal-led service option within the co-response.

The shift towards more involvement of mental health professionals when responding to mental health crises, away from the police as the point of first response, is supported by the RCVMHS (Recommendation 10). The support and success of the Co-Response Model in the NT underpins the shift towards an inclusion of mental health professionals at the point of first response. However, there remains a need for police apprehension powers as a last resort.

Recommendation 12:

That powers of emergency apprehension be reframed and clarified to reflect the Co-Response Model of responding to a mental health crisis, including NT Health, St John Ambulance and NT Police, and raising the threshold for apprehension as a last resort.

Recommendation 13:

The mental health act should allow for virtual provision of mental health services and assessments, wherever possible, to support rural and remote regions.

3.9 Search and seizure powers

What do you think about regulating the power to search someone and seize property under the legislation?

CVP and OPG were the only stakeholders who responded to this question in a written submission. During face-to-face consultation, clinicians also provided feedback.

CVP and OPG provided qualified supported for regulating these powers in legislation, submitting that strong safeguards and definitions be included that protect persons in mental health facilities and during assessment in other locations, in line with international law. Further, CVP submitted that the objective of the search needs to be clear, any action must be reasonably necessary and proportionate to achieving the objective and only authorised persons should be allowed to conduct searches.

OPG submitted that search powers should be 'minimised wherever possible and not be cruel or unnecessary. Appropriate safeguards must be detailed in the legislation including the requirement of any search to be undertaken by a person of the same gender and for the search to be conducted in a culturally safe manner' (OPG submission. p. 9).

Clinicians considered that search and seizure powers should be authorised in remote communities, providing an example of a weapon being wielded during a psychotic episode. There is an inherent risk, however, in circumstances where a weapon is present, which health staff are arguably not appropriately trained to respond, Police involvement is required. On this point, CVP submitted that where 'criminal activity is suspected then Police should conduct such searches and seizures' (CVP submission, p. 44).

However, the scope of this review does not include amendments to the powers of the NT Police to conduct searches under the *Police Administration Act 1978* or any other legislation. In relation to search and seizure powers, the review is limited to the powers of authorised persons regarding persons being assessed or admitted under the mental health legislation and persons visiting an Approved Treatment Facility.

The search powers under the new mental health legislation need to distinguish between objectives for searches and the circumstances, authorisation process and authorised persons allowed to conduct searches proportionate to the type of search. The *Mental Health Act 2016* (QLD) and the *Mental Health Act 2014* (WA) search and seizure provisions were supported by stakeholders as examples of model provisions.

Recommendation 14:

In addition to matters within the ambit of Part 12 Rights of patients and carers in the *Mental Health and Related Services Act 1998*, provisions should be included to:

a. **provide powers of search and seizure that are commensurate with identified risks, with least restrictive options for various circumstances that recognise the vulnerabilities of the person (including both patients and visitors) being searched, age, gender, sexuality and cultural background;**
b. **search and seizure powers contain protections for the person subject to the search that align with the principles of the mental health act and international law; and**
c. **expand Community Visitor Program monitoring powers to include monitoring of search and seizure powers.**

4. Part Four: Monitoring

4.1 Chief Psychiatrist

Introducing the position of the Chief Psychiatrist as a statutory position would align with frameworks in the majority of other Australian jurisdictions. Clear provisions around the position's role, functions, and responsibilities will strengthen transparency, clinical governance and independent advocacy.

How do you think the legislation can support the role of the Chief Psychiatrist?

All submissions that responded to this question were supportive of the establishment of the Chief Psychiatrist as a statutory position and the enactment of key independent monitoring, authorisation and oversight roles for the position, as set out in the discussion paper.

Stakeholder suggestions regarding specific powers and functions included:

- DDHS submitted that the Chief Psychiatrist deliver a mental health and wellbeing system that responds to the diversity of the NT's community, promotes access and equity of outcomes and strengthens the provision of Aboriginal cultural safety through the use of interpreting services, cultural and traditional medicines, and the promotion of cultural and health literacy.
- CVP stressed that legislative provisions would secure transparency and accountability and listed 14 functions for the Chief Psychiatrist, including public reporting, the provision of clinical leadership, the promotion of people's rights, and the development and provision of information, training and education. CVP also highlighted that the Chief Psychiatrist's role should have responsibility for the appointment, delegation and credentialing of the roles under the new legislation and for the monitoring and use of ECT.
- NAAJA emphasised the function of the Chief Psychiatrist in the monitoring of the use of restrictive practices.
- NTMHC submitted that the Chief Psychiatrist provide oversight and guidance according to contemporary best practice and develop a Charter of Rights to advocate for persons receiving care and treatment under the mental health legislation and to support the safeguarding of everyone's rights.
- OPG supported that the Chief Psychiatrist have powers of direct intervention and the initiation of investigations.

Based on the feedback provided by stakeholders, the statutory powers and functions of the Chief Psychiatrist should include, but not limited be to:

1. responsibility for the oversight of mental health treatment and care under the new mental health legislation;
2. oversight and responsibilities related to the statement of rights for persons accessing mental health treatment under the new mental health legislation;
3. administration of the mental health legislation including development of forms as well as publication of various guidelines, standards and policies to support the operation of the legislation;
4. monitoring compliance with the new mental health legislation including defining and receiving notifiable incidents, conducting audits, and establishing regular data collection processes;
5. endorsement processes including authorising treatment facilities as well as mental health practitioners to perform functions under new mental health legislation;

6. conducting investigations related to clinical events;
7. oversight or authorisation of practices such as seclusion, restraint, ECT and the involuntary treatment of children;
8. a role in monitoring the reduction and where possible elimination of restrictive practices;
9. a role in the operation of new forensic legislation including but not limited to provision of information to courts;
10. reporting to the Minister on an as-required basis, particularly in regard to matters pertaining to administration of the new mental health legislation; and
11. a role in interstate transfers and oversight of mutual recognition of civil mental health orders for people subject to the provisions of the relevant mental health act.

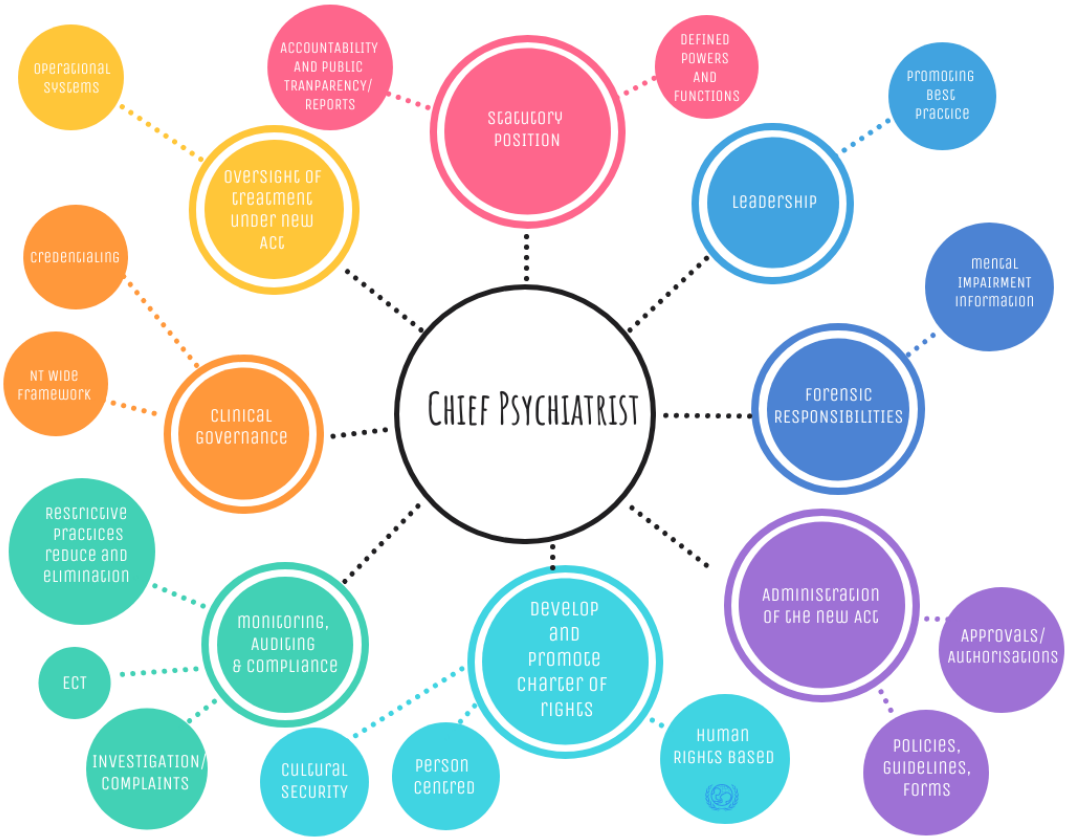

Image 2: Overview of Chief Psychiatrist powers and functions

The Chief Psychiatrist, as a statutory position with powers and functions as outlined above, would be responsible for the development of clinical policies and guidelines, the clinical governance framework and carrying out reporting, monitoring and review functions.

