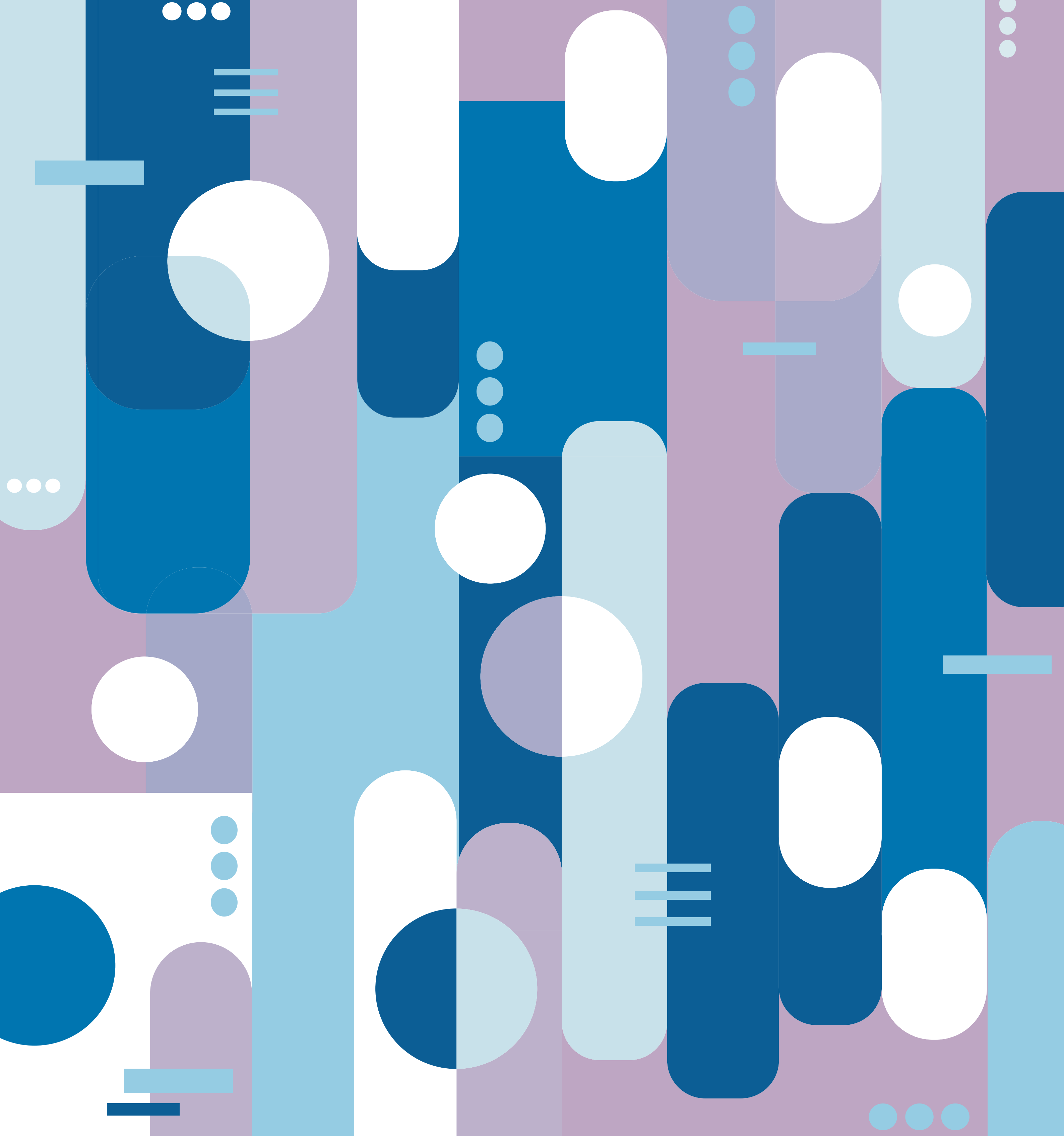


Summary of the

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

health.nt.gov.au

NORTHERN TERRITORY GOVERNMENT

Acknowledgments

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

Abbreviations

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

Terminology

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

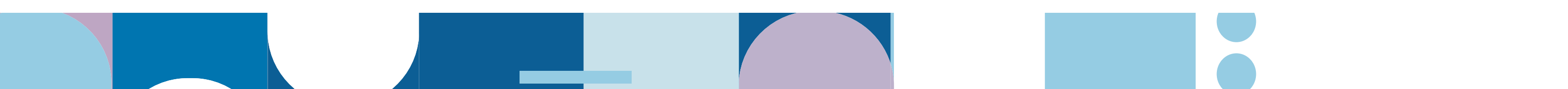
The term Aboriginal is used throughout this document to refer to all people of Aboriginal and Torres Strait Islander descent who are living in the Northern Territory.

