

Guide to Exposure Draft Mental Health Bill 2024

INTRODUCTION

The Department of Health (**NT Health**) is working to reform mental health legislation in the Territory.

The main legislation in the Territory is the *Mental Health and Related Services Act 1998* (**MHRSA**). The MHRSA commenced on 1 February 2000. Quite significant amendments have been made to the MHRSA since then. However, until 2020 there had been only one major review. That review took place in 2003.

Mental health law is an evolving area, and it is important for the Territory to keep up to date with today's standards and expectations. Principles, objects, processes and practices that were best practice in the past may no longer be fit for purpose.

Significant developments in the approach to mental health law in Australia include:

- In July 2008 Australia ratified the Convention on the Rights of Persons with Disabilities (**CRPD**). Mental health legislation since that time has been moving from the 'best-interests' approach in the MHRSA towards a person-centred, rights-based approach reflecting the principles in Article 3 of the CRPD –
 - respect for inherent dignity, individual autonomy (including the freedom to make one's own choices) and independence,
 - non-discrimination, and
 - full and effective participation and inclusion in society.
- In February 2021 the Royal Commission into Victoria's Mental Health System released its final report (**RCVMHS Report**). The RCVMHS Report set out a 10-year plan to systemically and culturally reform mental health and wellbeing services in Victoria, including a new Mental Health and Wellbeing Act. The *Mental Health and Wellbeing Act 2022* (VIC) commenced in September 2023.
- In February 2023 the South Australian Law Reform Institute (**SALRI**) published its Review of the *Mental Health Act 2009* (SA) making recommendations about reforms to mental health law and practice. SALRI was clearly influenced by the RCVMHS Report.

In 2020, NT Health commenced a new review of the MHRSA (**MHRSA Review**).

- In December 2020, NT Health released a discussion paper that asked open-ended questions about how the regulation of mental health treatment and care in the Territory could be improved.
- During 2020 and 2021 extensive stakeholder consultation took place.

- In 2022 a consultation report (**Consultation Report**) setting out the findings of the review and making recommendations was released. The full Consultation Report is at [Mental Health and Related Services Act 1998 Review](#).

The main finding of the Consultation Report was that the MHRSA is outdated and no longer fit for purpose. A new act with new rights-based, person-centred principles and clear regulation of processes is needed. The Consultation Report made 18 recommendations about a new law to replace the MHRSA.

The Consultation Report also made 10 recommendations for a new act about people with a mental illness or a cognitive impairment who come into contact with the criminal justice system.

The Northern Territory Government asked NT Health to develop a draft bill based on the 18 recommendations for a new law to replace the MHRSA. NT Health has developed an exposure draft Mental Health Bill 2024 (**Exposure Draft Bill**).

The Department of the Attorney-General and Justice is the lead agency for the development of the bill for a new act about people with a mental illness or a cognitive impairment who come into contact with the criminal justice system.

NT Health is consulting on the Exposure Draft Bill with the general public and stakeholders, to help the Northern Territory Government finalise a Bill to be introduced in the Legislative Assembly.

The Exposure Draft Bill does not have the scope of the *Mental Health and Wellbeing Act 2022* (VIC). It does not deal with the provision of and providers of 'wellbeing services'. The Exposure Draft Bill mainly deals with how treatment and care can be provided to the small group of people who experience mental illness and need to be detained in hospital to be provided with that treatment and care or receive compulsory treatment and care for mental illness or mental disorder in the community. The scope of the Exposure Draft Bill is limited to the provision of mental health services delivered primarily through public health services and hospitals.

This guide gives an overview and explains key parts of the Exposure Draft Bill. It should be read together with the Exposure Draft Bill. The guide does not explain every clause of the Exposure Draft Bill.

Summary of main features

The Exposure Draft Bill:

- Enhances the rights of persons with a mental illness or a mental disorder and their participation in their own treatment and recovery through –
 - including rights-based principles to guide the provision of treatment and care for mental illness and mental disorder, and
 - promoting the agency and autonomy of persons with a mental illness or mental disorder by
 - introducing a presumption of decision making capacity,
 - promoting the use of advance personal plans and the provision of treatment and care consistent with those plans,
 - requiring any communication to be in a language, form of communication and terms that the person is likely to understand. This may, for example, involve using an interpreter, or choosing a time to communicate when the person is not highly distressed,

- introducing the concept of providing appropriate supports to assist a person to make or participate in making decisions, and to communicate effectively,
- introducing the role of a nominated support person.
- Introduces improved pathways to compulsory treatment. This includes providing health practitioners with clear powers and duties and clear processes for exercising those powers and performing those duties.
- Legislates a health-led response to a mental health crisis.
- Improves and expands regulation of the use of restrictive interventions.
- Introduces the statutory role and functions of a Chief Psychiatrist.

The Exposure Draft Bill also acknowledges:

- the importance of language and terminology, for example, by minimising the use of 'patient' in favour of 'person', and
- the wide range of users of mental health legislation. It aims, therefore, to enhance readability by, for example –
 - including, at the beginning of each of the substantive, or practical, parts of the Bill (**Parts 3 to 17**) a clause setting out the purpose of the Part,
 - stepping out the processes that must be followed before any decision about compulsory assessment or treatment can be made.

Consultation process

NT Health would like to hear what you think about the Exposure Draft Bill.

The closing date for submissions is **31 May 2024**.

Electronic copies of submissions are preferred. Please send submissions or queries to MHActReview.DoH@nt.gov.au. Alternatively, submissions may be sent by post to:

Att: Senior Policy Officer
Mental Health, Alcohol and Other Drugs Branch
PO Box 40596
Casuarina NT 0811

Submissions may be made publicly available and may be published on the NT Health website, unless they are clearly marked as 'confidential'. NT Health may draw upon the content of submissions made and may publicly quote or refer to submissions unless a submission is clearly marked 'confidential'.

Part 1 Preliminary matters

Part 1 of the Exposure Draft Bill sets out preliminary matters that provide a foundation to how the proposed legislation is to be interpreted and applied. These provisions include:

- main objects and guiding principles,
- application provisions,
- general definitions used through the Exposure Draft Bill and important definitions.

Clause 3 sets out the main objects. In contrast to section 3 of the MHRSA, which is very detailed and focussed on the mechanics of the legislation, clause 3 is simple and high-level. There are two objects –

1. that the highest standard of treatment and care be given to persons with a mental illness or mental disorder, and
2. that treatment and care be given in a way that is least restrictive of the person’s rights and liberties and that promotes the person’s recovery and full participation in the community.

The Exposure Draft Bill applies only to persons who have a mental illness (**clauses 18 and 19**) or a mental disorder (**clause 17**). Mental disturbance and a primary diagnosis of complex cognitive impairment will no longer be grounds for compulsory treatment under mental health legislation. Mental disturbance in the MHRSA appears to focus on behavioural issues that do not relate to underlying mental ill health. The narrower ground of mental disorder, modelled on the definition in the *Mental Health Act 2009* (NSW), replaces mental disturbance.

Guiding principles

Clauses 4 to 11 set out the guiding principles underpinning the administration of the proposed legislation. The guiding principles, drafted to give effect to recommendation 3 of the Consultation Report, are designed to promote a person-centred, rights-based and culturally appropriate approach to mental health service delivery.

While there are some rights-based principles in the MHRSA, the principles in the Exposure Draft Bill are more holistic and aspirational. The principles are founded in the promotion and protection of the rights, dignity and autonomy of a person with a mental illness or mental disorder (**clause 5**).

Principle of least restriction

Clause 11 introduces the principle of least restriction. Running through the Exposure Draft Bill there are many references to doing something in the ‘least restrictive way’. There are two parts to this principle; it is both aspirational and practical.

The aspirational part of the principle is expressed in **clause 11(1)** and **(3)**, which provide that treatment and care are to be given with the least possible restriction to the person’s rights, dignity and autonomy with the aim of promoting their recovery and full participation in community life; and that a way is least restrictive if it adversely affects those rights to the extent required to protect the safety of the person or another person.

The practical part of the principle is expressed in **clause 11(2)** and **(4)**. The views and preferences of the persons should be key determinants of the nature of their recovery and participation (**clause 11(2)**); and there is a list of ways set out in **clause 11(4)** that are less restrictive than receiving compulsory treatment and care. These less restrictive ways apply where a person does not have decision making capacity to give

informed consent to treatment and care. If a person does have decision making capacity, then the treatment and care they receive is not 'instead of' compulsory treatment and care.

The less restrictive ways in which treatment and care may be given instead of compulsory treatment and care are:

- under an advance consent decision consenting to the treatment and care (made under the *Advance Personal Planning Act 2013*),
- with the consent of an adult guardian (appointed under the *Guardianship of Adults Act 2016*),
- with the consent of a decision maker (appointed under the *Advance Personal Planning Act 2013*),
- with the consent of a parent (if the person is a child), or
- with the consent of the Families CEO (if the person is a child in the Families CEO's care).

(The Families CEO is a shorthand way of referring to the CEO of the agency administering the *Care and Protection of Children Act 2007*. Currently, that is the Department of Territory Families, Housing and Communities.)

Advance planning

The Consultation Report recommended that a new mental health act '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' (recommendation 4(b)).

Embedded into the principle of least restriction and found throughout the Exposure Draft Bill are provisions that require health practitioners and the Northern Territory Civil and Administrative Tribunal (**NTCAT**), at key points when making decisions about treatment and care (including whether to make an order for compulsory treatment) to have regard to a person's wishes, views and preferences, including wishes, views and preferences expressed in an advance personal plan.

Since 2014, under the *Advance Personal Planning Act 2013*, adult Territorians with decision making capacity have been able to make an advance personal plan, which can be relied on if their capacity to make decisions later becomes impaired. As part of an advance personal plan an adult may:

- make a decision for future health care action (an advance consent decision),
- make a statement of their views, wishes and preferences (an advance care statement); and
- appoint one or more persons to make decisions for the person (a decision maker).

Although a person can make an advance personal plan setting out their decisions, wishes, views and preferences about future mental health treatment and care, Territorians have not made use of advance personal plans for this purpose. There are probably many reasons for this, including that the form for making an advance personal plan is not well suited to setting out decisions, wishes, views and preferences about future mental health treatment and care.