Some of these functions are currently performed by the Approved Procedures and Quality Assurance Committee (APQAC). The ongoing role of any committee must be consistent with the statutory role of the Chief Psychiatrist. NT Health recommends a flexible approach to establish advisory panels, similar to the power of the System Manager under the *Health Service Act 2021*.[42] An advisory panel established by the Chief Psychiatrist may be of limited duration, to address a particular issue, or may be established with terms of reference to give ongoing advice.

Recommendation 15:

That the mental health act establish the position of the Chief Psychiatrist. The powers and functions of the Chief Psychiatrist should include:

a. **overall responsibility for the oversight of mental health treatment and care under the act;**
b. **developing and promoting a statement of rights for persons accessing mental health treatment under the act;**
c. **administration of the act, including the development of forms, publication of guidelines, standards, and policies to support the operation of the act;**
d. **monitoring compliance with the act, including defining and receiving notifiable incidents, conducting audits, and establishing regular data collection processes;**
e. **establishing endorsement processes, including authorising treatment facilities and mental health practitioners to perform functions under the act;**
f. **conducting investigations related to clinical events;**
g. **oversight or authorisation of ECT, restrictive interventions, and the compulsory treatment of children;**
h. **a role in monitoring the reduction and, where possible, the elimination of restrictive practices;**
i. **a role in the operation of new forensic legislation including, but not limited to, provision of information to courts;**
j. **reporting to the Minister and the CEO, including provision of an annual report to the Minister, to be tabled in the Legislative Assembly;**
k. **a role in interstate transfers and oversight of mutual recognition of civil mental health orders under mental health legislation in other Australian jurisdictions; and**
l. **subsuming the role of the Approved Procedures and Quality Assurance Committee (APQAC) and the power to establish advisory panels.**

4.2 Community Visitor Program (CVP)

Submissions stressed the need for the oversight functions of the CVP and Principal Community Visitor to be separate from and complementary to the functions and powers of the Chief Psychiatrist. NTLAC stressed the importance of independent oversight and complaint bodies and how these support transparency and a person's confidence.

The majority of submissions supported an increased authority and remit of the CVP acknowledging the important role CVP plays as an independent oversight mechanism offering protection to people receiving treatment and care under the MHRSA. There was particular support for the CVP to have a role in oversight and monitoring of the use of restrictive practices, as discussed further below, However, the new role and functions of the Chief Psychiatrist will also have monitoring and reporting powers. Ensuring that the powers and functions of the CVP align with and complement these new powers will be addressed, in consultation with the CVP, during the process of drafting the new mental health act.

Feedback received from health professionals also raised concern about a lack of engagement of CVP on an operational level, with treating teams being confused about the powers of CVP and how independent advocacy operates alongside the CVP. Unambiguous provisions in the new mental health act, setting out the role and powers of the CVP and Principal Community Visitor will increase confidence and transparency of the service provided.

Recommendation 16:

That the Community Visitor Program including the Principal Community Visitor be retained, and expanded in relation to monitoring of search and seizure powers.

4.3 Regulating restrictive practices

In 2017, the second edition of the *National Safety and Quality Health Service* (NSQHS) *Standards* was endorsed by the Australian Government, state and territory Health Ministers. Under the Comprehensive Care Standard, Actions 5.35 and 5.36 establish a requirement that health services govern, report and work towards minimising the restrictive practices of restraint and seclusion. Action 5.35 states that 'where restraints are clinically necessary to prevent harm, the health service has systems that minimise and where possible, eliminate the use of restraint'.[43] In mental health settings across Australia the use of seclusion and restraint remain highly regulated to safeguard when and how they are used.

What do you think of the current approach to regulating the use of restrictive practices under the MHRSA? How do you think the legislation can further promote the elimination of restrictive practices?

Most submissions supported a higher threshold for the use of restrictive practices and strengthened monitoring and oversight mechanisms, calling for clear definitions of the different restraints and safeguards in mental health legislation. NAAJA suggested legislative changes similar to the model in the *Mental Health Act 2014* (VIC) and the *Mental Health Act 2007* (NSW), to ensure that restrictive practices are used only as a last resort, are monitored effectively and are trauma-informed. NAAJA also supported the inclusion of a 'reduction and elimination plan' as legislated in the *Mental Health Act 2016* (QLD). This is an individual plan developed by an authorised doctor for each person that monitors past restrictive practices. It is used to reduce and eliminate the use of restrictive practices on that person in the future.

Most submissions supported the reduction of the use of seclusion, with an ultimate goal of elimination, stressing that seclusion must be a last resort. MHACA quoted a person who had been secluded under the MHRSA, who stated 'They left me there for days [...] I did not get informed what was happening [...] it was traumatic.' (MHACA submission, p. 5) To ensure transparency and accountability of the use of mechanical restraint and seclusion, stakeholders wanted more awareness of the accessibility of this information.

The authorisation of mechanical restraint provisions in the MHRSA were not considered fit for purpose by Emergency Department medical staff, in particular for the senior registered nurse on duty to authorise mechanical restraint or seclusion 'in the case of an emergency'. Medical professionals advised that authorisation must always be from the person in charge of the shift, a role taken 24/7 by an appropriately trained senior doctor, and that it is thus not reasonable for the senior registered nurse on duty to take legal responsibility for this decision.

Police powers of apprehension are included in section 32A of the MHRSA and corrections officers under the *Correctional Services Act 2014*.[44] They are authorised to use reasonable force, which may include use of handcuffs (mechanical restraint) within an ATF. The issues associated with police and corrections officers continuing to use handcuffs while the person is admitted to an ATF has been raised as an ongoing concern by medical professionals. The use of mechanical restraint in these instances, while occurring in an ATF, is not authorised by an authorised psychiatric practitioner or senior registered nurse as required under the MHRSA. However, the monitoring and reporting requirements under the MHRSA must still be met by the health professionals. This scenario creates many issues as health professionals cannot remove the mechanical restraints, which may mean non-compliance with legislation. Also, the episode of mechanical restraint is recorded as an occurrence at the ATF even though it was not authorised in accordance with the MHRSA.

The new act needs to clearly delineate the use of restraint by police or corrections officers in an ATF from the obligations of health professionals in these circumstances.

Some stakeholders suggested the inclusion of the NDIS definitions and prohibitions regarding restrictive practices in mental health legislation. However, the NDIS definitions of restrictive practices were developed to apply in a different context to an ATF. There are measures and processes in NDIS settings that occur over extended periods to observe and document behaviours of concern which are not consistent with in-hospital and compulsory treatment contexts. While the majority of NDIS definitions are not fit for purpose in an ATF the new act will, as far as practicable, align with NDIS restrictive practices authorisation processes and definitions. For example, the NDIS definition of physical restraint as 'the use or action of physical force to prevent, restrict or subdue movement of a person's body, or part of their body, for the primary purpose of influencing their behaviour. Physical restraint does not include the use of a hands-on technique in a reflexive way to guide or redirect a person away from potential harm/injury, consistent with what could reasonably be considered as the exercise of care towards a person'.[45]

Recommendation 17:

That provisions regarding the use of restrictive practices reflect the principle of least restriction and that they:

a. **be clarified, including by defining 'physical restraint';**
b. **remove the concept of 'controlling' a person to transport the person to an Approved Treatment Facility;**
c. **define and regulate the use of medication as a 'chemical' restraint;**
d. **require the Chief Psychiatrist to develop a policy in relation to physical, mechanical and chemical restraint and seclusion.**

4.3.1 Children

Submissions supported the prohibition of seclusion of children and the reduction and elimination of the use of restrictive practices. Submissions raised concerns about the gap for services available to children who have an intellectual or developmental disability complicated by mental ill-health.

Some submissions also highlighted that the MHRSA authorises the seclusion of children. This is inconsistent with the *National Disability Insurance Scheme (Authorisations) Act 2019*, which prohibits the seclusion of children on an NDIS Plan. Submissions supported the prohibition of the seclusion of children and young people to align with the *National Disability Insurance Scheme (Authorisations) Act 2019*. The seclusion of children was an issue discussed at Clinicians Forums with medical practitioners from mental health settings. The difference between NDIS settings and Emergency Departments and Approved Treatment Facilities was emphasised. A key difference for Emergency Departments is that the patient history is often unknown and the reasons for the psychotic episode are unknown. In NDIS settings extensive planning, history, medication and other information on the participant must be provided before restraint can be authorised.