Issues Index

Acknowledgments 2
Abbreviations 2
Terminology 2
Introduction 5
We want to hear from you 6
Part One: Principles and Rights of the Patient 9
1.1 'Recovery' 9
1.2 Capacity and informed consent 9
Part Two: Person centred approach 11
2.1 Will and preferences 11
2.2 Nominated support person 12
2.3 Cultural security 13
Part Three: Admission and Treatment 14
3.1 Involuntary admission 14
3.2 Voluntary admission 14
3.3 Youth 15
3.4 Apprehension by Police 16
3.5 Leave 17
3.4 Search and seizure powers 18
Part Four: Monitoring 19
4.1 The Chief Psychiatrist 19
4.2 Regulating restrictive practices 20
4.3 Electroconvulsive therapy (ECT) 21
Part Five: Forensic provisions 22
5.1 Procedure for summary criminal offences (Local Court) 22
5.2 Procedure for indictable criminal offences (Supreme Court) 23
5.3 Clinical pathway for forensic clients 25

Introduction

This document is the Executive Summary of the Discussion Paper for the *Mental Health and Related Services Act* 1998 *(MHRS Act)* Review. The *MHRS Act* aims to provide for the care, treatment and protection of people with mental illness. A strong legislative framework is key to underpin a mental health policy that is fit-for-purpose and aligns with contemporary values. This is why the Northern Territory Government is committed to modernising the *MHRS Act*.



We want to hear from you

This Discussion Paper raises a variety of topics about mental health legislation in the Northern Territory, and concepts that have been introduced in other Australian jurisdictions. All submissions will be carefully considered to determine the best way forward. Please include reasons for your views and if available, any evidence that supports your views.

Please submit your submission via post or email:

Post: Mental Health Alcohol and Other Drugs Branch

Department of Health,
PO Box 40596,
Casuarina, NT 0811

Email: **MHActReview.DoH@nt.gov.au**

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

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

Lifeline 13 11 14 www.lifeline.org.au

Online information and support at www.ReachOut.com

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

Submissions must be received by 31 May 2021.

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

General Matters

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

Part One: Principles and Rights of the Patient

- How can we use the legislation to promote the rights of the voluntary consumer or involuntary patient when they are receiving care?
- Will incorporating the concept of 'recovery' into the legislation change how treatment and care is administered? Why do you think so?
- Do you have any suggestions for how the legislation can be changed to include the concept of recovery?
- Do you think the legislation considers the right criteria when determining if someone has capacity?
- Does the legislation need to include any other steps to make sure that a person has given informed consent? Do any steps need to be removed?
- What is your opinion about introducing the concept of investigating the 'will and preference' of someone to help make decisions about mental health treatment and care?
- What steps should be taken to find out someone's will and preference?

Part Two: Person-centred approach

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

Part Three: Admission and Treatment

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

Part Four: Monitoring

- What do you think of the current approach to regulating the use of restrictive practices under the *MHRS Act*?
- How do you think the legislation can further promote the elimination of restrictive practices?
- The Discussion Paper proposes existing legislative functions to transfer to the Chief Psychiatrist, what do you think about these proposals?
- What do you think about how the legislation regulates electroconvulsive therapy (ECT)? Can we make improvements?'

Part Five: Forensic Provisions

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

Part One: Principles and Rights of the Patient

For full discussion, see pages 10 – 20 of the Discussion Paper.

1.1 Recovery

Under the *MHRS Act*, a person's treatment and care is to be designed to assist the person to 'live, work and participate in the community and to promote and assist self-reliance'.[1] This alludes to the concept of recovery but does not mention 'recovery' specifically. Strengthening the incorporation of 'recovery' into the *MHRS Act* would align with a number of national standards, national policies and with modern mental health legislation in Australia including Western Australia, Queensland, South Australia and the Australian Capital Territory.

What 'recovery' means is different for every single person. There is no single, standard definition of 'recovery'.[2] Sometimes when legislative concepts are not defined, it leaves it open to interpretation by decision makers, and leaves potential uncertainty. Although legislation across Australia does include the concept of 'recovery' without defining the term.

1.2 Capacity and informed consent

It is the consent of the patient that makes a medical intervention lawful.[3] From an international law perspective, a mentally ill person who has capacity to make informed consent, should be permitted to refuse treatment in the same way as another capable patient.[4] Under the *MHRS Act*, giving informed consent to treatment means that:

- The consent is freely and voluntarily given
- The person understands the effects of giving that consent
- They are able to communicate that they consent.[5]

There are a number of things that must be done before asking someone to give informed consent. This includes but is not limited to: providing a clear explanation of the proposed treatment, the risks and alternatives, and giving clear answers to all the questions the person may have about it.[6] Before being asked to consent, a person must be given adequate time to consider the information,[7] they may request another person be present,[8] and they may be assisted by an interpreter.[9]

Actively involving patients in decisions about their treatment and care recognises the importance of autonomy and independence, including the freedom to make one's own choices.[10] It is also important to acknowledge that a person's capacity to give informed consent may fluctuate in response to variations in their health and circumstances.[11]

For individuals whose psychotic illness substantially impairs their decision-making, mandatory treatment may offer the best hope of becoming well enough to actively participate in their recovery.[12] When a person lacks capacity to consent to treatment, it may be necessary for that person to be admitted as an involuntary patient. In relation to informed consent the following table sets out the criteria to involuntary admission:

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

Modernised mental health legislation aims to strike a balance between clinical concerns, promoting individual wellbeing and legal fairness.