Rather than setting up an entirely separate scheme about future planning for mental health treatment and care, the approach in the Exposure Draft Bill is to support and promote the use of advance personal plans. The main ways that the Exposure Draft Bill supports and promotes the use of advance personal plans are:

- provision of treatment and care in accordance with an advance consent decision is a way in which treatment and care may be provided 'in a less restrictive way' (**clause 11(4)(a)**),
- in deciding whether the compulsory treatment criteria (**clause 23**) apply, an authorised psychiatrist or an authorised psychiatric practitioner must have regard to a person's wishes, views and preferences, including wishes, views and preferences expressed in an advance personal plan (**clause 88**),
- if an authorised psychiatrist makes an order for compulsory treatment and the person has an advance consent decision, the authorised psychiatrist must follow the procedural requirements in **clause 100**. This clause discussed in greater detail in this guide under the heading **Part 5 Treatment orders**,
- in deciding whether to vary an order for compulsory treatment an authorised psychiatrist must have regard to a person's wishes, views and preferences, including wishes, views and preferences expressed in an advance personal plan (**clause 119** and **clause 120**).
- provisions similar to **clause 88** and **clause 100** apply when an authorised psychiatrist or an authorised psychiatric practitioner makes a treatment decision about a person receiving compulsory treatment (**clause 200** and **clause 203**). These clauses are discussed in greater detail in this guide under the heading **Part 8 Treatment and care**,
- Electroconvulsive therapy may be administered to an adult who has consented to it in an advance consent decision (**clause 214(2)**),
- the Chief Psychiatrist must make a policy about when it is not appropriate for a person to receive treatment or care for a mental illness or mental disorder in accordance with an advance personal plan (**clause 303(1)(b)**).

Application of main objects and guiding principles

A person performing a function or exercising a power under the proposed legislation, which includes all decisions about treatment and care of people with a mental illness or a mental disorder, must –

- have regard to the main objects and guiding principles, and
- perform the function or exercise the power in a way that is consistent with the main objects and guiding principles (**clause 12**).

All communication (such as giving advice, an explanation, information, notice or a reason) with a person is to be in a language, form of communication and terms that the person is likely to understand (**clause 13**).

Effective communication is central to supporting a person to make or participate in making decisions about their treatment and care. Effective communication may involve using an interpreter, speaking to the person in a space where they feel comfortable, or providing other appropriate supports (**clause 21** explains the meaning of and gives examples of appropriate supports).

Interpretation and important concepts

Division 4 deals with interpretation.

Clause 16 sets out definitions used in the Exposure Draft Bill. Where a definition is only used in one Part of the Exposure Draft Bill, the definition is found at the beginning of that Part.

Some of the terms used frequently in this guide are set out in the table below, with a reference to any equivalent term in the MHRSA.

term	meaning	MHRSA
approved mental health facility	Premises or part of premises declared by the Minister, that provides treatment and care to persons on an inpatient treatment order or a temporary inpatient treatment order.	approved treatment facility
approved mental health service	A body or organisation declared by the Minister, that provides treatment and care to persons on a community treatment order or a temporary community treatment order.	approved treatment agency
assessment order	An order made by a medical practitioner or authorised mental health practitioner, that authorises a compulsory psychiatric assessment by an authorised psychiatrist or an authorised psychiatric practitioner.	recommendation for psychiatric examination
authorised mental health practitioner	A psychologist, registered nurse, occupational therapist, Aboriginal and Torres Strait Islander health worker, social worker or paramedic. Appointed by the Chief Psychiatrist.	designated mental health practitioner
authorised psychiatrist	A psychiatrist appointed by the CEO. A psychiatrist is a medical practitioner who is registered under the Health Practitioner Regulation National Law in the speciality of psychiatry.	falls within the definition of authorised psychiatric practitioner
authorised psychiatric practitioner	A psychiatric registrar, or a medical practitioner employed or engaged by NT Health at an approved mental health facility or an approved mental health service. Appointed by the Chief Psychiatrist.	authorised psychiatric practitioner
community treatment order	An order made by NTCAT, authorising compulsory treatment in the community for a mental illness or a mental disorder.	community management order
inpatient treatment order	An order made by NTCAT, authorising compulsory treatment for a mental illness at an approved mental health facility.	an order made by NTCAT under section 123(5)(a)
person in charge	The person in charge of an approved mental health facility or an approved mental health service.	person-in-charge

temporary community treatment order	An order made by an authorised psychiatrist, authorising compulsory treatment in the community for a mental illness or a mental disorder.	interim community management order
temporary inpatient treatment order	An order made by an authorised psychiatrist, authorising compulsory treatment for a mental illness at an approved mental health facility.	no equivalent
temporary treatment order	An order made by an authorised psychiatrist, authorising compulsory treatment for a mental illness or a mental disorder. The order may be a temporary community treatment order or a temporary inpatient treatment order.	no equivalent
treatment order	An order made by NTCAT authorising compulsory treatment in an approved mental health facility or, in the community, by an approved mental health service.	an order made by NTCAT under section 123(5)(a) or (c)

Clause 17 defines ‘mental disorder’. Modelled on section 15 of the *Mental Health Act 2009* (NSW), this is a narrower concept than ‘mental disturbance’ under the MHRSA.

Clauses 18 and 19 replicate section 6 of the MHRSA, with some modernisation. Clause 18 sets out the meaning of mental illness. A person must not be considered to have a mental illness simply because of one or more of the circumstances listed in clause 19. Clause 19(2) has been included to clarify how the use of alcohol or other drugs may be an indication that a person has a mental illness. Similar provisions are found in other mental health acts in Australia.

Clause 20 defines treatment for a mental illness or mental disorder. Treatment does not include detention. It also does not include a restrictive intervention. From a clinical perspective the use of a restrictive intervention is not treatment.

Clauses 22 and 23 introduce new concepts, central to the operation of the proposed legislation.

- **Clause 22** sets out the compulsory assessment criteria. These are the criteria that must be satisfied before an order for a compulsory psychiatric assessment (**Part 4**) can be made. These clearer and more stringent criteria replace section 34 of the MHRSA.
- **Clause 23** sets out the compulsory treatment criteria. These are the criteria that must be satisfied before an order for compulsory treatment can be made.

Clause 21 introduces the concept of appropriate supports. This is a shorthand term for measures which can reasonably be provided to a person to assist the person to—

- make decisions and participate in decision making, or
- understand information and their rights, or
- communicate their wishes, views, preferences, questions, or decisions.

Providing appropriate supports is a means of promoting a person’s autonomy in decision making.

Clause 26 acknowledges that, although examinations or assessments are best conducted in person, sometimes this is not practicable. The demographics of the Territory raise challenges of health equity, which 'telehealth' can assist in mitigating.

The MHRSA provides that some but not all examinations and assessments can be conducted remotely. Clause 26 promotes health equity by clarifying that, where it is not practicable, any examination or assessment can be conducted remotely.

Part 2 Decision making capacity and informed consent

Part 2 sets out the fundamental concept that an adult has full decision making capacity, unless the contrary is proved, and provides a clear definition of capacity to provide informed consent. It also addresses the capacity of children to consent to treatment.

The MHRSA has no presumption of decision making capacity. This is inconsistent with principles of autonomy and recovery. It is also inconsistent with:

- the CRPD,
- mental health legislation in other Australian jurisdictions, and
- other Territory legislation, namely the *Advance Personal Planning Act 2013*, the *Guardianship of Adults Act 2016* and the *Health Care Decision Making Act 2023* (uncommenced), all of which provide that an adult is presumed to have decision making capacity.

Clause 27 sets out the presumption of decision making capacity. This presumption applies to adults.

Clause 28 explains that the common law for the decision making capacity of children continues to apply. At common law, parents have the power to consent to medical treatment for a child. This power becomes less as the child matures. The age at which a child has capacity to make a health care decision depends on the individual child. This is sometimes referred to as being 'Gillick competent' (after *Gillick v West Norfolk and Wisbech Area Health Authority & Anor* [1986] AC 112).

Clause 29 explains the meaning of decision making capacity. Capacity is decision specific and can fluctuate. A person has capacity if they can make a decision with practical and appropriate support.

Clause 29 has been drafted to align, as far as possible, with similar provisions in the *Advance Personal Planning Act 2013*, the *Guardianship of Adults Act 2016* and the *Health Care Decision Making Act 2023* so that in Territory legislation there is a consistent approach to human rights and the point at which interference with those rights is authorised. It is, however, not as detailed as the provisions in those acts because many of the matters that are considered in determining decision making capacity are considered at an earlier stage in mental health legislation, namely when a person is not to be considered to have a mental illness or a mental disorder (see **clause 19**).

Clause 30 sets out what it means to give informed consent. People should make their own decisions wherever possible. If a person needs help, they should be provided with support.

Part 3 Protection of rights

Part 3 is about the rights of persons who come within the ambit of the proposed legislation. Putting these provisions near the beginning of the Exposure Draft Bill emphasises their importance.

Part 3 provides for:

- preparation by the Chief Psychiatrist of a statement of rights of a person who is being assessed or receiving treatment and care under the proposed legislation,
- requirements about giving the statement of rights to a person being assessed or receiving treatment and care under the proposed legislation and to other persons,
- the right of a person admitted to an approved mental health facility or detained at an approved mental health facility under an assessment order to communicate with others,
- some limitations in communicating about a person being assessed or receiving treatment and care under the proposed legislation to other people, and
- the role and functions of a nominated support person.

Statement of rights

A statement of rights is a document that sets out the rights of a person while the person is being assessed or receiving treatment and care under the proposed legislation. The Chief Psychiatrist must prepare and publish a statement of rights.

The statement of rights will set out the rights of a person, for example the right to communicate with other people, to receive information and to have support when making decisions. It must also include information about the right to make a complaint and how to make complaints and information about the Community Visitor Program (see **Part 14** for provisions about the Community Visitor Program).

A statement of rights must be given to a person and to specified support people at key points during the person's assessment and treatment. When a person is given a statement of rights, all reasonable steps must be taken to make sure that the statement is explained to the person.