Medical practitioners considered the seclusion of children as a practice of last resort, used infrequently. However, it is considered necessary in certain limited circumstances to prevent serious harm (to the young person or others), where no other least restrictive option is appropriate. The example was given of a young person aged 17 years who presented to the Emergency Department in crisis, highly agitated. There was no information on the cause of psychotic episode. In these circumstances other forms of restraint may have been more intrusive and dangerous, for example the use of sedative medications may have caused an adverse medication interaction. Operationally, the use of seclusion could be improved by the introduction of continuous supervision.

When mechnically restrained, young people require continuous supervision, which could be improved by adding a second person for supervision. Clinicians also raised concerns around the transport of young people, submitting that management policy relies on 'good underlying principles of care', rather than prescriptive and restrictive legislation to take into account all the different types of transport and different settings, for example on a plane, or on the road from Don Dale Youth Detention Centre.

Stakeholders were supportive of strengthened safeguards in the use of seclusion and mechanical restraint for young people under a new mental health act, including specific provisions regarding the restraint of children distinct from the restraint of adults. The legislation should require that these restraints only be used as a last resort in limited circumstances with defined authorisation requirements, time limits, monitoring, notification and reporting requirements.

Recommendation 10(b) and (c):

That, in addition to the general principle at Recommendation 3(f), the new act should, at a minimum, include the following provisions in relation to children:

b. specific measures to reduce the use of restrictive measures (additional to Recommendation 17)
c. seclusion can only be used as measure of last resort.

4.4 Medication

The national trend is towards reducing the use of medication other than when it is clinically necessary for the treatment or care of a person suffering from a mental or physical illness. The use of medication, specifically sedation, as a form of restraint is strictly regulated and its use beyond what is legislatively permitted may be a criminal offence. It falls within the definition of 'non-psychiatric treatment' in section 63(1) of the MHRSA and its use is limited to the circumstances set out in section 63(3) and (4).

Some stakeholders, however, reported concerns about the use of medication to control behaviour. For example, at the Alice Springs public consultation a person with lived experience raised the long-term impacts sedation has when used to control behaviour. Sedative medication given in an ATF several years ago not only severely affected the person's physical mobility at the time but also continues to have a physical impact now.

DDHS highlighted the use of medication can also be used as a 'method of convenience to manage difficult behaviour.' (DDHS submission, p. 16)

Submissions strongly supported ongoing regulation and the inclusion of legislative safeguards for the use of medication primarily to restrict behaviour. From an operational perspective, medical practitioners and staff from mental health service providers submitted that the appropriate use of medication to restrain a person be clearly set out in the new mental health act. The provisions need to cover the use of medication in an ATF and also during the transport of persons to an ATF.

Section 63 of the MHRSA lacks the clarity of more modern mental health legislation, for example, the *Mental Health Act 2016* (QLD), which provides that it is an offence to administer medication where there is no clinical need as part of a person's treatment and care for a medical condition. Treatment and care include preventing imminent serious harm to the patient or others.[46] The Chief Psychiatrist must make a policy in relation to the appropriate use of medication, including ways of minimising any adverse impacts on patients. Anyone performing a function or exercising a power under the *Mental Health Act 2016* (QLD) must comply with the policy.[47]

The RCVMHS also supported defining and regulating the use of chemical restraint as a way of protecting consumers and enabling the practice to be appropriately monitored[48]. Part 3.7 (Restrictive interventions) of

the Mental Health and Wellbeing Bill 2022 (VIC) regulates seclusion bodily restraint (physical and mechanical) and chemical restraint.

4.5 Electroconvulsive therapy

What do you think about how the legislation regulates electroconvulsive therapy (ECT)? Can we make improvements?

Stakeholders who responded to this issue acknowledged that ECT is an important treatment option. To ensure the safe use and delivery of ECT, submissions called for strong and clear safeguards to be legislated as well as a requirement for the Chief Psychiatrist to develop prescriptive guidelines and policies. Stakeholders stressed the importance of the role of the Chief Psychiatrist in monitoring the use of ECT.

Stakeholders also raised concerns about the use of ECT as an involuntary treatment and administration in an emergency submitting that the number of treatments be defined, as legislated in most other states and the ACT.[49] To strengthen the monitoring of ECT, NTLAC suggested the establishment of an electronic register to capture data for evaluation and improvement processes.

NTLAC raised concerns about the provision of ECT in an involuntary setting, highlighting the need for legislation to comply with paragraph 13 of Principle 11 of the *United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*, which states that no major medical procedure should be conducted on someone who is unable to provide informed consent. NTLAC submitted reform to mental health legislation in relation to ECT should:

- 'explicitly note that all other reasonable treatment options have been performed, or explored;
- explicitly note that the ability to provide informed consent in relation to ECT is decision specific, and a person should not be regarded to be unable to provide informed consent to ECT solely because they have been determined unable to provide informed consent in relation to another decision;
- provide a list of what NTCAT must consider before making an ECT order, including the views of the person to be provided the treatment and any other person, as NTCAT sees fit;
- ensure that there is clarity on the process to be followed if emergency ECT is performed and that NTCAT is informed as soon as possible; and
- explicitly note that an application for ECT should not be accompanied by an application for further involuntary detention, unless there are exceptional circumstances warranting the application.' (NTLAC submission, p. 17)

NT Health supports the NTLAC's recommendations in relation to ECT. They will provide appropriate additional safeguards for persons on compulsory treatment orders, in particular the recognition of a separate assessment of capacity to provide consent for ECT and the requirement for NTCAT to consider the preference of the person who is to be provided ECT treatment.

Recommendation 18:

That Electroconvulsive Therapy (ECT) provisions be strengthened to:

a. **require a record of all other reasonable treatment options that have been performed or explored prior to ECT;**
b. **explicitly note that the ability to provide informed consent in relation to ECT is separate to other capacity determinations;**
c. **provide a list of matters that NTCAT consider before making an order for ECT, having regard to guidelines made by the Chief Psychiatrist about the administration of ECT;**

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d. set out clear processes to be followed if emergency ECT is administered, including informing NTCAT as soon as possible; and
e. clearly provide that an application for ECT should not be accompanied by an application for further compulsory treatment, unless there are exceptional circumstances warranting the application.

5. Part Five: Forensic provisions

Is the current legislation effective in regulating forensic mental health? Can we make improvements to the legislation?

NT Health received eight written submissions in relation to the questions asked in Part 5 of the discussion paper. It also conducted face-to-face consultation with six stakeholder groups, five of which meetings were conducted jointly with AGD. A further follow up meeting with the Chief Judge and Deputy Chief Judge of the Local Court was held in October 2021. NT Health subsequently consulted with AGD regarding a draft of this part of the consultation report and the proposed recommendations. AGD's comments are accepted by NT Health and have been incorporated into the consultation report.

The questions in the discussion paper centred on legislative improvements that could be made in relation to 'forensic mental health', including the provision of effective and appropriate clinical pathways, and whether forensic provisions should be contained in a standalone act.

Part 5 of the discussion paper did not directly ask stakeholders to make submissions about how the current legislation operates in the Youth Justice Court and whether there should be any legislative reforms specific to children.

While the questions were primarily directed at legislative reform, the overwhelming message from stakeholders was the need for improvement of mental health services in the area of forensic mental health. This is consistent with feedback received during consultation conducted by the Aboriginal Justice Unit of AGD in relation to the Aboriginal Justice Agreement.

As CVP stated, 'Various reports have been conducted into forensic services over the last three years, and legislative reform to flow from them is difficult until a plan is prepared for the provision of mental health services in the NT more broadly and where Forensic services will sit.' (CVP submission, p. 71)

The reports that the CVP refers to are:

- the NT Law Reform Committee *Report on the interaction between people with mental health issues and the criminal justice system*, May 2016 (NTLRC Report);
- the report of the Senate Standing Committee on Community Affairs Inquiry: *Indefinite detention of people with cognitive and psychiatric impairment in Australia*, November 2016 (Senate Report);
- Dr Peter Norrie's *Report on the independent review of Part IIA orders*, April 2018 (the Norrie Report); and
- David McGrath Consulting's *Report on the review of forensic mental health and disability services within the Northern Territory*, January 2019 (the McGrath Report).