SA

Under the *Mental Health Act 2009,* a person has impaired decision making capacity, if:

- the person is not able to understand matters of a technical or trivial nature or
- they can only retain the information for a limited time or
- they may fluctuate between having impaired decision-making capacity and full decision-making capacity or
- their decision may result in an adverse outcome, they may still have capacity to give consent.

QLD

A person has capacity to consent to be treated if the person is capable of understanding that they have an illness, the nature of the treatment proposed, the benefits and risks (and alternatives), and is capable of communicating the decision in some way. A person may have capacity to consent to be treated even though the person decides not to receive treatment.

VIC

Under the *Mental Health Act 2014*, a person's capacity to give informed consent is specific to the decision the person is about to make. A person's capacity to give informed consent may change over time and a determination that a person does not have capacity should not be made only because the person made an 'unwise' decision.

ACT

In the *Mental Health Act 2015* it is presumed that someone has decision-making capacity unless the contrary is established. Capacity is particular to the decision the person is about to make and an unwise decision or impaired decision-capacity under another Act does not mean they lack capacity.

Part Two: Person centred approach

For full discussion, see pages 21 – 40 of the Discussion Paper.

2.1 Will and preferences

A power or function conferred or imposed by the *MHRS Act* is to be exercised or performed so that 'the administration of medication to a person serves the best interests and health needs of the person'.(14) Recent reform to mental health legislation in Australia has incorporated the concept of considering the will and preference of an involuntary patient when making decisions about their treatment and care.

Recognising the will and preference of a person promotes consumer engagement and is an important step in facilitating mental health recovery.[15] Incorporating a consideration for people to participate in communication with their treating team about their care promotes 'the central premise that consumers and carers are both major stakeholders in the planning and delivery of healthcare'.[16]

WA
The *Mental Health Act 2014* defines 'best interests' and 'wishes' of a person as separate and defined concepts. Practitioners must have regard to any advance health directive, enduring power of guardianship and anything that the patient has said.

QLD
The *Mental Health Act 2016* states that when making decisions about treatment a person is encouraged to take part in making decisions about their treatment and care and their views, wishes and preferences are to be taken into account.

TAS
Under the *Mental Health Act* 2013 an approved medical practitioner may authorise treatment as being urgently needed in the patient's best interests if the necessary treatment outcome would be compromised by waiting for Tribunal authorisation.

2.2 Nominated support person

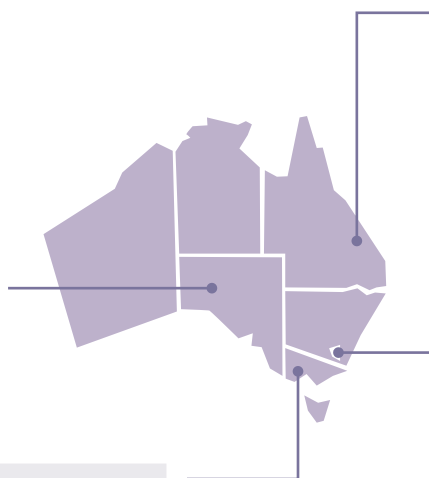
More recent reform to mental health legislation has introduced the concept of a 'nominated support person' to support the consumer in their care and treatment if they are, or become, an involuntary patient. The purpose of the role is to receive notifications, and assist the person by making sure their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

For example, in Victoria, a 'nominated person' will be informed when:

- a Court order is varied, revoked or expires
- a patient's right to communicate is restricted
- a restrictive intervention is used on a person
- a patient is absent without leave from a designated mental health service
- a second psychiatric opinion report is made (and reasonable steps must be taken to provide the nominated person with a copy of the report)
- the Chief Psychiatrist reviews a patient's treatment or makes a written direction to a service in respect of the treatment provided to the person
- the Mental Health Tribunal lists a matter for hearing and/or grants or refuses to grant an application for the performance of ECT.

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

SA
Under the Mental Health Act 2009, a nominated person:
- receives a copy of all involuntary orders that are made, varied or revoked by psychiatrists or authorised medical practitioners
- receives a copy of the statement of the patient's rights
- is allowed to lodge applications for community treatment orders, review of orders and appeal against decision
- can contact the community visitor.
- Has capacity to give consent.



QLD
The *Mental Health Act 2016,* provides that it is the right of the patient to nominate one or two support persons in the event they become an involuntary patient.

ACT
The *Mental Health Act 2015,* contains the presumption that someone has decision-making capacity unless the contrary is established. Capacity is particular to the decision the person is about to make and they must not be treated as lacking capacity because they make an unwise decision or if they have impaired decision-capacity under another Act, in relation to another decision.

VIC
Under the *Mental Health Act 2014*, a consumer can nominate a person to receive information and provide them with support in the event they become unwell and require involuntary treatment.