Right of person to communicate

The Exposure Draft Bill provides that a person being assessed or receiving treatment and care in an approved mental health facility has the right to communicate with other people; for example, to seek legal advice, to talk to a community visitor, and to have contact with friends and family. Communication may be, for example, by phone, messaging or receiving visits.

A person being assessed or receiving treatment and care in an approved mental health facility will also have the right to receive and send mail.

The right to communicate exists in the MHRSA. The Exposure Draft Bill makes these rights a bit clearer and more modern, acknowledging electronic forms of communication that did not exist 25 years ago.

The Exposure Draft Bill also clarifies that the right to receive visitors and communicate by other means is the right of the person being assessed or receiving treatment and care in an approved mental health facility.

If the person does not wish to have communication with another person, they have the right to refuse to communicate.

The right to communicate is not absolute. Apart from practical restrictions such as receiving visitors 'at reasonable times' there may be a need for therapeutic or safety reasons to restrict a person's right to communicate.

Unlike the MHRSA, the Exposure Draft Bill provides for *restriction* of the right to communicate (**clause 39**) but not *denial* of the right. This better reflects the person-centred, human rights approach of the Exposure Draft Bill and facilitates application of the principle of least restriction. It is also a more accurate descriptor, as the right to communication is never to be absolutely denied or prohibited.

Any restriction must be the least restrictive practicable to protect the health, safety and wellbeing of the person or another person.

Communication with the following cannot be restricted:

- a legal representative,
- the Chief Psychiatrist,
- NTCAT,
- a community visitor,
- the Commissioner for Health and Community Services Complaints, or
- the Families CEO, if the person is a child in the Families CEO's care.

If a person's right to communicate has been restricted, they are to be informed that this is happening, the reasons why and that they have a right to apply to NTCAT to review the decision to restrict their right. Relevant persons are also to be notified of the restriction and the reasons for it.

Communication about a person

Throughout the Exposure Draft Bill there are provisions that require health practitioners to communicate about a person with family, carers and supporters at defined points of care. These provisions apply unless person says they do not want the communication to happen (**clause 44**) or, for communication to a parent about a child, it is not in the best interests of the child (**clause 45**).

Where a decision is made not to communicate with a child's parent where the Exposure Draft Bill otherwise requires communication, this must be recorded in the child's medical record along with the reasons for not communicating.

Nominated support person

Recent mental health acts in Australia have introduced the role of a 'nominated support person'.

A person who might lose decision making capacity in the future can choose a nominated support person at a time when they do have capacity. The nominated support person then supports them to make and participate in making decisions, exercise their rights and express their wishes and preferences, if they become unwell and receive compulsory treatment and care.

The Consultation Report recommended that a new mental health act should include provisions about the appointment, role, and responsibilities of nominated persons to support a person. Most stakeholders considered that a person should be able to nominate more than one support person.

In **Division 5**, the Exposure Draft Bill sets out –

- how a person appoints one or two nominated support persons (and how they can revoke the appointment),
- how a nominated support person accepts and resigns from an appointment,
- the role of a nominated support person, which involves both supporting the appointing person and advocating for them (**clause 52**), and
- the duty of the person in charge of an approved mental health facility or an approved mental health service to take all reasonable steps to support a nominated support person to carry out their role, including by consulting them and giving them information at key points when the appointing person is receiving treatment and care (**clause 53**).

Parts 4 and 5: Treatment pathways

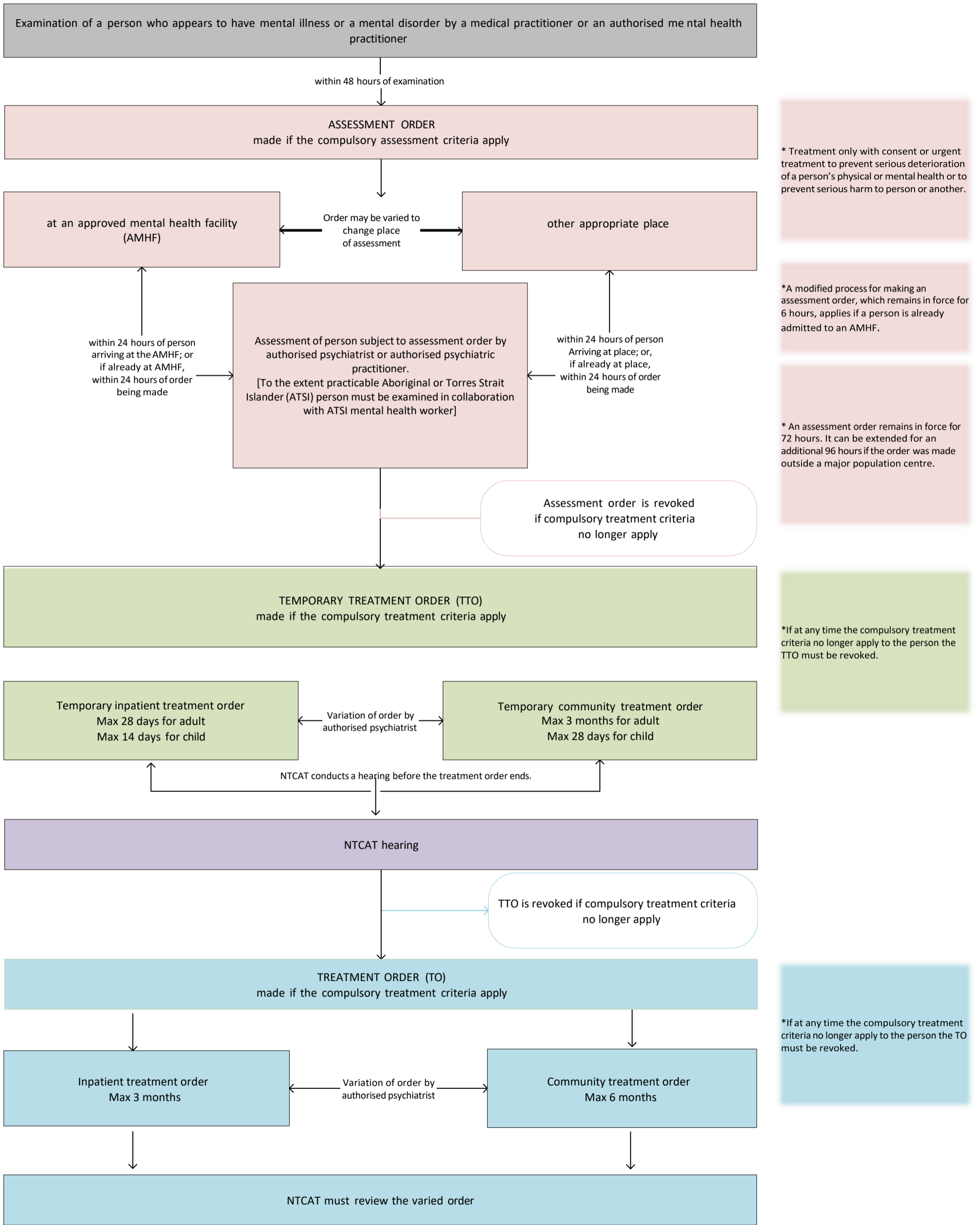
Parts 4 and 5 set out the proposed processes and pathways that lead to and authorise a person being given compulsory treatment and care for a mental illness or a mental disorder. During the MHRSA Review, a strong message from both health practitioners and persons with lived experience of mental illness was that the provisions in the MHRSA are confusing and are not stepped out clearly.

The Consultation Report recommended that a new mental health act clearly set out the criteria and processes for admission to an approved treatment facility and the criteria for compulsory treatment and that it strengthen the oversight and accountability mechanisms to reflect the guiding principles.

The provisions in Parts 4 and 5 of the Exposure Draft Bill step out what needs to happen at each point of the treatment pathways, namely who are the decision-makers, what decisions are to be made and what criteria are to be applied in making the decisions. Flowcharts are included to illustrate the stages of the proposed treatment pathways.

Flow chart 1 illustrates an overview of the proposed treatment pathway.

Flow chart 1 Compulsory assessment and treatment



* Treatment only with consent or urgent treatment to prevent serious deterioration of a person's physical or mental health or to prevent serious harm to person or another.

* A modified process for making an assessment order, which remains in force for 6 hours, applies if a person is already admitted to an AMHF.

* An assessment order remains in force for 72 hours. It can be extended for an additional 96 hours if the order was made outside a major population centre.

* If at any time the compulsory treatment criteria no longer apply to the person the TTO must be revoked.

* If at any time the compulsory treatment criteria no longer apply to the person the TO must be revoked.

Part 4 Examination and assessment

Part 4 sets out the first two steps in the proposed treatment pathways:

- a medical practitioner or an authorised mental health practitioner examines a person to –
 - decide whether the compulsory assessment criteria apply,
 - make an assessment order if the compulsory assessment criteria apply and there is no less restrictive way to for a psychiatric assessment to be conducted, and
- an authorised psychiatrist or an authorised psychiatric practitioner conducts a psychiatric assessment to decide whether the compulsory treatment criteria apply.

An assessment order replaces the recommendation for psychiatric examination in section 34 of the MHRSA.

The term 'psychiatric assessment' replaces 'psychiatric examination' and 'examination and assessment' in the MHRSA.

A medical practitioner or an authorised mental health practitioner may make an assessment order after they examine a person. An assessment order can only be made if the practitioner is satisfied that the compulsory assessment criteria apply.

At the first step, from examination by a medical practitioner or an authorised mental health practitioner until a psychiatric assessment is conducted, the Exposure Draft Bill improves upon the MHRSA by:

- setting a higher threshold and providing greater guidance about what a medical practitioner or an authorised mental health practitioner needs to be satisfied of before making an assessment order,
- clarifying the process if a person is already admitted to an approved mental health facility (**Part 4 Division 2 subdivision 2**), and
- setting clearer and tighter time frames for the period between conducting an examination and conducting a psychiatric assessment.