Stakeholders expressed concern about the absence of a secure forensic mental health hospital facility and community-based accommodation and support. This is a longstanding issue and one regularly raised by the Supreme Court when placing persons found not guilty on the grounds of mental impairment or unfit to stand trial on a custodial supervision order. For example, in 2018, Grant CJ observed that, 'supervised persons subject to custodial supervision orders continue to be detained in mainstream correctional facilities for extended periods due to the unavailability of any suitable alternative'.[50] This unsatisfactory situation applies

to adults and youths; to persons suffering from a mental illness and to persons suffering from cognitive impairment. In placing a young person with severe cognitive impairment on a custodial supervision order in 2020, Grant CJ made a similar observation and noted that 'the Court is entirely reliant on the Executive to make appropriate facilities and services available for the custody, care or treatment of accused people who continue to present the relevant level of risk to either themselves or the community'.[51]

The 'Catch-22' is that a lack of therapeutic treatment or care in the mainstream correctional system and a lack of facilities outside of that system means that 'stepping down' from a custodial to a non-custodial supervision order is more difficult, exacerbating and extending the time that forensic patients spend in prison.

Stakeholders identified a number of areas in which legislative reform could better deal with defendants suffering from mental health impairment or cognitive impairment (or, in many cases, both). Clear, comprehensive legislation will provide a framework for the more effective delivery of services.

Should forensic provisions be contained in its own piece of legislation?

The MHRSA is the main legislation governing the interface between the criminal justice system and mental illness and mental disturbance for matters dealt with in the Local Court and the Youth Justice Court. In the Supreme Court, Part IIA of the Criminal Code governs the interface between the criminal justice system and mental impairment and cognitive impairment. There are, however, provisions in other legislation that can be relevant when defendants suffer from mental or cognitive impairment.[52]

There are standalone forensic acts in New South Wales, Victoria, Tasmania and Western Australia.[53]

Stakeholders did not widely comment on this question. Those who did, including the Local Court, were generally supportive of a separate forensic act. As the OPG noted, a standalone act would provide 'greater certainty and usability' as well as 'an opportunity to adopt the recommendations contained in the reviews and independent reports'. (OPG submission, p. 11)

CVP did not think separate legislation was required if there was clarity about how mental health legislation and the Criminal Code are applied and interact. However, under mental health legislation, defendants in the Local Court and Youth Justice Court who have a 'mental impairment' that is not a mental illness or a mental disturbance fall through a gap. There is an increasing cohort of defendants who have FASD, a trend confirmed by court staff and clinicians. FASD is not a mental illness. In some cases, a person suffering from a 'mental impairment' or a cognitive impairment of sufficient severity would meet the defence of mental illness or mental disturbance in section 77(4) of the MHRSA. To address these gaps there is a need for clear contemporary definitions of mental and cognitive impairment, such as have been enacted in NSW in the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* (NSW).[54]

AGD is supportive of a single forensic act, which has the benefit of creating clarity and consistency in the design of procedures in all courts exercising criminal jurisdiction, especially in how matters are transferred to the Supreme Court. AGD notes that it is appropriate for the Attorney-General and Minister for Justice to have portfolio responsibility for a forensic act, given the existing responsibility for Part IIA of the Criminal Code and because it will be primarily concerned with matters to do with criminal responsibility and criminal procedures.

Stakeholders also raised the need to better facilitate the provision of information to courts. For example, the Local Court noted, particularly in the context of defendants who are NDIS clients, that 'nothing is joined up' and there 'is no flow of information to the court' (Meeting with Local Court Judges, 13 May 2021). The DPP raised problems of communication from one part of NT Health to another and issues of uncertainty about service provision under the NDIS. SFNT also raised the artificial distinction in NT Health between forensic mental health and forensic disability clients, which the Supreme Court does not recognise. Most Part IIA Criminal Code clients are both. A multidisciplinary team in NT Health would be ideal.

The NTLRC Report recommended a formalised exchange of information 'between the Department of Health, Mental Health Review Tribunal, court clinicians and the Court'.[55] Since that recommendation was made, the NDIS has become a cornerstone for delivery of services to forensic patients. In addition, other non-government organisations provide mental health and other health services. NTLAC recommended broadening the scope of the NTLRC Report recommendation and NT Health concurs with that submission.

Recommendation 19:

That a new, standalone forensic mental health act be developed concurrently with the new mental health act (refer Recommendation 1).

Recommendation 20:

That the forensic mental health act be developed jointly by the Department of the Attorney-General and Justice and the Department of Health in consultation with other relevant NT government agencies and targeted stakeholders, with the Attorney-General and Minister for Justice having primary portfolio responsibility.

Recommendation 21:

That the forensic mental health act:

a. **include contemporary definitions of mental illness, mental disturbance, mental impairment and cognitive impairment that are consistent with like definitions in other NT legislation, including the new mental health act; and**
b. **provide criminal procedures and dispositions, available in all NT courts exercising criminal jurisdiction, for defendants who have a mental health impairment or a cognitive impairment as defined.**

Recommendation 22:

That information sharing, in compliance with the *Information Act 2002*, between government agencies, NTCAT, court clinicians, the courts, and non-government providers of health, mental health and ancillary services be facilitated through legislation or by a formal non-legislative means.

5.1 Procedure for summary criminal offences (Local Court)

Legislative powers

There are various legislative provisions that touch on the interface between the criminal justice system on the one hand and mental and/or cognitive impairment on the other. For matters in the Local Court the main provisions are in Part 10 of the MHRSA and Part 4 of the *Sentencing Act 1995*. Mental health orders under Part 4 of the *Sentencing Act 1995* are not confined to the Local Court. They were also beyond the scope of the discussion paper, but will need to be reviewed as part of the development of a single forensic act.

Briefly, Part 10 of the MHRSA sets out the powers of a court exercising summary jurisdiction.[56]

Under Division 1, the court may get pre-assessment advice about whether a person needs treatment and whether there are resources available and can then order an assessment report. The report must state whether the person satisfies the criteria for involuntary admission, or involuntary treatment in the community, or other treatment under the MHRSA.

Under Division 2, the court must dismiss a charge unconditionally if, having received a certificate from the Chief Health Officer (CHO), it is satisfied that the defendant was suffering from a mental illness or mental disturbance at the time of carrying out the conduct for the alleged offence and the defence of 'mental illness or mental disturbance' is established. The test under section 77 is the same as the test for mental impairment under Part IIA of the Criminal Code.

a. However, stakeholders noted that the defendant must be suffering from a mental illness or mental disturbance, which is considerably narrower than a 'mental impairment' as defined in section 43A of the Criminal Code.
b. There is no power for the court to make any therapeutic supervisory order if the defence is successful. The only option is unconditional dismissal of the charge.

Under Division 3 the court may adjourn proceedings and grant bail to a defendant so that the defendant can participate in a voluntary treatment plan. The limitations are that the defendant must plead or be found guilty and must have a mental illness or mental disturbance. It is understood that voluntary treatment plans are underutilised, although the DPP sometimes uses Part 10 Division 3 to negotiate with the defence. In the first instance defence seeks to rely on section 77 (see below), the DPP advises it will not consent to jurisdiction and defence consents to entering into a voluntary treatment plan. At the end of the treatment plan the defendant comes back to court and the charges are dismissed, or the person is dealt with under the *Sentencing Act 1995*. If the treatment plan is not completed, the defendant can agree to an extension of up to six months. If the plan is not completed or not completed after the extension, the defendant must be dealt with under the *Sentencing Act 1995*. If a treatment plan is not appropriate the court must deal with the defendant under the *Sentencing Act 1995*.

Mental Health Diversion List

The Local Court has also established, by practice direction, a Mental Health Diversion List (MHDL).[57] It is a specialist mental health list and, although it utilises provisions of the *Bail Act 1982*, the MHRSA and the *Sentencing Act 1995*, it is not underpinned by legislation. The MHDL is a process for diverting defendants with a mental illness/mental disturbance or a cognitive impairment to a more therapeutic outcome.[58] It operates only in Darwin and has some of the features of a 'problem-solving' court.

Issues

Neither Part 10 of the MHRSA or the MHDL (and the legislation it utilises) provide clear and comprehensive pathways for dealing with defendants who suffer from a mental or cognitive impairment. There are gaps regarding who is covered and what dispositions are available to the court.

The main gaps are:

- Part 10 of the MHRSA does not provide options for dealing with persons suffering from a cognitive impairment who do not also have a mental illness or mental disturbance. They do not fall within the ambit where a therapeutic order could be made. There can be no dismissal of charges under section 77 of the MHRSA, although in the Supreme Court, a person suffering from a cognitive impairment may be found not guilty on the ground of mental impairment or not fit to stand trial.
  This means the only options are to:
  - utilise bail conditions to 'divert' the defendant and then take whatever treatment / care was undertaken while on bail into account in sentencing; and / or
  - ask the court to take the cognitive impairment into account as a sentencing factor.[59]
- If the defence under section 77(4) of the MHRSA is established, the only option is to dismiss the charge.
- There is no power to determine fitness to stand trial. If fitness were raised in a matter that could only be dealt with summarily, the court would have to grant a permanent stay. For an indictable matter

that could be dealt with summarily, a defendant raising fitness would have to be committed to the Supreme Court.