2.3 Cultural security

The NT has the highest per capita population of Aboriginal people in Australia, accounting for 30.3 percent of the NT population.[18] The majority of Aboriginal people, 85 percent, live in remote and very remote areas.[19] In 2018/19, NT Health provided mental health occasions of services to a total 7,914 clients. Of those occasions, 3,603 (45 percent) identified as Aboriginal.[20]

The *MHRS Act* contains provisions that require practitioners to have regard to preserving the cultural security of a consumer or patient that identifies as Aboriginal.[21] When providing treatment and care to an Aboriginal person or person identifying as Aboriginal, the person's treatment and care is to be appropriate to and consistent with the person their cultural beliefs, practices and more, taking into account the views of the person's family and community and where possible, to be provided in collaboration with an Aboriginal and Torres Strait Islander health practitioner.[22]

The legislation also provides a number of sections that reference the use of an interpreter if a person is unable to communicate adequately in English but can communicate adequately in another language.[23] In the 2018-19 Annual Report, the Community Visitor Program identified that culturally safety and lack of use of interpreters were common issues raised by in-patients.[24]

A commitment to cultural security means building a system where Aboriginal people feel safe, secure and able to participate as staff and consumers of NT Health, including mental health services, without fear of judgement or discrimination.[25] Providing culturally secure, safe and trauma informed care focused on recovery is a priority under the *NT Mental Health Strategic Plan 2019-2025*.

WA
Assessment, examination and provision of treatment must be conducted in collaboration with Aboriginal Mental Health workers or significant members of the person's community, including elders and traditional healers.

Communicating with a person must be in a language, form of communication and terms that the person is likely to understand using an interpreter if necessary and practicable.

QLD
Clinicians and decision makers must recognise and take into account the unique cultural, communication and other needs of Aboriginal people.

Treatment, care and support is to be provided in a way that is culturally appropriate and respectful.

In practicable circumstances, consumers and patients are to be assisted by an interpreter.

SA
An interpreter must be arranged if a person is to be examined but is unable to communicate adequately in English.

Mental Health Services should involve collaboration with health workers and traditional healers from the consumer's community.

Part Three: Admission and Treatment

For full discussion, see pages 41 – 77 of the Discussion Paper.

3.1 Involuntary admission

When admitting and treating a person as an involuntary patient the following principles apply under the *MHRS Act:*

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

A person can be admitted to an approved treatment facility or an approved treatment agency on an involuntary basis under three different grounds – mental illness, mental disturbance or complex cognitive impairment. Each of these grounds have different considerations and processes before a person can be admitted as an involuntary patient.

3.2 Voluntary admission

Part 5 of the *MHRS Act* regulates voluntary admissions. A person's adult guardian or decision maker can also make an application for someone to be admitted as a voluntary patient. A person cannot be admitted on a voluntary basis unless an authorised psychiatric practitioner is satisfied that they are willing to be admitted.[26]

3.3 Youth

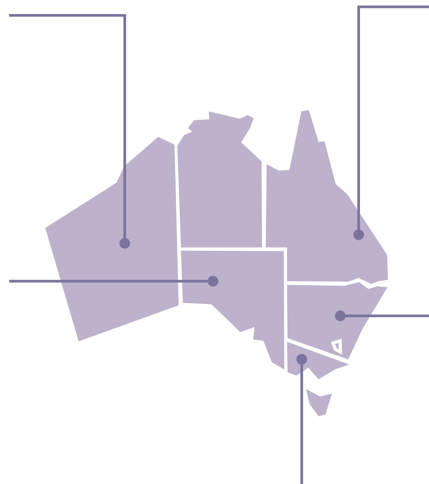
Mental health legislation across Australia sets out the criteria for health practitioners to determine capacity of the person to make treatment decisions.[27] However, across Australia there are different approaches to assessment of capacity for children, which impacts on voluntary admission and consent to treatment.

Under section 25 of the *MHRS Act*, someone 14 years or over may apply to be admitted as a voluntary patient. A parent or guardian of a person who is under 18 years may apply to have the person admitted to an approved treatment facility as a voluntary patient.[28] Part 6 of the *MHRS Act* regulates involuntary admissions andincludes reference to a 'person', without reference to age.

The transition period between childhood mental health services and adult mental health services is a vulnerable period.[29] It is accepted that a child or young person under 18 may make decisions about their own medical treatment if they are assessed as capable of understanding its significance.[30] However, another factor to consider is the consent of the parent, the authority that stems from a caring relationship and is implicitly understood to be the determination of what is best for the welfare of the child.[31]

WA
Under the *Mental Health Act 2014*, a child is presumed to not have the capacity to make a decision about a matter relating to themselves, unless the child is shown to have that capacity.

SA
The *Mental Health Act 2009* assumes that a child has decision making capacity from 16 years. Care and treatment for a child should be tailored to recognise the different developmental stages of each child.