At the second step, the psychiatric assessment, the Exposure Draft Bill:

- establishes one clear set of criteria for authorising compulsory treatment,
- sets a higher threshold to be met before compulsory treatment may be authorised,
- sets clear time frames for conducting a psychiatric assessment.

The Exposure Draft Bill also clarifies what treatment can be provided before a temporary treatment order is made.

Flow chart 2 illustrates the process for making an assessment order and conducting the psychiatric assessment authorised by an assessment order.

Flow chart 2 Assessment orders

Compulsory assessment criteria:

- (a) the person appears to have a mental illness or mental disorder; and
- (b) because the person appears to have a mental illness or mental disorder, the person appears to need immediate treatment to prevent:
 - (i) serious deterioration in the person's mental or physical health; or
 - (ii) serious harm to the person or anyone else; and
- (c) if an assessment order is made, the person can be assessed; and
- (d) there is no less restrictive way reasonably available for the person to be assessed.

A modified process for making an assessment order, which remains in force for 6 hours, applies if a person is already admitted to an AMHF.

- ### Restrictions on treatment while an assessment order is in force
- Treatment for a mental illness or mental disorder may only be given:
- (a) if the person consents to the treatment; or
 - (b) if the practitioner is satisfied that the person needs urgent treatment to prevent -
 - (i) serious deterioration in the person's mental or physical health; or
 - (ii) serious harm to the person or anyone else.

A person presents at or is brought to a medical practitioner or authorised mental health practitioner (practitioner)

For example, at an Emergency Department or a community health clinic.

The person appears to have a mental illness or mental disorder

The practitioner must – identify themselves to the person, inform the person that the practitioner will examine them and take all reasonable steps to explain the purpose of the examination

An examination must be conducted in the least restrictive way and in the least restrictive environment practicable.

The practitioner examines the person to determine if the compulsory assessment criteria apply
[To the extent practicable, Aboriginal or Torres Strait Islander (ATSI) person must be examined in collaboration with ATSI mental health worker]

Examination must be in person if practicable. If not practicable it may be conducted remotely. If conducted remotely, a health professional must be physically present with the person.

The practitioner must consider any relevant information communicated by the person and may consider any other relevant information

within 48 hours of examination

Assessment order made if the compulsory assessment criteria apply

The order must be in the approved form and include all specified information, including the AMHF or other appropriate place at which the assessment is to be conducted.
The assessment order may authorise the person to be transported to the AMHF or other place.

at an approved mental health facility (AMHF)

other appropriate place

Order may be varied to change place of assessment

The practitioner must notify the person in charge of the AMHF or an authorised psychiatrist or authorised psychiatric practitioner at the appropriate place where the psychiatric assessment is to be conducted.

The practitioner:
(a) informs the person to whom the order applies of the order;
(b) explains to the person the purpose and effect of the order; and
(c) gives the person a copy of the order and a statement of rights

The practitioner must take all reasonable steps to notify other relevant persons that an assessment order has been made

The psychiatric assessment under the order must be conducted within 24 hours after the order is made or within 24 hours of when the person arrives at the AMHF or other place of assessment.

The person is assessed to determine if the compulsory treatment criteria for the making of a temporary treatment order apply (see flow chart 3)

An authorised psychiatrist or an authorised psychiatric practitioner may extend an assessment order -

- for up to a further 48 hours if the extension is necessary and the person was not at the AMHF or other place of assessment when the order was made; and
- for up to a further 24 hours if an additional assessment is required.

An assessment order ends when:

- it expires
- an authorised psychiatrist or an authorised psychiatric practitioner revokes it because the compulsory treatment criteria do not apply, or
- an authorised psychiatrist makes a temporary treatment order

Assessment orders

An assessment order authorises an authorised psychiatrist or an authorised psychiatric practitioner to conduct a psychiatric assessment without the consent of a person. The purpose of the assessment is to determine whether a person has a mental illness or mental disorder and needs compulsory mental health treatment and care.

In most cases an assessment order would be made by a medical practitioner or an authorised mental health practitioner after they have examined a person. The exception (see below) is where a person is already admitted to an approved mental health facility.

The Exposure Draft Bill sets out four pathways for making an assessment order:

- where the person is not admitted to an approved mental health facility (**Division 2 subdivision 1**),
- where the person is admitted to an approved mental health facility (**Division 2 subdivision 2**),
- where NTCAT makes an order for compulsory examination (**Division 3**).
- when a person has been taken into care and control in response to a mental health crisis (**Part 7 Division 2**).

Assessment order for person who is not admitted to an approved mental health facility – Division 2 subdivision 1

A medical practitioner or an authorised mental health practitioner may make an assessment order for a person if they have examined the person within the previous 48 hours and are satisfied that the compulsory assessment criteria apply. The examination must be conducted:

- in person unless this is not practicable. It may then be conducted remotely with the safeguard that a health professional is present with the person being examined, and
- in the least restrictive way and in the least restrictive environment.

The compulsory assessment criteria (**clause 22**) replace section 34 of the MHRSA. During the MHRSA Review, health practitioners and people with lived experience raised the operation of section 34 as a key area of confusion. There is very little guidance in section 34 on how a practitioner may be satisfied that a person meets the statutory criteria for making a recommendation for psychiatric examination. The compulsory assessment criteria provide clearer guidance to practitioners and set a higher threshold that needs to be satisfied before making an assessment order.

The provisions in **Division 2 subdivision 1** set out that an assessment order:

- authorises a compulsory psychiatric assessment at an approved mental health facility or other appropriate place, and detention of the person at the facility or place until the assessment is conducted,
- may authorise transport to the approved mental health facility or other place where the assessment is to be conducted,
- may authorise the detention of a person while waiting for transport for a period up to 24 hours, which may be extended if the person is outside a major population centre,

- expires after 72 hours, unless it is made outside a major population centre and is likely to expire before the person can get to the approved mental health facility or other place where the assessment is to be conducted, and
- must be revoked if the compulsory assessment criteria no longer apply to the person.

If the person is in a major population centre, neither the duration of an assessment order nor the period of detention can be extended. Major population centre will be defined by regulation.

Including a power to extend the duration of an assessment order (**clause 62**) and to extend the time a person may be detained pending transport if the person is outside a major population centre (**clause 63**) recognise the difficulties of remoteness in the Territory.

Regarding detention, it might not be possible to transport a person to an approved mental health facility or other place appropriate for a psychiatric assessment within the 24-hour period allowed in clause 63(1). Therefore, it is proposed that the time may be extended, in 24-hour increments, if the practitioner who made the assessment order considers it necessary; for example, if the weather is too bad for a Careflight plane to come to Groote Eylandt to transport a person to Darwin, the practitioner may authorise a continuation of detention for another 24 hours. If, in those 24 hours, transport can still not take place, the practitioner may authorise a continuation of detention for a further 24 hours. The maximum length of detention is 168 hours outside a major population centre.

Even if extended to the maximum duration, the periods in **clause 62** and **clause 63** are much shorter and more tightly monitored than the 14 days duration of a recommendation for a psychiatric examination under section 34(7) of the MHRSA.

It is anticipated that the powers to extend the duration of an assessment order or to extend the period of detention pending transport should be rarely used. The reason is that a psychiatric assessment may be conducted remotely. Using the Groote Eylandt example again, an assessment order could potentially specify that the place for psychiatric assessment is the Alyangula Health Clinic, and a psychiatric assessment could be conducted online rather than in person.

Assessment order for person at approved mental health facility – Division 2 subdivision 2

Separate provisions are set out in **clause 70** to **clause 78** about the process for making an assessment order for a person who is already receiving treatment and care at an approved mental health facility, but not under a compulsory order. Submissions made during the MHRSA Review highlighted a lack of transparency and understanding about how and why a person's admission status may be changed from 'voluntary' to 'involuntary'.

The provisions in **clause 70** to **clause 78** provide clarity about the processes that apply before a decision can be made to change the admission status of a person by making a temporary treatment order.

Many of the provisions that are appropriate for making an assessment order under **Division 2 subdivision 1** will not be necessary or appropriate. Where the person is already admitted to an approved mental health facility it is proposed that:

- no examination is needed,
- a medical practitioner or a senior registered nurse may make an assessment order if –
 - the person wishes to leave the approved mental health facility against medical advice, and

- the medical practitioner or senior registered nurse is satisfied that the compulsory assessment criteria apply to the person,
- the assessment order lasts for 6 hours. There is no justification for a longer period, as the person is already at the approved mental health facility.

This pathway is not set out in **flow chart 2** except as a note that there is a modified process for making an assessment order if a person is already admitted to an approved mental health facility. After an assessment order is made, the same information and notifications as for an assessment order under **Division 2 subdivision 1** apply and a psychiatric assessment is authorised.

Restrictions on treatment while assessment order is in force – Division 2 subdivision 3

While an assessment order is in force, a person may only be given treatment for their apparent mental illness or mental disorder if they give informed consent or treatment is required as a matter of urgency (**clause 79**).

Order for compulsory examination – Division 3

An order for compulsory examination replaces section 37 of the MHRSA. The Exposure Draft Bill reframes NTCAT's power as the power to make an order rather than issue a warrant; in that way moving away from the language of wrongdoing.

This power is included to cover the very small number of cases where it may not be possible for a medical practitioner or an authorised mental health practitioner to conduct an examination, but the situation has not reached the stage of requiring an emergency response to a mental health crisis. An order for compulsory examination authorises entry to a person's premises and an involuntary examination.

At the point a person is examined by a medical practitioner or an authorised mental health practitioner, the processes set out in **flow chart 2** apply.

Psychiatric assessment

When an assessment order has been made, an authorised psychiatrist or an authorised psychiatric practitioner must conduct a psychiatric assessment to decide whether the compulsory treatment criteria (**clause 23**) apply.

The compulsory treatment criteria are a single set of criteria that must be satisfied before compulsory treatment may be given to a person. In contrast, the MHRSA sets out different criteria for admission depending on whether the admission is on the ground of mental illness, mental disturbance or complex cognitive impairment. There are also different criteria for making an interim community management order.

The threshold for compulsory treatment is also raised to focus on the person's present condition and the need for *immediate* treatment.