Even for defendants who are or appear to be suffering from a mental illness of mental disturbance, there is a lack of clarity about the operation and purpose of Part 10 Division 1 of the MHRSA. Voluntary treatment plans under Part 10 Division 3 are, at best, underutilised. One stakeholder was of the view that they are not used at all.

The focus of stakeholder comment was, as expected, on the deficiencies of section 77, which has been much criticised.[60] Other issues are discussed below. Recommendations regarding reform of legislative powers of courts exercising summary jurisdiction are found at the end of the discussion of section 77 and the other issues.

Section 77 and the defence of not guilty on the ground of mental illness or mental disturbance

The well-documented criticisms of section 77 relate to:

- the absence of any power to make an order other than dismissal when the defence of not guilty on the ground of mental illness or mental disturbance is established. Section 77 does not provide for any pathway that would enable supervision or treatment of a person. The result is a reluctance by the prosecution to consent to jurisdiction and sometimes a reluctance of the Local Court to exercise jurisdiction.
- The procedure set out in section 77 for determining whether the defence is established. There is a disconnect between the question asked of the CHO under section 77(2) and the ultimate question to be determined by the court under section 77(4). No other Australian jurisdiction has this intermediate step, involving a CHO or Chief Psychiatrist addressing an issue that does not bear on the ultimate issue. The NTLRC Report described the process as 'unnecessarily protracted, complicated and inefficient – and overall is an unsatisfactory process in a robust court of summary jurisdiction'.[61]

In addition, stakeholders expressed a lack of confidence in the expertise of reports provided to the court by clinicians, which may seek to serve two purposes, namely the foundation for the CHO certificate under section 77(2) and evidence on the ultimate issue for the court under section 77(4). If a report is found to be inadmissible on the ground that the writer was not an expert, the court may be left with insufficient evidence to be satisfied that the defence in section 77(4) is established. In the Supreme Court, expert evidence on the defence of not guilty on the ground of mental impairment is accepted only from a forensic psychiatrist.

The deficiencies in section 77 can lead to results where defendants are committed to the Supreme Court[62] and face being placed on an indefinite supervision order, or they plead guilty to avoid such outcome.

The NTLRC Report recommended that a Mental Health Court or MHDL be empowered to make a simplified version of a Part IIA Criminal Code supervision order limited to a 'specific period of time, no longer than 12 months, having regard to the therapeutic needs of the person'.[63] The NTLRC Report recommendation envisaged a scheme less onerous that in Part IIA of the Criminal Code. Despite the wording of Recommendation 18, the NTLRC was open to, for example, a scheme that 'incorporates the most appropriate elements of [Part IIA of the Criminal Code, Part 7 of the MHRSA and Part 4 of the *Sentencing Act 1995*]'.[64] It also envisaged that the supervision order could be custodial or non-custodial.

When consulted, the Local Court was not supportive of being empowered to impose a custodial supervision order. Noting the lack of suitable facilities outside of the mainstream correctional system, a short-term custodial supervision order would be largely indistinguishable from a sentence of imprisonment.

Regarding the operation of a supervisory order, it is proposed that AGD and NT Health work with the Local Court to finesse the features of such an order for inclusion in an exposure draft bill.

The issue of ongoing management of defendants on a supervision order was the subject of several submissions but as this issue applies also to supervision orders under Part IIA of the Criminal Code, it is dealt with below.[65]

Specialist 'problem-solving' court or list

Some stakeholders supported the establishment of a specialist Mental Health Court (exercising summary jurisdiction) or elevating the MHDL to a statutory footing. NAAJA recommended a specialised Mental Health Court with its own legislation, including provision for culturally appropriate support, co-designed with relevant stakeholders. In NAAJA's view the MHDL is not working very well, and the Practice Direction is 'missing bits' (NAAJA face-to-face meeting, 31 May 2021). NAAJA considered that a human rights approach should be taken to forensic mental health.

A Mental Health Court or statutory MHDL would accord with the recommendations in the NTLRC Report.[66]

There are mental health problem-solving courts in Victoria, South Australia, Western Australia and Tasmania. NTLAC recommended that consideration be given to establishing a joint mental health diversion/substance abuse list, with different streams, similar to South Australia's Treatment Intervention Court.

Problem-solving courts are associated with the practice of therapeutic jurisprudence. They generally feature: a specialised list; a dedicated court team; mandated community treatment; continuing (sometimes intense) supervision; rewards and sanctions, and voluntary participation.

Problem-solving courts provide the option of court-supervised 'diversion', with the sword of sentencing under sentencing legislation hanging over the defendant who does not satisfactorily participate or complete the diversion program. They are very resource intensive for courts, as they require regular court appearances to update progress. There are operational challenges for courts outside major urban centres. This is due to both a lack of suitable programs and an inability for the court to adequately undertake the therapeutic supervisory role.

A Mental Health Court or statutory MHDL would not have to adopt all the features of a problem-solving court but operational challenges outside of Darwin would exist and this could result in different levels of justice for defendants with mental or cognitive impairment, depending on where they live.

In addition, the problem-solving courts or problem-solving lists elsewhere in Australia do not have jurisdiction to consider fitness to stand trial or the defence of mental impairment. Although, the NTLRC envisioned that a specialist mental health court or MHDL would be invested with such jurisdiction this would result in even greater disparity in access to justice than having a purely diversionary function. It could mean that a defendant in Darwin would be able to raise the defence of mental impairment, but the defence would not be available to a defendant in, for example, Alyangula.

Given the scarcity of resources in the NT and the small population base, NT Health does not consider that a problem-solving court is a suitable model at this time. However, expanding and clarifying existing diversionary pathways is recommended.

Diversion

It is recommended that the potential diversionary pathway provided in Part 10 Divisions 1 and 3 be expanded, clarified and strengthened. The diversionary model in NSW and the *Crimes Act 1914* (CTH) may be used as a model.

NSW has had a regime of diversion of defendants with mental health or cognitive impairment since 1990. Similar provisions were enacted in 1990 in the *Crimes Act 1914* (CTH) for 'the summary disposition of persons suffering from mental illness or intellectual disability'.[67] During consultation on the discussion paper, NAAJA expressed support for adopting a provision based on that in the *Crimes Act 1914* (CTH).

The NSW regime was expanded and clarified in the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* (NSW), adopting some of the recommendations of the NSWLRC in its Report on Diversion.[68] In particular, section 15 of the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* (NSW) provides a list of non-exhaustive factors to provide guidance to the court when making a decision about diversion. A diversion order is not limited to treatment. It may be about providing support services (which is likely more appropriate if a person suffers from a cognitive impairment). It can last up to 12 months.

The NSW model of diversion differs from the 'problem-solving court' model in that it does not involve the intensive ongoing monitoring by the court. The focus is on diverting out of the criminal justice system rather than engaging the defendant in intensive court monitoring. The NSWLRC noted criticisms of problem-solving courts including being 'a distraction from the problem of inadequate community services'.[69] The NSW approach has been to 'mainstream' diversion avoiding such problems as so-called 'post code justice'.[70] As noted above, problem-solving courts are generally only found in urban or metropolitan centres.[71]

Regarding the advantages of diversion, the NSWLRC stated:

> *The advantages of diversion are many. It can benefit both the offender and the wider community by addressing the causes of offending, and thus reducing offending behaviour. It can reduce involvement in the criminal justice system which may be particularly detrimental for people with cognitive and mental health impairments. There may be potential cost savings associated with diversion, for example reduction in costs of incarceration or hospital readmissions*[72].

It is acknowledged that there are also disadvantages with diversion. It can net-widen. It can be a greater burden than a sanction under general sentencing law and it is generally not suitable for more serious offending. To mitigate against such disadvantages, a legislative provision giving guidance to the court when making a decision about diversion should be included.

Youth Justice Court

As noted above, Part 5 of the discussion paper did not specifically address young people in the criminal justice system who suffer from mental impairment or cognitive impairment. In addition, to the general application of the MHRSA and Part IIA of the Criminal Code, there are some provisions in the *Youth Justice Act 2005* and practice directions that reinforce the need for young people to understand proceedings and legal implications[73], including a power to obtain a report on the 'mental condition' or a youth in some circumstances[74]. However, the *Youth Justice Act 2005* provisions are not comprehensive.

Although mental health determinations are rare in the Youth Justice Court, a forensic mental health act should 'cover the field' and allow application in the Youth Justice Court when required. Consideration needs to be given to whether any modifications or safeguards are required in relation to children, including any amendments required to the *Youth Justice Act 2005*.