QLD
In the *Mental Health Act 2016*, capacity to consent to treatment does not affect the common law in relation to the capacity of a minor to consent to be treated or a parent of a minor consenting to treatment of the minor.

NSW
Under the *Mental Health Act 2009*, persons under the age of 16 years may be admitted as a voluntary patient, but a person under 14 years must not be admitted as a voluntary patient if their parent objects to their admission.

VIC
Under the *Mental Health Act 2007*, patients under 18 years who don't have capacity to give informed consent may be treated with the consent of a person who has the legal authority and is reasonably available, willing and able to make the decision.

3.4 Apprehension by Police

When a person needs to be taken to an approved treatment facility or into custody for assessment, the assistance of a police officer is to be sought only as a last resort.[32] Specific criteria applies for police to apprehend a person:

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

The wording of the legislation may put police in a scenario where they are unable to apprehend the person because they are not causing harm that is 'serious' enough to justify their apprehension. This may impact on the reliance of police as a 'last resort', or it gives rise to a situation that delays apprehension until a person's condition deteriorates to satisfy the criteria.

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

SA
Requires there to be a 'significant' risk of harm to themselves or to property to justify police apprehension.

QLD
A doctor or authorised mental health practitioner may do the following in circumstances where someone is subject to an 'examination authority'.

- enter a place to find the person and
- examine the person at the place at which the person is found at the facility and
- detain the person at the place at which the person is examined, up to 1 hour if outside a facility and up to 6 hours if at the facility.

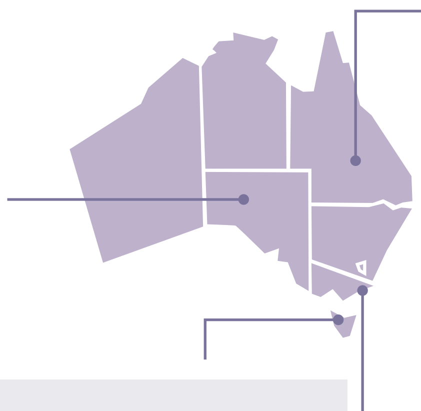
A doctor or authorised mental health practitioner may ask a police officer for help in exercising or performing this function.

3.5 Leave

An involuntary patient may be granted leave from the hospital so long as it's in accordance with the approved procedures, recorded in the appropriate form and subject to conditions determined by the authorised psychiatric practitioner.(33)

Legislating the ability for voluntary patients to take leave is not included in legislation. This may be because the ability to take leave is inherent within the rights of a voluntary patient by nature of their admission. However, there have been concerns about the ability for a voluntary patient to go on a period of leave with rules 'based on legislation for involuntary consumers [being] applied to voluntary consumers'.(34)

SA
A person admitted as a voluntary inpatient may leave the centre at any time. Leave of absence for involuntary patients may be subject to conditions.



QLD
'Escorted day leave' means the patient, for a period of not more than 1 day is authorised to leave the service and is required to remain in the physical presence of a health service employee. The legislation does not explain what considerations are taken into account to grant leave.

TAS
Leave can be for a continuous period of not more than 14 days and can be subject to conditions. An involuntary patient can ask any staff member in the approved hospital for help making an application. A practitioner who refuses leave must give notice with reasons to the applicant and place the record on the patient's clinical record.

VIC
In determining whether to grant a leave of absence, the authorised psychiatrist must have regard to the person's views and preference, the views of the person's nominated person or guardian.

3.6 Search and seizure powers

The *MHRS Act* does not permit an employee of Health to search a person on admission or authorise police to search a person when they handover a person to be assessed. The object of the *MHRS Act* is to provide for the care and treatment of a person, protecting any restriction on the liberty of the person, and any interference with their rights, dignity, privacy and self-respect is to be kept to a minimum.

Early consultations have suggested that the Queensland legislation provides a thorough model, and is summarised in the table below for consideration.

Summary of searches under the Mental Health Act 2016 (QLD) Chapter 11, Part 7 [35]

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

Part Four: Monitoring

For full discussion, see pages 78 – 98 of the Discussion Paper.

4.1 The Chief Psychiatrist

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

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

A common theme of feedback from early consultations is that the Chief Psychiatrist role provides an oversight in the quality and safety in mental health service delivery. An independent review into the role of the Chief Psychiatrist identified five core aspects of a quality and safety role: workforce development; compliance with the mental health legislation and operationalising service standards; oversight of complaints and investigations; national participation and strategic direction. This would be further supported by the suggestion for the Chief Psychiatrist to be statutorily required to Chair the Approved Procedures Quality Assurance Committee (APQAC).

NSW
The Chief Psychiatrist is not a statutory position. The Chief Psychiatrist provides professional leadership to NSW mental health clinicians, clinical input to policy development and implementation.

Common aspects of the role in ACT, TAS, SA, WA, VIC, QLD.

The Chief Psychiatrist is a statutory role that provides:

- overall responsibility for the oversight of mental health treatment and care
- promotion of patient rights
- administration of legislation and monitoring compliance
- authorising treatment facilities oversight over restrictive practices
- conducting investigation related to clinical events
- a role in interstate transfers of individuals subject to the provision of the legislation.