In deciding whether the compulsory treatment criteria apply to a person an authorised psychiatrist or authorised psychiatric practitioner must have regard to:

- person's wishes, views and preferences, whether expressed at the time or in an advance personal plan,
- to the extent practicable, the views of family, carers and supporters.

If the assessment order applies to a person who is already admitted to an approved mental health facility, the psychiatric assessment must take place within 6 hours; otherwise, the assessment order expires, and the person may no longer be detained.

In all other cases the psychiatric assessment must take place within 24 hours of:

- the assessment order being made, if the person is already at the approved mental health facility or other place where the assessment is to be conducted. For example, if the person presents at the Emergency Department of Royal Darwin Hospital and is examined there by a doctor, who makes an assessment order, or
- the person's arrival at the approved mental health facility or other place where the assessment is to be conducted.

It is, however, recognised that, in the second scenario (when the person arrives from somewhere else), there may need to be some flexibility to extend the time frame for conducting the psychiatric assessment. For example, a person may be intubated for transport to an approved mental health facility and still be sedated when they arrive or, due to injury, they may require surgery on arrival. It might not be possible to conduct the psychiatric assessment within 24 hours. In such circumstances, it is proposed that an authorised psychiatrist or authorised psychiatric practitioner may extend the period of detention in 24-hour increments for a maximum of an additional 48 hours, if they consider it necessary to finish or carry out the assessment (**clause 85**).

After conducting the psychiatric assessment an authorised psychiatrist or an authorised psychiatric practitioner:

- must revoke the assessment order if the compulsory treatment criteria no longer apply, or
- may extend the assessment order for up to a further 24 hours to allow for another psychiatric assessment if they are unable to determine whether the compulsory treatment criteria apply.

If the compulsory treatment criteria do apply, an authorised psychiatrist may revoke the assessment order and make a temporary treatment order. Only an authorised psychiatrist has the power to make a temporary treatment order.

Part 5 Treatment orders

Part 5 sets out the processes and requirements for making orders authorising compulsory treatment in an approved mental health facility or in the community. These orders are:

- a temporary treatment order – made by an authorised psychiatrist, and
- a treatment order – made by NTCAT.

A temporary treatment order may be for treatment in the community (temporary community treatment order) or in an approved mental health facility (temporary inpatient treatment order).

A treatment order may be treatment in the community (community treatment order) or in an approved mental health facility (inpatient treatment order).

Part 5 also deals with associated matters:

- variation of the terms of a temporary community treatment order or a community treatment order (**Division 5 subdivision 1**),
- variation of a temporary treatment order or a treatment order, from inpatient to community or from community to inpatient (**Division 5 subdivision 2**),
- revocation of a temporary treatment order or a treatment order (**Division 5 subdivision 3**),
- granting leave of absence from an approved mental health facility to a person on a temporary treatment order or a treatment order (**Division 6**),
- absence without leave from an approved mental health facility (**Division 7**), and
- absence of a person on a temporary community treatment order or a community treatment order (**Division 8**).

Temporary treatment orders – Division 2

Under the MHRSA, until treatment is authorised by NTCAT, only emergency treatment under section 55(2) can be administered to a person admitted to an approved treatment facility as an involuntary patient. A person may be detained for up to 14 days before the admission is reviewed by NTCAT.

There is a bit more leeway for compulsory treatment in the community, as an authorised psychiatric practitioner may make a 14-day interim community management order under section 45 of the MHRSA.

In practice, it is understood that, relying on section 55(2), treatment often commences before the NTCAT hearing. This practice lacks transparency. It is inaccurate to call treatment over a potential 14-day period 'emergency treatment'. In most other Australian jurisdictions, a psychiatrist is empowered to make an order that enables treatment to commence prior to review by a mental health review tribunal. This model better reflects the appropriate delineation of functions between the treating psychiatrist, who is in a position to make clinical judgements and decisions about treatment and care, and a tribunal, whose primary function is to review treatment and care decisions, not make them.

The Exposure Draft Bill introduces a power for an authorised psychiatrist to make a temporary treatment order if satisfied that the compulsory treatment criteria apply to the person. This may be a temporary

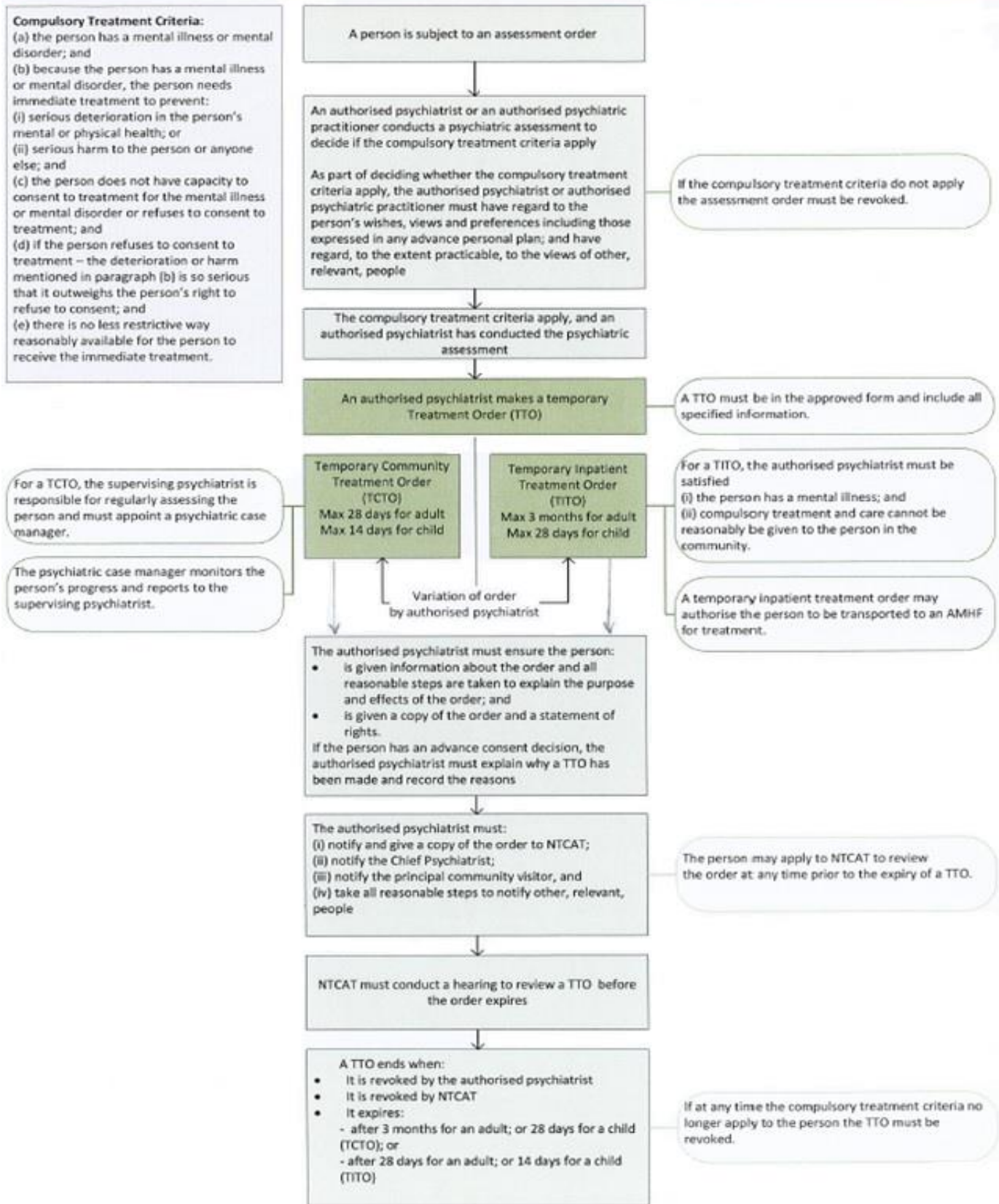
community treatment order or a temporary inpatient treatment order. This reform increases transparency about the provision of treatment.

To ensure adequate safeguards, the Exposure Draft Bill provides:

- only an authorised psychiatrist, not an authorised psychiatric practitioner, may make a temporary treatment order,
- an authorised psychiatrist may only make a temporary treatment order if they have personally conducted a psychiatric assessment (in other words, an authorised psychiatrist cannot rely on a psychiatric assessment conducted by an authorised psychiatric practitioner),
- the only ground for making a temporary inpatient treatment order is mental illness,
- the duration of a temporary inpatient treatment order is 28 days for an adult, 14 days for a child,
- a temporary community treatment order may be made on the grounds of mental illness or mental disorder,
- the duration of a temporary community treatment order is 3 months for an adult, 28 days for a child,
- an authorised psychiatrist cannot extend a temporary treatment order, and
- the person to whom a temporary treatment order applies may apply to NTCAT for review during the time a temporary treatment order is in effect.

Flow chart 3 illustrates the processes and requirements for making a temporary treatment order.

Flow chart 3 Temporary treatment orders



Credit: styled on flow charts published by the Victorian Department of Health as part of the *Mental Health and Wellbeing Act 2022 Handbook*.

Flow chart 3 notes that, in deciding whether the compulsory treatment criteria apply, regard is to be given to a person's wishes, views and preferences, including those expressed in an advance personal plan.

Clause 100 sets out what an authorised psychiatrist must do if they make a temporary treatment order, and the person has made an advance consent decision. In other words, a decision is made that although giving treatment under an advance consent decision is less restrictive than under a temporary treatment order (**clause 11(4)(a)**) it is not clinically appropriate.

An advance consent decision does not, legally, affect the power to make an order for compulsory treatment under the MHRSA and that position is maintained under the Exposure Draft Bill. An authorised psychiatrist may make a temporary treatment order despite a person having made an advance consent decision.

The policy reason for enabling an advance consent decision to be overridden is to balance the need to ensure the integrity of the right to consent to health treatment in advance with the competing need to mitigate risk to the health and safety of the person or another person.