Beyond legislation, NTLAC noted 'very high rates of young people with complex vulnerabilities and disabilities that impact on their ability to engage with [criminal] proceedings' (NTLAC submission, p. 22) and recommended the engagement of communication intermediaries at the Youth Justice Court in Darwin and Alice Springs (NT LAC submission, p. 30). The Local Court judges noted that the forensic mental health service does not deal with children as it has no expertise. There is a need for a forensic mental health practitioner with expertise in teenagers.

Fitness to stand trial

Some stakeholders also submitted that the Local Court be empowered to determine a defendant's fitness to stand trial. The NTLRC Report recommended that questions of fitness for all matters that 'the Court of

Summary Jurisdiction would have jurisdiction to hear summarily (including minor indictable offences) … should be dealt with by the Mental Health Court or Mental Health Diversion List'.[75]

Legislation in Tasmania, South Australia, Western Australia and the Australian Capital Territory (ACT) empower magistrates' courts to determine fitness and to impose orders, including custodial supervision, on unfit defendants. In Western Australia and the ACT monitoring of custodial orders is then dealt with by the Mentally Impaired Accused Review Board and ACAT respectively. In Western Australia there is no special hearing. The processes in the other jurisdictions are complex and potentially time consuming and costly, although it is noted that, in the ACT, there is a discretion not to conduct an investigation and dismiss a charge unconditionally if certain criteria are met.[76]

In Queensland, the jurisdiction of a Magistrates Court is narrower. There is a power to dismiss simple offence charges and refer a defendant who is not fit to plead to disability or health services, as long as the defendant does not have a mental illness. There is a power to make an 'examination order' where a defendant does have a mental illness or the court cannot decide whether or not the defendant has a mental illness or another mental condition. If the charge is indictable, there are circumstances where the matter may be referred to Queensland's Mental Health Court. There appear to be gaps in the Queensland procedure, for example where the charge is indictable but the conditions in section 175 of the *Mental Health Act 2016* (QLD) for referral to the Mental Health Court are not satisfied.[77]

In recent years the NSW Law Reform Commission, the Victorian Law Reform Commission and the UK Law Commissioners have made recommendations that magistrates' courts be empowered, at least in some circumstances, to determine fitness to stand trial. None of these recommendations have been adopted in those jurisdictions. In addition, federal magistrates' courts do not have the power to determine fitness under the provisions of the *Crimes Act 1914* (CTH).

The advantages of empowering the Local Court to determine fitness to stand trial are:

- to enable defendants, in appropriate cases, to have the chance of being found not guilty in the Local Court. It is understood, anecdotally, that some defendants who may be unfit, plead guilty to avoid the risk of being dealt with in the Supreme Court under Part IIA of the Criminal Code. This would mean that some defendants are, in fact, being wrongly convicted and punished.

- to avoid matters where fitness to stand trial is raised having to be committed to the Supreme Court, where the process of determining fitness to stand trial involves a jury.

There are, however, some concerns about providing the Local Court with this power at this time. These include:

- there is very limited capacity in the NT for forensic psychiatrists to provide the necessary reports to determine fitness to stand trial. Although the number of defendants who may raise fitness in the Local Court is an unknown quantity, any increase in court reporting requirements by a forensic psychiatrist will strain resources and potentially lead to delays;

- the risk of net-widening and increased restrictions on persons charged with minor offending caught up in a complex and costly process to determine fitness to stand trial -

    - this includes remaining in the system if it appears that the person may become fit to stand trial within a particular time period (in the Supreme Court it is 12 months)[78] and

    - potentially also (depending on what powers of disposition the Local Court would have) increased costs of court-ordered supervision;

- increased court, legal and forensic psychiatry costs. Fitness procedures are complex and costly which may detract from resourcing for the provision of therapeutic services.

These risks are similar to those identified by the NSWLRC[79], which was also concerned about diminishing the role of diversion. The NSWLRC recommended that the Local Court only be empowered to determine fitness after first considering diversion.[80] As noted above, this recommendation has not been adopted in NSW. The new *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* (NSW) expanded and clarified the diversion regime in the NSW Local Court. It did not empower the NSW Local Court to consider fitness to stand trial or the defence of not guilty on the ground of mental impairment.

While there are cogent reasons to empower the Local Court (and the Youth Justice Court) to determine fitness, on balance, it is recommended that this matter be deferred and reconsidered when the forensic act has been operating for a period of time. During that time, data can be gathered to better inform the resource implications of conferring this power.

Recommendation 23:

That the forensic mental health act provide that a court exercising summary jurisdiction may:

a. **request and order assessment from the Chief Psychiatrist and, if appropriate make an admission order, where it appears the defendant may require treatment under the mental health act**
b. **divert a defendant with a mental health impairment or cognitive impairment from the criminal justice system without determining criminal responsibility**
c. **hear and determine whether a defence of mental impairment is established.**

Recommendation 24:

That the forensic mental health act clarify and simplify the process where the defence of mental impairment is raised in a court exercising summary jurisdiction and provide that where the defence is established and the court is satisfied the evidence establishes that the defendant carried out the conduct that constituted the alleged offence the court may:

a. **dismiss the charge unconditionally; or**
b. **make a non-custodial supervision order for a specific period, no longer than 12 months.**

Recommendation 25:

That the Department of Attorney-General and Justice, the Department of Health and the Department of Territory Families, Housing and Communities consult with stakeholders as to whether any modifications or safeguards are required for the application of Recommendations 22 and 23 to the Youth Justice Court, including whether any amendments are required to the Youth Justice Act 2005.

Recommendation 26:

That the issue of empowering a court exercising summary jurisdiction to determine fitness to stand trial be deferred.

5.2 Procedure for indictable criminal offences (Supreme Court)

Part IIA of the Criminal Code

Part IIA of the Criminal Code sets out the procedures and outcomes where the issue of fitness to stand trial or the defence of mental impairment is raised in a trial in the Supreme Court. Where an accused person is found not guilty on the ground of mental impairment or is unfit to stand trial but, following a special hearing, is found either not guilty on the ground of mental impairment or found to have 'committed' the offence, the

Supreme Court must make a supervision order or discharge the person unconditionally. A supervision order may be custodial or non-custodial. Supervision orders are regularly reviewed by the Supreme Court and a custodial supervision order may be varied to a non-custodial order. Conditions of either order may also be varied.

Section 43ZC of the Criminal Code provides that a supervision order is for an indefinite term. While a major review is required after the expiry of the nominal term fixed under section 43ZG[81], it is not uncommon for persons to remain on an order long after the expiry of the nominal term. The Senate Report recommended adoption of a position that 'indefinite detention is unacceptable, and that state and territory legislation be amended in line with that principle'.[82]

Stakeholders who addressed the procedure in Part IIA of the Criminal Code were supportive of reform, in particular of introducing a time limit to supervision orders. CVP noted that indefinite orders were 'inconsistent with [the] episodic nature of mental illness and [of the] recovery model' (CVP submission, p. 71).

There are also human rights concerns. As the McGrath Report stated:

> *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*.[83]

As AGD has pointed out and NT Health acknowledges, removing the availability of indefinite orders will require NT Health, in cooperation with service providers, to step in and provide appropriate supports to ensure that, by prescribing 'end dates' for supervision orders, there are no unmanageable risks to the supervised person or the rest of the community. Safeguards will need to be included in any legislative amendment. For example, the capacity for a party to make an application to extend an order before its expiration.

Although, stakeholders did not raise any other major legislative issues with Part IIA, some gaps have been identified.[84] Such gaps can be addressed during ongoing agency and stakeholder consultation as new legislation is developed.

Oversight of supervision orders

Some stakeholders submitted that, after a supervision order is made by the Supreme Court, the functions of ongoing oversight of the order should be transferred to NTCAT. This is consistent with position in most other jurisdictions and with Recommendation 10 of the McGrath Report[85] and Recommendation 16 of the Norrie Report.[86]

However, the McGrath Report noted the following caveats to transfer of oversight of forensic patients to the former Mental Health Review Tribunal (now NTCAT),[87]

> *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*.[88]

NTCAT confirmed that it would need to build the therapeutic expertise to take on such a role. The DPP also considered that NTCAT lacked the relevant expertise for this role. In the current fiscal climate and noting difficulties recruiting suitable expertise it is not recommended that resources be expended at this time to

transfer oversight of forensic patients to NTCAT. It is recommended that this issue[89] be considered at a later time.