4.2 Regulating restrictive practices

Restrictive practices are serious interventions typically only used where there is a significant risk to the person involved or others and as a last resort. The *MHRS Act* directly prohibits the use of mechanical restraint and seclusion except in circumstances where no less restrictive method of control is applicable or appropriate.

All jurisdictions regulate restrictive practices to ensure that it is used only as a last resort when no other least restrictive option is available and to prevent harm to the patient or others. Legislation that regulates the use of seclusion, restraint or any other restrictive practice in mental health setting must address:

- preserving the fundamental human rights of the patient
- maintaining the therapeutic relationship
- ensuring the safety of patients and staff
- satisfying that the primary purpose for the use of the restrictive practice is the least restrictive means of protecting the person or others from harm.

This section aims to highlight how other jurisdictions have different approaches to the reporting of restrictive practices, post-event debriefing, notification processes and reduction and elimination planning.

SA
Restrictive practice includes the use of physical, mechanical or chemical means and seclusion. The Chief Psychiatrist may issue binding standards to provide a more flexible approach to updating records, reporting and observation standards as they can be updated without legislative amendment.

QLD
There are restrictions on the use of mechanical restraint, seclusion and physical restraint, and the appropriate use of medication. There are also requirements for reduction and elimination planning.

VIC
Restrictive interventions involve the use of physical and mechanical restraint and seclusion and applies to all patients, regardless of legal status or age.

- They are only used after all reasonable and less restrictive options have been tried or considered
- They are only be used where necessary to prevent serious and imminent harm to the person or another person.
- When a restrictive intervention is used, the person's key support people must be notified and a report provided to the Chief Psychiatrist.

4.3 Electroconvulsive therapy (ECT)

ECT is a therapeutical medical procedure for the treatment of severe psychiatric disorders, with a primary purpose to relieve psychiatric symptoms.[34] ECT is a safe and effective treatment for 'where its antidepressant effect is found to be superior to medication strategies,'[35] but should only be administered 'for an illness where there is adequate evidence of effectiveness and an appropriate clinical indication.'[36]

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is responsible for the training, educating and representation of psychiatrists in Australia and New Zealand. RANZCP in Position Statement 74 was critical of 'legislative restrictions' that reduced access to ECT.[37]

In August 2019, the Northern Territory's Health and Community Services Complaints Commission (HSCC) released an Investigative Report that was critical of section 66 of the MHRS Act that legislated for 'emergency' administration of ECT (i.e. without prior authorisation from NTCAT).

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

Australian Capital Territory

Part 9.2 (sections 147-166) of the Mental Health Act 2015 (ACT) regulates electroconvulsive therapy. Adults with decision making capacity can consent to ECT.[38] For an adult who does not have decision making capacity, ECT may be administered if the person has an advance consent direction consenting to ECT, it is administered in accordance with the direction, and they do not refuse or resist.[39]

However, ECT may also be administered to a person without decision making capacity if it is administered in accordance with an ECT order or an emergency ECT order. These orders are made by application to the ACT Civil and Administrative Tribunal (ACAT) by the Chief Psychiatrist or a doctor.[40]

Part Five: Forensic Provisions

For full discussion, see pages 99 – 118 of the Discussion Paper.

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

The Criminal Code contains two type of offences: summary offences and indictable (serious) offences. There are different procedures for each type of offence, depending on which court has jurisdiction to hear it.

5.1 Procedure for summary criminal offences (Local Court)

Summary offences and some indictable offences are prosecuted in the Local Court which is the Northern Territory's court of summary jurisdiction.

Under the *MHRS Act*, the Local Court can:

✓ Request the person accused of a summary offence to be assessed, and for a report to be produced that states whether the accused satisfies the criteria for involuntary admission on the grounds of mental illness or mental disturbance[41]

✓ Adjourn the proceedings and make an order for the accused to be detained in an approved treatment facility for an examination and assessment

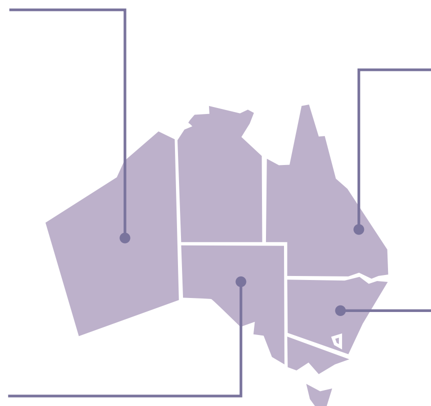
✓ Accept a voluntary treatment plan if the accused pleads guilty to the summary offence, and dismiss the charge upon completion of the voluntary treatment plan[42]

✓ Dismiss the charge if satisfied that the accused was suffering from a mental illness or mental disturbance, didn't know the nature and quality of their conduct, or that the conduct was wrong, or was not able to control their actions[43] (section 77 certificate)

✗ Does not have the power to determine unfitness to stand trial for summary matters.