However, unlike the MHRSA, the Exposure Draft Bill includes requirements that provide accountability and transparency, namely:

- if an authorised psychiatrist makes a temporary treatment order and the person has made an advance consent decision the authorised psychiatrist must explain to the person why the order is being made, record those reasons and report to the Chief Psychiatrist (**clause 100**), and
- the Chief Psychiatrist must make a policy about when it is not appropriate for a person to receive treatment or care for a mental illness or mental disorder in accordance with an advance personal plan (**clause 303(1)(b)**).

Flow chart 3 also notes that an authorised psychiatrist may:

- vary a temporary inpatient treatment order to a temporary community treatment order, and
- vary a temporary community treatment order to a temporary inpatient treatment order.

The provisions setting out when variation of the type of order may be made, the factors that need to be considered, and the recording and notification requirements are in **Division 5 subdivision 2**.

In practice, there is some fluidity between inpatient and community treatment. The Exposure Draft Bill provides clarity and transparency about when and how changes in the place of treatment may be made. Clarity and transparency are missing in the MHRSA. For example, the MHRSA does not cater for a scenario where a person who is on a Community Management Order becomes acutely unwell, requiring admission to an approved treatment facility, but who has not failed to comply with the Community Management Order.

To ensure that NTCAT has oversight if a temporary treatment order is varied, the Exposure Draft Bill provides that:

- NTCAT must be notified of the variation and must fix a hearing date (**clause 123**),
- variation of a temporary treatment order (inpatient to community) does not change the duration of the order,
- the duration of a temporary treatment order (community to inpatient) cannot be longer than 28 days. For example, a temporary community treatment order is made on 4 March, with a duration of 3 months (ending on 3 June). On 6 March it is varied to a temporary inpatient treatment order. The

varied order cannot end any later than 3 April. Otherwise, the person could potentially be detained on a temporary inpatient treatment order for almost three months without NTCAT review.

Treatment orders – Division 3

A treatment order authorises the provision of compulsory mental health treatment and care. A treatment order is made by NTCAT following review of a temporary treatment order or review of an existing treatment order.

These provisions replace section 123 of the MHRSA. Provisions setting out NTCAT’s jurisdiction, constitution and procedures are in **Part 15**.

NTCAT must conduct a hearing to review a temporary treatment order before the order expires. When an authorised psychiatrist makes a temporary treatment order, they must notify NTCAT. NTCAT will set a date for the review. If the temporary treatment order is revoked before the date set for the review, the authorised psychiatrist must notify NTCAT, and the hearing will be vacated.

Following a hearing NTCAT must:

- make a treatment order if the compulsory treatment criteria apply, or
- revoke the temporary treatment order or treatment order if not satisfied that the compulsory treatment criteria apply.

NTCAT may make a community treatment order that can be no longer than 6 months in duration; or an inpatient treatment order that can be no longer than 3 months in duration. This is the same as the length of orders under the MHRSA.

The provisions in **Division 5** about variation and revocation of temporary treatment orders also apply to variation and revocation of treatment orders.

An authorised psychiatrist may:

- vary an inpatient treatment order to a community treatment order (**clause 119**), and
- vary a community treatment order to an inpatient treatment order (**clause 120**).

To ensure that NTCAT has oversight if a treatment order is varied, the Exposure Draft Bill provides that:

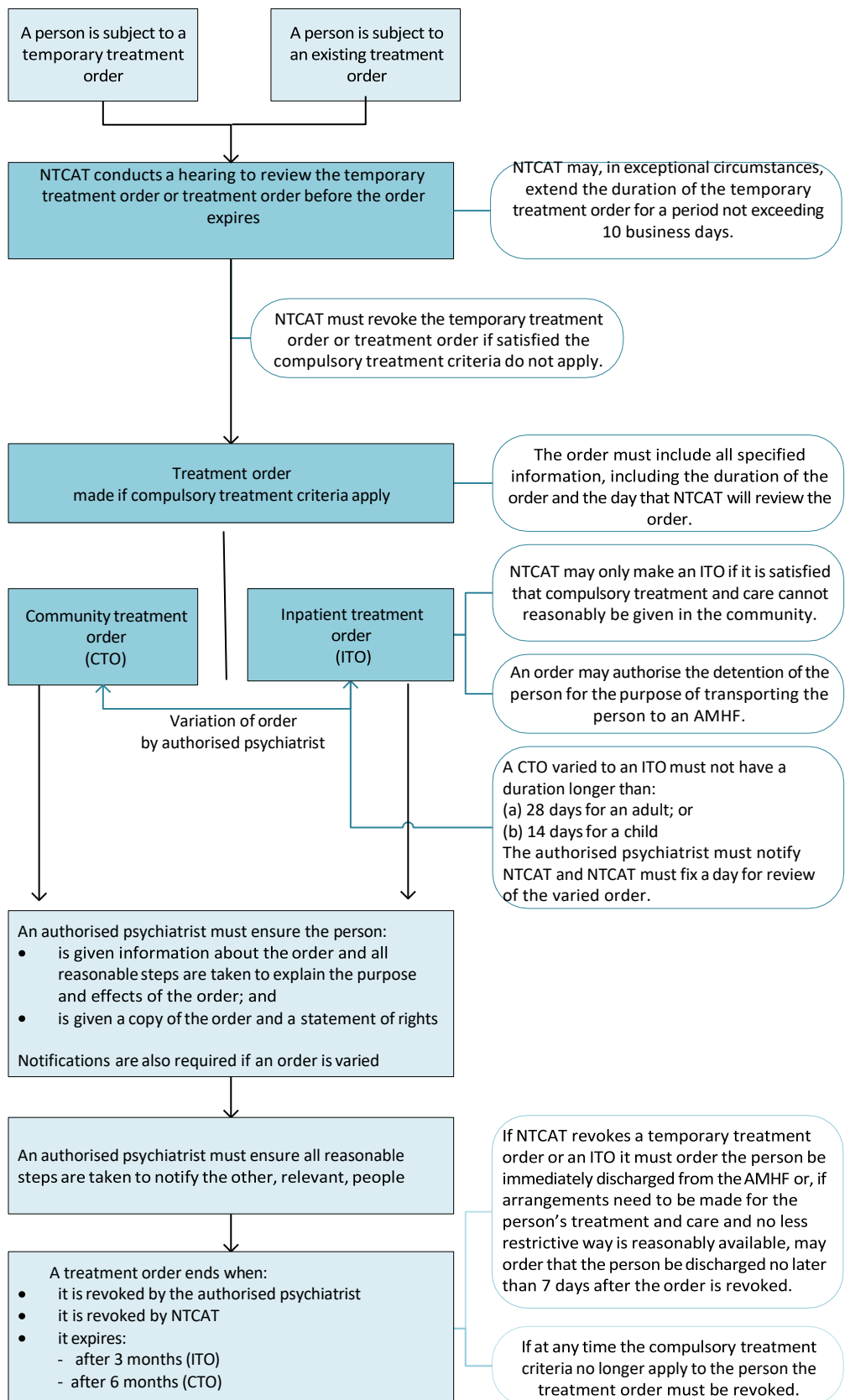
- NTCAT must be notified of the variation and must fix a hearing date (**clause 123**), and
- variation of a treatment order (inpatient to community) does not change the duration of the order,
- the duration of a treatment order (community to inpatient) cannot be longer than 28 days.

Flow chart 4 illustrates the processes and requirements for making a treatment order.

Flow chart 4 Treatment orders

Compulsory Treatment Criteria:

- (a) the person has a mental illness or mental disorder; and
 (b) because the person has a mental illness or mental disorder, the person needs immediate treatment to prevent:
 (i) serious deterioration in the person's mental or physical health; or
 (ii) serious harm to the person or anyone else; and
 (c) the person does not have capacity to consent to treatment for the mental illness or mental disorder or refuses to consent to treatment; and
 (d) if the person refuses to consent to treatment – the deterioration or harm mentioned in paragraph (b) is so serious that it outweighs the person's right to refuse to consent; and
 (e) there is no less restrictive way reasonably available for the person to receive the immediate treatment.



Flow chart 4 notes that NTCAT may, in exceptional circumstances, extend the duration of a temporary treatment order for a period no longer than 10 days. **Clause 370** provides the power for NTCAT to adjourn a hearing about a person on a temporary treatment order and to extend the order. Only NTCAT has this power, and it can only be exercised in exceptional circumstances.

Flow chart 4 also notes that, if revoking a temporary inpatient treatment order or an inpatient treatment order, NTCAT must order the immediate discharge of the person (**clause 106(a)**).

However, **flow chart 4** further notes that the discharge may be 'delayed' for up to 7 days. This is consistent with section 123(8)(b) and (9) of the MHRSA, which permits a delayed discharge if arrangements need to be made for the person's treatment and care. The Exposure Draft Bill (**clause 106(b)**) requires, in addition to the need to be make arrangements for treatment and care, the extra requirement that no less restrictive option is reasonably available.

It is understood that, given the demographics in the Territory, discharge after 7 days is often required so that suitable arrangements can be made for a person. An order is required, otherwise the continued detention when the compulsory treatment criteria are not met would be a deprivation of liberty. The criterion of a need to make suitable arrangements is pragmatic. However, adding a further criterion of no less restrictive option is an added safeguard that aligns with the human rights focus of the Exposure Draft Bill.

Duties of a supervising psychiatrist and a psychiatric case manager – Division 4

The provisions in Division 4 apply where a temporary community treatment order or a community treatment order has been made. They replace sections 50 and 51 of the MHRSA.

Division 4 sets out the duties of:

- the authorised psychiatrist who supervises a temporary community treatment order or a community treatment order (**clause 113**). This person is called the 'supervising psychiatrist' (defined in **clause 16**), and
- the psychiatric case manager (**clause 115**), appointed by the supervising psychiatrist (**clause 114**).

Leave of absence from an approved mental health facility – Division 6

Being able to take leave from an approved mental health facility while admitted under a temporary inpatient treatment order or an inpatient treatment order is important both to a person's treatment and recovery. Leave provides the means for people to maintain important connections while in hospital, to exercise autonomy and to attend to matters that are important to them.

During the MHRSA Review, stakeholders noted a lack of guidance in section 166 of the MHRSA about leave for people receiving compulsory inpatient treatment. The Consultation Report recommended including clear provisions in the new mental health act (recommendation 8).