Recommendation 27:

That Part IIA of the Criminal Code be repealed and re-enacted in the forensic act except that:

a. **supervision orders made in the Supreme Court be of a limited term**
b. **ancillary amendments to the provisions currently in Part IIA of the Criminal Code be made, as required.**

Recommendation 28:

That the transfer of jurisdiction to NTCAT to have oversight of orders made under the forensic mental health act, including the power to make decisions about detention, treatment and release of supervised persons, be considered at a later time.

5.3 Clinical Pathway for forensic clients

Do you think the legislation provides effective and appropriate clinical pathways for forensic clients? How can the Northern Territory improve this?

In response to this question, stakeholders focussed on the operational absence of a therapeutic clinical pathway for persons on a supervision order. While there is a clear need for some legislative reform, as discussed at 5.1 and 5.2, providing effective and appropriate clinical pathways for forensic clients primarily involves system and operational reform within a given legislative framework.

It is arguable that the oversight of supervision orders falls within this question, but it is addressed above.

Most responses to this question recommended that the NT Government implement the findings and recommendations of specialised reports. In particular, stakeholders supported the establishment of a stepped resource model of care for persons on supervision orders, as recommended in the McGrath Report.[90]

At agency level, work supporting the implementation of recommendations in the McGrath Report is ongoing.

Recommendation 29:

That, concurrently with the development of legislative reforms, the Department of Health continue work supporting the implementation of recommendations from the *Report on the review of forensic mental health and disability services within the Northern Territory* (McGrath Report).

Appendix A: Consultations

List of stakeholders engaged in pre-consultation phase

1. Top End Mental Health Service (TEMHS)
2. Central Australia Mental Health Service (CAMHS)
3. Solicitor for the Northern Territory (SFNT)
4. Mental Health Australia
5. NT Mental Health Coalition (NTMHC)
6. Health and Community Services Complaints Commission (HCSCC)
7. NT Community Visitor Program (CVP)
8. NT Legal Aid Commission (NTLAC)
9. Law Society NT
10. NT Coroner
11. Northern Territory Civil and Administrative Tribunal (formerly the Mental Health Tribunal) (NTCAT)
12. Office of the Public Guardian (OPG)
13. North Australian Aboriginal Justice Agency (NAAJA)
14. Darwin Community Legal Service
15. Director of Emergency Medicine, Royal Darwin Hospital
16. Aboriginal Medical Services Alliance NT (AMSANT)
17. Department of Health, Queensland Government
18. Office of the Chief Psychiatrist, Queensland Government
19. Forensic Mental Health Service, Queensland Government
20. STAR Court, Government of Western Australia

List of stakeholders engaged in consultation phase

1. Aboriginal Medical Services Alliance NT (AMSANT)
2. Batchelor Institute
3. Catholic Care NT
4. Staff of Central Australia Health Service (CAHS)
5. Chief Judge
6. Darwin Aboriginal & Islander Women's Shelter (DAIWS)
7. Darwin Community Legal Service
8. Department of Attorney- General and Justice
    a. Aboriginal Justice Unit
    b. Correctional services
    c. Prosecutions
9. Department of Corporate and Digital Development (DCDD) - Acacia
10. Department of Education
11. Department of Health (QLD)
    a. Forensic MH Service
    b. DoH
12. Department of Health (VIC)
13. Department of Health (WA)
14. Department of Local Government, Housing and Community Development
15. Department of Territory Families, Housing and Communities
16. Department of the Chief Minister
17. Disability Advocacy Service (Alice Springs)
18. Headspace
19. Health and Community Services Complaints Commission (HCSCC)
20. Ignite Potential
21. Larrakia Nation
22. Law Society NT
23. Live Well Grow Well
24. Local Court
    a. Judges
    b. MH Diversion List
    c. MH staff
25. Mental Health Association of Central Australia (MHACA)
26. Mental Health Australia
27. Multicultural Council NT
28. National Disability Services (NDS)
29. North Australian Aboriginal Justice Agency (NAAJA)
30. NT Civil and Administrative Tribunal (NTCAT)
31. NT Community Visitor Program (CVP)
32. NT Council of Social Services (NTCOSS)
33. NT Legal Aid Commission (NTLAC)
34. NT Lived Experience Network (NTLEN)
35. NT Mental Health Coalition (NTMHC)
36. NT Police, Fire and Emergency Services
37. NT Primary Health Network (NTPHN)
38. Office of Disability, NT Department of Health
39. Office of the Chief Health Officer
40. Office of the Public Guardian (OPG)
41. Palmerston Indigenous Network
42. Palmerston Youth Programs
43. Red Cross
44. Save The Children
45. Solicitor for the NT (SFNT)
46. St John Ambulance
47. StandBy – Support After Suicide
48. TeamHEALTH
49. Territory Families
50. Staff of Top End Health Service (TEHS)
51. Regional Youth Programs and Services Coordinators

Appendix B: References

[1] *Royal Commission into Victoria's Mental Health System Final Report* includes people with lived experience in its Recommendations: 4, 6, 9, 23, 25, 26, 28, 29, 30, 41, 44, 45, 50, 54, 58 and 59.
[2] Productivity Commission 2020, *Mental Health Inquiry Report* no. 95, Canberra, See for example p. 1113.
[3] Productivity Commission 2020, *Mental Health Inquiry Report* no. 95, Canberra p. 453: The Victorian Mental Illness Awareness Council is a peak body run by and for consumers, its six core beliefs are: People's experiences are respected and valued, People are experts in their own lives, People have a right to self-determination, People have capacity to make genuine choices, free from coercion, People should be safe, respected, valued and informed, People's diversity is embraced.
[4] Productivity Commission 2020, *Mental Health Inquiry Report* no. 95, Canberra p. 35.
[5] *Royal Commission into Victoria's Mental Health System – Final Report* showcases the importance of recovery and community in personal stories.
[6] *NT Mental Health Strategic Plan 2019-2025*: In Priority Area 2 the plan adopts a strengths-based, recovery-oriented approach for mental health services in the Northern Territory, p17.
[7] *Convention on the Rights of Persons with Disabilities* (CRPD) Article 12(2).
[8] *Convention on the Rights of Persons with Disabilities* (CRPD) Article 12(3).
[9] See *Mental Health and Related Services Act 1998* s 14(b)(iii), 15(d), 15A(e), 16(b)(iii), 42(2)(b). Section 126 refers to 'capable of providing informed consent'.
[10] With the exception of NSW. The *Mental Health Act 2007 (NSW)* does not provide a definition of capacity and only provides criteria for determining informed consent in relation to ECT (see s 91).
[11] See sections 7 and 8 re Decision-making capacity of the *Mental Health Act 2015* (ACT).
[12] See *Mental Health and Related Services Act 1998* sections 14(b)(iii), 15(d), 16(b)(iii), 42(2)(b).
[13] See *Mental Health Act 2015 (ACT)* s 58(2) re Psychiatric treatment orders and s 66(2) re Community care orders.
[14] See *NT Mental Health Strategic Plan 2019-2025:* Priority Area 3; also reference to the COAG 'Ten Year Roadmap for Mental Health Reform 2012-2022" was has at p. 33 Priority 1 'Promote person-centred approaches'.
[15] Productivity Commission 2020, *Mental Health Inquiry Report* no. 95, Canberra, see for example pp. 63, 164, 188, 674, 1007.
[16] Noted also *Royal Commission into Victoria's Mental Health System Final Report*, Recommendation 42.1.c) that mental health legislation needs to 'support the delivery of services that are responsive to the needs and preferences' [of service users].
[17] *Royal Commission into Victoria's Mental Health System Final Report* Volume 3 p. 145.
[18] *Royal Commission into Victoria's Mental Health System Final Report* Volume 3 p. 145.
[19] Also known as 'traditional doctors'.
[20] Productivity Commission 2020, *Mental Health Inquiry Report* no. 95, Canberra, p. 403.
[21] *Hand-In-Hand. Report On Aboriginal Traditional Medicine*, Dr Francesca Panzironi 2013
[22] Productivity Commission 2020, *Mental Health Inquiry Report* no. 95, Canberra, p. 22 and Rec. 8 on p. 67.
[23] *Mental Health Act 2016* (QLD) Section 39(1)(b) in s39 Making recommendation for assessment.
[24] *Mental Health and Related Services Act 1998* s 40(1) in s 40 On-going examinations.
[25] NT Health is committed to publishing relevant documents and has already commenced this process.
[26] Health and Community Services Complaints Commission *De-identified Investigation Report 8 August 2019*, Recommendation 8, p. 62.
[27] *Mental Health and Related Services Act 1998* s 14(b)(ii)(A), s 15(c)(i), s 15A(c)(i) and s 16 (b)(ii)(A).
[28] *Mental Health and Related Services Act 1998* s 123 Review of involuntary admissions and community management orders.
[29] *Mental Health Act 2016* (QLD) s 12(1) Treatment criteria.
[30] *Mental Health Act* 2014 (VIC) s 5 What are the treatment criteria? See also s 29 Criteria for an Assessment Order.
[31] *Royal Commission into Victoria's Mental Health System Final Report* Volume 4, p. 363.
[32] The Royal Australian & New Zealand College of Psychiatrists, *Powers and duties of psychiatrists in Australian and New Zealand Mental Health Acts: a literature review* (2017), pp. 14-15.
[33] See also Productivity Commission 2020, *Mental Health Inquiry Report* no. 95, Canberra, p. 1061: 'the number of mental health orders (both inpatient and community) has increased over the past several years'.
[34] *Royal Commission into Victoria's Mental Health System Final Report*, Volume 4, p. 364; and Recommendation 55.1.
[35] Productivity Commission 2020, *Mental Health Inquiry Report* no. 95, Canberra, p. 2. The report also referenced the expansion of community treatments and supports and their expansion as a key theme.
[36] The Productivity Commission 2020, *Mental Health Inquiry Report* no. 95, Canberra: determined 'access to appropriate housing as a key factor in the recovery of people experiencing mental ill-health.', p. 187.