WA
Under the *Criminal Law (Mentally Impaired Accused) Act 1996*, the court of summary jurisdiction must determine whether the accused will be mentally fit to stand trial within 6 months. If it is satisfied, the court must make an order to dismiss the charge and either release the accused, or make a custody order.

SA
The court of summary jurisdiction can dismiss a charge, make a supervision order, adjourn the proceedings, remand the defendant on bail, or make any other order the court sees fit.



QLD
The Magistrates Court may dismiss a complaint 'for a simple offence' under the *Mental Health Act 2016* if the court is reasonably satisfied, on the balance of probabilities, that the person charged with the offence was, or appears to have been, of unsound mind when the offence was allegedly committed or is unfit for trial.

NSW
The new *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* strengthens the ability for the Local Court to make diversion orders with mental health or cognitive impairments in summary proceedings.

5.2 Procedure for indictable criminal offences (Supreme Court)

Some offences are too serious, complex or difficult to be dealt with by the court of summary jurisdiction (Local Court). In the NT, indictable offences of this nature are tried in the Supreme Court. The Supreme Court has review and decision-making jurisdiction under Part IIA of the Criminal Code.

Under Part IIA of the Criminal Code, the Supreme Court can:

✓ Hear evidence about the accused's mental competence and determine whether the defence of mental impairment is established[(44)]

✓ Hear evidence about the accused's fitness to stand trial[(45)]

✓ Hold a special hearing to hear evidence about the accused's fitness to be tried[(46)]

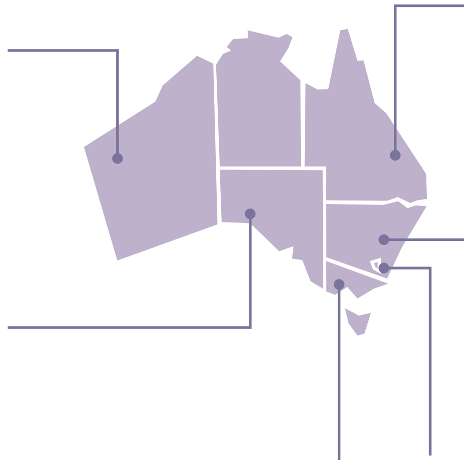
✓ Make a supervision order[(47)] (custodial or non-custodial)[(48)] where it is found the defendant is not guilty because of mental impairment

✓ Review supervision orders. Unless varied, reviewed or revoked, a supervision order is for an indefinite term[(49)]

✓ Request reports to be produced to inform the court when reviewing a supervision order.[(50)]

WA
The *Criminal Law (Mentally Impaired Accused) Act 1996* sets out the types of orders that may be made where a person is found not guilty on account of unsoundness of mind, including custody orders. A custody order requires a mentally impaired accused to be 'detained until released by an order of the Governor'.

SA
The court may specify in a supervision order with reference to the term of imprisonment that would otherwise have applied had the defendant been found guilty of the matters alleged. At the end of the limiting term, a supervision order lapses.



QLD
A forensic order under the Criminal Code allows the involuntary treatment and care of a person for a mental condition and, if necessary, detention in an authorised mental health service.

NSW
The *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* (NSW) introduced a special verdict of 'act proven but not criminally responsible because of mental health or cognitive impairment'. This verdict is not a conviction, but recognises that the accused did in fact, commit the act.

VIC
Where an accused is acquitted on grounds of mental impairment, the *Crimes* (*Mental Impairment and Unfitness to be Tried) Act 1997* requires the court to either declare the person liable to supervision, or release them unconditionally. Supervision orders are of indefinite duration.

ACT
The court can refer matters to Australian Capital Territory Civil & Administrative Tribunal (ACAT) to hear evidence about the accused's mental competency. If ACAT determines the accused is unfit to plead, the court conducts a 'special hearing' and make any orders it thinks appropriate.

5.3 Clinical pathway for forensic clients

The 'clinical pathway' for a person describes the systems and processes that recognise how a person's treatment needs are supported to ensure progress towards attaining independence and physical, mental, social and vocational ability is evaluated and supported. The Forensic Review identified the 'prevailing need for a clear clinical pathway of care with stepped resource model for persons subject to Part IIA orders and others in contact with the criminal justice system.'[51]

QLD

The *Mental Health Act 2016* (QLD) establishes the role of an 'authorised doctor' as an appointed role with responsibilities for providing appropriate patient treatment and care for forensic patients.

NSW

The new *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* provides flexibility to the court to make an order to nominate a 'responsible person' that is appropriate to support the defendant's clinical pathway.

Endnotes

[1] *Mental Health and Related Services Act 1998* (NT) s9(c).

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

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

[4] Callaghan, S and Ryan, C. *Rising to the human rights challenge in compulsory treatment – new approaches to mental health law in Australia,* Australian & New Zealand Journal of Psychiatry 46(7) 611-629.

[5] *Mental Health and Related Services Act 1998* (NT) s7(2).

[6] *Mental Health and Related Services Act 1998* (NT) s7(3).