The provisions in **Division 5** aim to provide the recommended clarity and guidance. The provisions also apply to a person who is detained at an approved mental health facility on an assessment order but do not apply to correctional patients (prisoners and detainees). Separate provisions, allowing for very limited leave for correctional patients, are included in **Part 6 Division 5** of the Exposure Draft Bill.

Absence without leave from an approved mental health facility – Division 7

The provisions in **Division 6** replace section 166A of the MHRSA, setting out procedures where a person who is admitted to an approved mental health facility under a temporary inpatient treatment order or an inpatient treatment order or who is detained under an assessment order is absent without leave.

Absence of a person on a temporary community treatment order or a community treatment order – Division 8

Where a person on a temporary community treatment order or a community treatment order becomes very unwell, an authorised psychiatrist can, as discussed above, vary the order to a temporary inpatient treatment order or an inpatient treatment order.

However, simply varying an order may not be effective in circumstances where a person on a temporary community treatment order or a community treatment order has not been attending the place that they are required to attend to receive treatment and care or has not been present at the person's residence to receive treatment or care as required in the order. **Division 8** proposes addressing the issue by empowering an authorised psychiatrist to make a transport and detention order where:

- all reasonable steps have been taken to try to obtain the person's cooperation to attend or be present for treatment and care,
- the person continues to fail to attend the place that they are required to attend or be present when they should be at home,
- the authorised psychiatrist believes on reasonable grounds that the person is likely to suffer serious deterioration in their mental or physical health or cause serious harm to themselves or another person.

A transport and detention order may authorise:

- an authorised person (defined in **clause 16**) to transport the person to a place named in the order (for example, Royal Darwin Hospital), and
- detention of the person until the first of the following things occurs –
 - the treatment (for example, depot medication) is given, or
 - an authorised psychiatrist varies or revokes the temporary community treatment order or community treatment order, or
 - 6 hours from the time the person is received at the place named in the order expires.

Part 6 Correctional patients

Part 6 of the Exposure Draft Bill replaces Part 11 of the MHRSA. It sets out processes that apply to prisoners and detainees who need to be transferred from their place of custody to an approved mental health facility for treatment for a mental illness, because treatment cannot appropriately be provided in the place of custody. If they are admitted to an approved mental health facility, they become a 'correctional patient'.

'Prisoner' is defined in **clause 16** of the Exposure Draft Bill to have the same meaning as in section 6 of the *Correctional Services Act 2014* and 'detainee' is defined as having the same meaning as in section 5 of the *Youth Justice Act 2005*. In Part 11 of the MHRSA prisoners and detainees come under the single umbrella of 'prisoner'.

A prisoner or detainee does **not** need to be transferred to an approved mental health facility where:

- they can be treated as an outpatient in their place of custody, in other words they have decision making capacity and have given informed consent to treatment (or someone who can consent to treatment does so on their behalf) and the level of treatment is available in the place of custody, or
- they fulfil the compulsory treatment criteria, but treatment can be provided in the place of custody (**clause 95(d)** and **(e)**). In other words, they can be put on a temporary community treatment order or, subsequently, a community treatment order. There is no need for the more restrictive inpatient treatment order.

A prisoner or detainee may need to be transferred to an approved mental health facility:

- for a psychiatric assessment, if a medical practitioner or an authorised mental health practitioner makes an assessment order (see **Division 2**) and the place where the psychiatric assessment is to be conducted is an approved mental health facility. An assessment order can only specify an approved mental health facility as the place where the psychiatric assessment is to be conducted if there are facilities available at the approved mental health facility (**clause 149(2)**). Most psychiatric assessments will be conducted in the place of custody,
- when an authorised psychiatrist who has conducted a psychiatric assessment at the place of custody makes a temporary inpatient treatment order or varies a temporary treatment order or a treatment order from community to inpatient (**clause 157**), or
- when an authorised psychiatrist or an authorised psychiatric practitioner arranges for a prisoner or detainee to be admitted to an approved mental health facility with the informed consent of the prisoner or detainee (**clause 159**). It must be clinically appropriate for the prisoner or detainee to be receive the treatment and care at an approved mental health facility rather than in the place of custody and there must be facilities available at the approved mental health facility.

Part 6 also includes provisions about granting a very limited leave of absence for a correctional patient (**Division 5**) and procedures where a correctional patient is absent without leave (**Division 6**).

Part 6 also provides for the release (**clause 167**) of a correctional patient and their return to custody (**clause 168**).

A correctional patient needs to be 'released' if there is no authority to detain them *as a correctional patient* at an approved mental health facility. For example, the correctional patient's sentence of imprisonment has expired, or they have been released on bail or parole. Treatment could be continued under a temporary

inpatient order if the compulsory treatment criteria apply or may be continued if the correctional patient gives informed consent to treatment (or someone who can consent to treatment does so on their behalf).

A correctional patient needs to be returned to their place of custody if:

- it is no longer clinically appropriate to provide treatment and care to the correctional patient in an approved mental health facility, or
- the correctional patient is not on an inpatient order or a temporary inpatient order and withdraws consent to treatment.

Part 7 Care and control and transport

Part 7 sets out:

- a health led response where a person may be experiencing a mental health crisis,
- clear provisions about transport for persons to and from and within an approved mental health facility,
- clear powers of authorised officers when responding to a mental health crisis and when providing transport.

An 'authorised officer' includes a medical practitioner, paramedic, registered nurse, authorised mental health practitioner and police officer. The full list is in **clause 16**.

Health led response to mental health crisis – Divisions 1 and 2

The approach in the MHRSA for an emergency response where a person may be experiencing a mental health crisis is apprehension by police.

In Darwin, since 2020, NT Health and NT Police have been trialling a Co-Response Model to better address and meet the needs of persons experiencing a mental health crisis. The Co-Response Model, which involves a triage team of a mental health practitioner, a paramedic and a police officer, corresponds with a wider trend for a health-led rather than a police-led response to mental health emergencies.

The Consultation Report recommended (recommendation 12) clarifying and reframing the powers of emergency apprehension to reflect the Co-Response Model and raising the threshold for apprehension.

To support a health-led approach to responding to a mental health crisis, the Exposure Draft Bill:

- does not use the language of 'apprehension by police', which has connotations of wrongdoing, but rather 'taking a person into care and control in a mental health crisis',
- provides a wider range of 'authorised persons' than police who can take a person into their care and control, namely a paramedic, a police officer and a member of a prescribed class of persons,
- provides that a police-led response is the response of last resort, while accepting the reality that this may be the only reasonably practicable response in the circumstances,
- provides that any exercise of a power is to be in the least restrictive way possible,
- raises the threshold for taking a person into care and control; an authorised person must be satisfied that –
 - the person appears to have a mental illness or mental disorder, and
 - because of the apparent mental illness or mental disorder, it is necessary to take the person into care and control to prevent immediate, serious harm to the person or to another person.

Transport provisions – Divisions 3 and 4

Division 3 and **Division 4** bring together in a single place in the Exposure Draft Bill provisions about the circumstances where an authorised person (defined in **clause 16**) may transport a person to whom a treatment order or temporary treatment order applies or who are detained at an approved mental health facility.

In many cases, transport under these provisions will not be needed. For example, where a medical practitioner or authorised mental health practitioner has made an assessment order for a person, a friend or relative of the person may drive them to the approved mental health facility where the psychiatric assessment is to be conducted. In this situation, transport by an authorised person would not be needed.

On the other hand, if the person is a prisoner or detainee, transport under the transport provisions will always be required.

The provisions include transport:

- within an approved mental health facility,
- to or from an approved mental health facility,
- between different approved mental health facilities, and
- when a person is absent without leave.

Clause 182 provides that, if a person has been transported under an assessment order from a place in the community to an approved mental health facility, the person in charge of the approved mental health facility must take reasonable steps to ensure the person is transported back to a place in the community. This provision, modelled on section 362 of the *Mental Health Act 2016* (QLD) has been included in response to stakeholder feedback during the MHRSA Review. Some stakeholders, in particular people with lived experience, described confusion and distress in situations where a person has been transported to an approved treatment facility for a psychiatric examination but, after the psychiatric examination, the involuntary admission criteria are not met, and the person is 'stranded' in Darwin or Alice Springs.

Powers and responsibilities of authorised persons – Divisions 5 and 6

Division 5 sets out the powers of an authorised person when they are responding to a mental health crisis or providing transport.

Although there are provisions scattered throughout the MHRSA giving certain persons the power to 'apprehend' another person, use force and enter premises, they are not clear or comprehensive. Also, there are no powers to search a person or seize anything from them.

The powers enable an authorised person to:

- detain and restrain a person. This power is necessary because the person may not be consenting to transport. It will be strictly regulated –
 - bodily restraint may only be used if all reasonable and less restrictive options have been tried or considered and found unsuitable and it is necessary to prevent imminent and serious harm to the person or others,
 - there may be occasions where medication for sedation (chemical restraint) is necessary. Sedation is currently used, for example during aeromedical transport. However, it is not

regulated under the MHRSA. The Exposure Draft Bill introduces regulation. **Clause 191** is included to prevent the risk of routine or automatic use of chemical restraint, without assessment of risk or clinical need. It provides that, if a medical practitioner is transporting a person, the medical practitioner may use chemical restraint but only if it is to prevent imminent and serious harm to the person or others. A medical practitioner may also direct registered nurse or a paramedic to use chemical restraint for the same reason,

- enter premises if the authorised person believes on reasonable grounds that the person may be found there,
- search the person if the authorised person suspects on reasonable grounds that the person may have something that may be a serious risk to the person's own health or safety or the health or safety of someone else, and seize things found during the search.

The search and seizure provisions include detailed requirements about how a search is to be conducted, to ensure the minimum intrusion of the person's privacy and dignity (**clause 195**). There are additional requirements if the search involves any touching of the person (**clause 195(2)**).

There are additional safeguards if the person being searched is a child (**clause 195(1)(c)**).

Clear statutory authority for the exercise of these powers is a common feature in mental health legislation in other Australian jurisdictions. Including these powers in the Exposure Draft Bill allows them to be specially tailored to apply in a human-rights focussed context and not a 'law enforcement' context.