[37] All other states and the ACT include specific and comprehensive leave provisions in their mental health legislations: *Mental Health Act 2015* (ACT) s 62; *Mental Health Act 2016* (QLD) s 221; *Mental Health Act 2009* (SA) s 36; *Mental Health Act* (TAS) s 60; *Mental Health Act 2014* (VIC) s 64; *Mental Health Act 2014* (WA) Part 7 Division 6; *Mental Health Act 2007 (NSW)* Part 3 Division 4.
[38] As legislated in *South Australia Mental Health Act 2009*, s 5A(1).
[39] As legislated in *Western Australia Mental Health Act 2014*, s 14(2).
[40] Productivity Commission 2020, *Mental Health Inquiry Report* no. 95, Canberra p. 1026; *Royal Commission into Victoria's Mental Health System Final Report*, Recommendation 10 (2)(b), Vol 1 p. 507:' Support Ambulance Victoria, Victoria Police and the Emergency Services Telecommunications Authority to work together to revise current protocols and practices such that, wherever possible and safe (b) responses to mental health crises requiring the attendance of both ambulance and police are led by paramedics (with support from mental health clinicians where required)'.
[41] *Criminal Code Act 1983* (NT) Part 1, Division 1 Definitions.
[42] *Health Service Act 2021* (NT) Division 5 Advisory panels.
[43] *National Safety and Quality Health Service Standards* Second Edition Action 5.35 re restraint and Action 5.36 re seclusion.
[44] NT *Correctional Services Act 2014* s 137.
[45] *National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018*, s 6.
[46] *Mental Health Act 2016* (QLD) s 271 & s 272.
[47] *Mental Health Act 2016* (QLD) s 273.
[48] *Royal Commission into Victoria's Mental Health System Final Report* Volume 4, p. 335.
[49] For example *Mental Health Act 2015 (ACT)* Division 9.2.3.
[50] *The Queen v Skeen* [2018] NTSC 28 at [45].
[51] *The Queen v KG* [2020] NTSC 24 at [32].
[52] *NT Sentencing Act 1995*, *Part 4 Mental health orders; NT Youth Justice Act 2005*, *NT Bail Act 1982* and *NT Disability Services Act 1993*.
[53] *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* (NSW), *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (VIC), *Criminal Justice (Mental Impairment) Act 1999* (TAS) and *Criminal Law (Mentally Impaired Accused) Act 1996* (WA).
[54] See section 4 (Mental health impairment) and section 5 (Cognitive impairment) of the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* (NSW).
[55] NT Law Reform Committee *Report on the interaction between people with mental health issues and the criminal justice system* May 2016, Recommendation 21.
[56] Although no definition of 'court' so unclear if ss74, 74A and 75 could apply in the SCT – sections 74A(5) and 75(5) suggest must be Local Court but the wording is unclear.
[57] *Local Court Practice Direction 33* Mental Health Diversion List.
[58] The aims of the Mental Health Diversion List are set out in 33.2 of the *Practice Direction*.
[59] Possibly under section 5(2)(e) 'intellectual capacity', 5(2)(f) 'presence of a mitigating factor' or 5(2)(s) 'any other relevant circumstance' of the *Sentencing Act 1995*.
[60] For a detailed summary see the NTLRC *Report on the interaction between people with mental health issues and the criminal justice system*, May 2016 pp. 32 -45.
[61] NTLRC *Report on the interaction between people with mental health issues and the criminal justice system*, May 2016 p. 39.
[62] See for example *Mununggur v Gordon and Mununggur v Baldwin* [2010] NTSC 82 and *Taylor v Bamber* [2011] NTSC 36.
[63] NTLRC *Report on the interaction between people with mental health issues and the criminal justice system* May 2016 Recommendation 18.
[64] NTLRC *Report on the interaction between people with mental health issues and the criminal justice system* May 2016 p. 39.
[65] See p. 48 of this report
[66] NTLRC *Report on the interaction between people with mental health issues and the criminal justice system* May 2016 Recommendations 5 to 19.
[67] NSWLRC Report 135 *People with cognitive and mental health impairments in the criminal justice system - Diversion*, June 2012.
[67] Part 1B, Division 8 *Crimes Act 1914* (CTH).
[68] NSWLRC Report 135 *People with cognitive and mental health impairments in the criminal justice system - Diversion*, June 2012.

[70] NSWLRC Report 135 *People with cognitive and mental health impairments in the criminal justice system - Diversion*, June 2012 at paragraph 11.104
[70] NSWLRC Report 135 *People with cognitive and mental health impairments in the criminal justice system - Diversion*, June 2012 at paragraph 12.5.
[71] The NSWLRC Report 135 *People with cognitive and mental health impairments in the criminal justice system – Diversion*, June 2012 did recommend supplementing the general diversion powers with a specialist list to be reserved for defendants with a cognitive or mental health impairment who face a serious prospect of imprisonment (Rec 12.3). However, that recommendation was not adopted.
[72] The NSWLRC Report 135 *People with cognitive and mental health impairments in the criminal justice system – Diversion*, June 2012 at paragraph 0.52.
[73] For example, section 61 of the *Youth Justice Act 2005* and *Practice Direction* 26.12.
[74] Section 67 of the *Youth Justice Act 2005*.
[75] NTLRC *Report on the interaction between people with mental health issues and the criminal justice system* May 2016 Recommendation 19.
[76] The Tasmania Law Reform Institute (TLRI) in its *Review of the Defence of Insanity in s16 of the Criminal Code and Fitness to Plead*, *Final Report* No. 28, December 2019 recommended a similar power be included in the *Criminal Justice (Mental Impairment) Act 1999* (TAS).
[77] See s 175(1)(b) *Mental Health Act 2016* (QLD).
[78] See s 43R *Criminal Code* (NT).
[79] Chapter 12 NSWLRC *People with cognitive and mental health impairments in the criminal justice system Criminal responsibility and consequences* Report No. 138, May 2013.
[80] Ibid Recommendation 12.1(2).
[81] This is the term equivalent to the period of imprisonment or supervision that the court considers would have been the appropriate sentence if the supervised person had been found guilty of the offence charged.
[82] Recommendation 8 Senate Standing Committee on Community Affairs Inquiry: *Indefinite detention of people with cognitive and psychiatric impairment in Australia.*
[83] David McGrath Consulting *Report on the review of Forensic Mental Health and Disability Services within the Northern Territory* January 2019, p. 66.
[84] These include: the absence of a definition of 'appropriate place', although the term is used throughout Part IIA; the CEO of the Department of Territory Families, Housing and Community is not listed as an 'appropriate person' in section 43A even though a child may be subject to an order made under Part IIA; and the arbitrary 30 day timeframe for provision of a report under section 43ZJ, which is often not able to be complied with.
[85] David McGrath Consulting *Report on the review of Forensic Mental Health and Disability Services within the Northern Territory* January 2019, p13, pp. 73-76.
[86] Norrie Report, *Report on the Independent Review of Part IIA Orders* April 2018, p. 7.
[87] The MHRT was abolished, and its jurisdiction transferred to NTCAT by the *Mental Health and Related Services Amendment Act 2020*.
[88] David McGrath Consulting *Report on the review of Forensic Mental Health and Disability Services within the Northern Territory* January 2019, p. 76.
[89] David McGrath Consulting *Report on the review of Forensic Mental Health and Disability Services within the Northern Territory* January 2019 See also recommendation 8 as a matter for review.
[90] David McGrath Consulting *Report on the review of Forensic Mental Health and Disability Services within the Northern Territory* January 2019, Recommendation 2 and p. 8.