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

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

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

[10] Wolstenholme, M. *Current Trends in Mental Health Legislation*, Government of Western Australia Mental Health Commission, p. 10.

[11] *PBU & NJE v Mental Health Tribunal* [2018] VSC 564 at [148].

[12] Wolstenholme, M. *The experiences of the legal processes of involuntary treatment orders: Tension between the medical and legal frameworks.* International Journal of Law and Psychiatry 38 p 45.

[13] *Mental Health and Related Services Act 1998* (NT) s8(d).

[14] Lenagh-Glue, J et al (2018) A MAP to mental health: the process of creating a collaborative advance preferences instrument *New Zealand Medical Journal* p19.

[15] Lenagh-Glue, J et al (2018) A MAP to mental health: the process of creating a collaborative advance preferences instrument *New Zealand Medical Journal* p18.

[16] Department of Treasury and Finance, Population – NT Economy: Aboriginal Population (2018)

[17] Department of Treasury and Finance, Population – NT Economy: Aboriginal Population (2018)

[18] Mental Health Occasions of Service and Number of Clients estimated 2018/2019

[19] *Mental Health and Related Services Act 1998* (NT) s8(g).

[20] *Mental Health and Related Services Act 1998* (NT) s11.

[212] *Mental Health and Related Services Act 1998* (NT) ss 7(5), 8(f), 87(2), 134(2).

[22] Community Visitor Program Annual Report 2018-2019, p 13.

[23] NT Department of Health, *NT Health Aboriginal Cultural Security Policy*

[24] *Mental Health and Related Services Act 1998* (NT s27(2).

[25] *Mental Health Act* (WA) s18; *Mental Health Act 2016* (QLD) s14; *Mental Health Act 2009* (SA) s5A.

[26] *Mental Health and Related Services Act 1998* (NT) s25(1)-(2).

[27] Taking the Next Step Forward Building a Responsive Mental Health and Addictions System for Emerging Adults, Mental Health Commission of Canada by Jenny Carver, Mario Cappelli, Simon Davidson, Warren Caldwell, Marc-André Bélair, Melissa Vloet (2015)

[28] *Gillick v West Norfolk and Wisbech Area Health Authority & Anor* [1986] 1 AC 112; *Secretary, Department of Health and Community Services (NT) v JWB and SMB* (1992) 175 CLR 218.

[29] *Secretary, Department of Health and Community Services (NT) v JWB and SMB* (1992) 175 CLR 218 at [26].

[30] *Mental Health and Related Services Act 1998* (NT) s10(b).

[31] *Inquest into the death of Linden Alan Kunoth* [2019] NTLC 028 at [16].

[32] Community Visitor Program Annual Report 2018-2019, p25.

[33] Weiss, Hussain, Ng et al. (2019) Royal Australian and New Zealand College of Psychiatrists professional practice guidelines for the administration of electroconvulsive therapy. *Australian and New Zealand Journal of Psychiatry 53: 609-623.*

[34] Mahli, Bassett, Boyce et al. (2015) Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for mood disorders. *Australian and New Zealand Journal of Psychiatry 49(12) 1-185, 41.*

[35] Weiss, Hussain, Ng et al. (2019) Royal Australian and New Zealand College of Psychiatrists professional practice guidelines for the administration of electroconvulsive therapy. *Australian and New Zealand Journal of Psychiatry 53: 609-623.*

[36] Royal Australian and New Zealand College of Psychiatrists (2019) Position Statement 74: Electroconvulsive Therapy (ECT) Available [On-line] at https://www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/electroconvulsive-therapy-(ect).

[37] Mental Health Act 2015 (ACT) s148.

[38] Mental Health Act 2015 (ACT) s149(2).

[39] Mental Health Act 2015 (ACT) ss153(2) and 160(1) .

[40] *Mental Health and Related Services Act 2016* Fact sheet (QLD).

[41] *Mental Health and Related Services Act 1998* (NT) s74A(6).

[42] *Mental Health and Related Services Act 1998* (NT) Part 10, Division 3.

[43] *Mental Health and Related Services Act 1998* (NT) s77.

[44] *Criminal Code Act 1983* (NT) s43C.

[45] *Criminal Code Act 1983* (NT) s43J.

[46] *Criminal Code Act 1983* (NT) s43T.

[47] *Criminal Code Act 1983* (NT) s43Z.

[48] *Criminal Code Act 1983* (NT) s43ZA.

[49] *Criminal Code Act 1983* (NT) s43ZC.

[50] *Criminal Code Act 1983* (NT) ss 43ZK-43ZL.

[51] David McGrath Consulting (2019) *Review of Forensic Mental Health and Disability Services Recommendation* 10(a) *available at:* https://health.nt.gov.au/__data/assets/pdf_file/0007/727657/Report-on-the-Forensic-Mental-Health-and-Disability-Services-within-the-NT.pdf.

NORTHERN TERRITORY

Summary of the

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

Northern Territory Department of Health

www.health.nt.gov.au

NORTHERN TERRITORY GOVERNMENT