The powers do not displace other common law or statutory powers, for example police powers under the *Police Administration Act 1978*. However, those other powers should only be used where they are needed for a reason other than taking a person into care and control in a mental health crisis or providing transport under **Part 7** of the Exposure Draft Bill.

Division 6 sets out the information that an authorised person is to provide to a person when taking the person into care and control in response to a mental health crisis, or when transporting the person. If the person is a child, the authorised person must give the information to a parent or carer of the child or, if the child is in the care of the Families CEO, to the Families CEO.

Part 8 Treatment and care

Part 8 sets out:

- the procedures for making treatment decisions and planning treatment,
- how the provision of urgent health care is to be reported, and
- the circumstances in which research, clinical trials and experimental treatments can be conducted in relation to people receiving treatment and care for a mental illness or mental disorder.

The provisions in **Division 2** clarify and emphasise that a person receiving treatment and care for a mental illness or mental disorder under a treatment order, or a temporary treatment order is an active participant in the decisions about that treatment and care. This contrasts with the MHRSA, which (apart from discharge planning under section 89) does not give to a person, or any other support person, the opportunity to be involved in decisions about their own treatment.

When making any treatment decision about a person on a treatment order or temporary treatment order, the Exposure Draft Bill provides that an authorised psychiatrist or authorised psychiatric practitioner must:

- have regard to the person's wishes, views and preferences about the proposed treatment. These wishes, views and preferences may be expressed at the time the decision is being made or, in advance, in an advance personal plan,
- have regard to the reasons for the person's wishes, views and preferences and also what recovery outcome the person wants,
- to the extent practicable, consult with and seek the views of the support persons listed in **clause 201**, and
- consider alternative treatments, any second psychiatric opinion, and the likely consequences of not providing the proposed treatment.

Treatment plans and discharge plans must also be developed in consultation with the person and their supporters.

Clause 203 sets out additional requirements that an authorised psychiatrist or authorised psychiatric practitioner must follow if the person has an advance personal plan and the proposed treatment is inconsistent with the person's wishes, views and preferences expressed in that plan.

A decision not to give treatment and care in accordance with an advance personal plan must be made in compliance with the policy or guideline made by the Chief Psychiatrist about the circumstances when it may not be appropriate to give treatment and care in accordance with an advance personal plan (**clause 303(1)(b)** and **(3)**).

Clause 208 seeks to ensure that the particular needs and circumstances of Aboriginal or Torres Strait Islander persons is taken into account. To the extent practicable, treatment and care must be provided in collaboration with Aboriginal or Torres Strait Islander mental health workers, and also, where appropriate, elders and traditional healers.

The remainder of Part 8 sets out:

- reporting requirements if urgent health care is given to a person admitted to an approved mental health facility or receiving treatment and care under a community treatment order or a temporary community treatment order. The provision of the urgent health care is dealt with in the *Health Care Decision Making Act 2023*,
- in **clause 210**, the requirements for conducting approved research, a clinical trial or experimental treatment on a person receiving treatment and care for a mental illness or mental disorder. This replaces section 65 of the MHRSA.

Part 9 Regulated treatment

Part 9 sets out regulatory provisions for the administration of electroconvulsive therapy and the performance of neurosurgery for mental illness. Both are recognised forms of treatment for severe mental illness. They are more invasive than other treatments and, therefore, require more stringent safeguards.

Electroconvulsive therapy

Electroconvulsive therapy is a medical procedure performed under general anaesthesia, used for the relief of symptoms of severe psychiatric disorders. It involves delivery of a small electric current to the brain, that induces a seizure, for therapeutic purposes.

The use of electroconvulsive therapy is regulated by express provisions in Australian mental health legislation and by policies and guidelines made under the legislation. During the MHRSA Review, stakeholders supported strengthening the provisions that regulate the use of electroconvulsive therapy. The Consultation Report recommended (recommendation 18) strengthened safeguards and governance.

The provisions in **clause 212** to **clause 226** are modelled on the electroconvulsive therapy provisions in the *Mental Health Act 2015* (ACT). They explain clearly:

- when electroconvulsive therapy may be administered by consent or under an order made by NTCAT,
- what matters NTCAT must consider before it makes an order authorising electroconvulsive therapy,
- the processes that are to be followed if electroconvulsive therapy is administered in an emergency (that is, without either consent or an order from NTCAT), and
- record keeping requirements about the administration of electroconvulsive therapy.

Neurosurgery for mental illness

Neurosurgery for mental illness is defined in **clause 16**. A similar definition is found in mental health legislation in other Australian jurisdictions. When performed within a strictly regulated legislative framework, neurosurgery for mental illness is permitted in other Australian jurisdictions. It is recognised by the Royal Australian and New Zealand College of Psychiatrists as an effective treatment for severe and incapacitating mental disorders when all other attempts at treatment have failed.

Neurosurgery for mental illness is not carried out to alter behaviour and the definition makes this clear. This makes it fundamentally different from 'psychosurgery' in the MHRSA, which is completely prohibited.

Although there is currently no one in the Territory with the necessary qualifications and experience to perform neurosurgery for mental illness and there are no suitable facilities, this may change during the lifespan of the proposed legislation. That is why a framework for performing neurosurgery for mental illness (**clause 227** to **clause 233**), which may only be performed under an order by NTCAT, has been included in the Exposure Draft Bill.

Part 10 Restrictive interventions

Part 10 sets out how practices of restraint and seclusion (restrictive interventions) are to be regulated.

The use of restrictive interventions of restraint and seclusion are highly regulated under mental health legislation throughout Australia. The national trend is towards minimising and, if possible, eliminating these practices. The national trend is also towards reducing the use of medication other than where it is clinically necessary for the treatment or care of a person suffering from a physical or mental illness. Medication, specifically sedation, should only be used as a 'restraint' in very limited circumstances.

During the MHRSA Review, most stakeholders supported:

- a higher threshold for the use of restrictive interventions,
- strengthened monitoring and oversight mechanisms,
- clear definitions of different types of restraint, and
- clear provisions about the use of medication used for sedation.

Recommendation 17 of the Consultation Report reflected these views.

In relation to children, recommendations 10(b) and 10(c) of the Consultation Report supported further safeguards of including specific measures to reduce the use of restrictive interventions and expressly providing that seclusion can only be used as a measure of last resort.

The Exposure Draft Bill adopts the recommendations made in the Consultation Report by:

- expanding the types of restraint that are regulated and providing clear definitions of each type of restraint, including the use of chemical restraint,
- raising the threshold of when a restrictive intervention may be used (**clauses 236 and 237**),
- clearly stepping out the processes of authorisation, monitoring and reporting of the use of a restrictive intervention,
- requiring the person in charge of an approved mental health facility or an approved mental health service to provide a plan to the Chief Psychiatrist about the reduction of the use of restrictive interventions on children (**clause 247**), and
- requiring the Chief Psychiatrist to make and publish a restrictive intervention policy (**clause 248**).

The provisions in Part 10 of the Exposure Draft Bill apply to the use of restrictive interventions on:

- any person receiving treatment and care in an approved mental health facility regardless of their admission status,
- a person detained in an approved mental health facility under an assessment order, and
- a person receiving treatment and care from an approved mental health service under a temporary community treatment order or a community treatment order.

Types of restrictive intervention

Sections 61 and 62 of the MHRSA regulate the use of mechanical restraint and seclusion. There is no regulation of other forms of restrictive intervention.

Chemical restraint is the use of medication as a means of controlling behaviour. It does not include giving medication as a form of treatment. There are no clear provisions for the use of chemical restraint in the MHRSA, although the practice does occur. That means its use is not regulated. Including a definition of chemical restraint (**clause 16**) and including the use of chemical restraint in the provisions regulating the use of restrictive interventions means that its use can be measured, monitored and reported on.

There is also no express regulation of physical restraint (the use by a person of their body to prevent or restrict another person's movement) in the MHRSA. For completeness, definitions of physical restraint and bodily restraint (which covers physical and mechanical restraint) have been included in **clause 16**.

Authorisation, monitoring and reporting

The Exposure Draft Bill proposes that a restrictive intervention may only be used if no less restrictive way is practicable to prevent immediate serious harm to the person or another person or to prevent the person from persistently destroying property. Bodily restraint may also be used if no less restrictive way is practicable to administer treatment (for mental illness or mental disorder) or medical treatment to the person.

In deciding there is no less restrictive option, a person authorising the use of a restrictive intervention must have regard, to the greatest extent practicable, to:

- the likely effect of the restrictive intervention on the person, including any past experience of trauma, and
- the person's culture, beliefs, values and personal characteristics. (**clause 237**).

For the circumstances in which a restrictive intervention may be used when a person is being transported see **Part 7**.

The Exposure Draft Bill clarifies that the use of a restrictive intervention must be authorised by an authorised psychiatrist. If an authorised psychiatrist is not reasonably available, other listed persons may give authorisation, but they must notify an authorised psychiatrist as soon as practicable.

A person authorising the use of a restrictive intervention must comply with the Chief Psychiatrist's restrictive intervention policy and, if the use is for a child, the plan made under **clause 247**.

The authority to use a restrictive intervention ends when it is no longer necessary to achieve the purpose for which it was authorised.

Clause 240 to clause 246 detail monitoring, recording, reporting and notification requirements if a restrictive intervention is used.

Restrictive intervention policy

The person in charge of the approved mental health facility or an approved mental health service must:

- report to the Chief Psychiatrist on the use of restrictive interventions, and

- submit a plan for approval by the Chief Psychiatrist outlining measures to be taken to reduce the use of restrictive interventions on children (which the Chief Psychiatrist may approve when satisfied with the measures proposed).

These requirements are designed to inform the development of the restrictive intervention policy by the Chief Psychiatrist, to assist the Chief Psychiatrist to fulfill their function of monitoring compliance with the policy, and to promote reduction in the use of restrictive interventions on children.

Part 11 Security at approved mental health facilities

Part 11 sets the powers and procedures, in an approved mental health facility, about:

- carrying out searches of persons and their possessions,
- excluding particular visitors, and
- examining things sent to persons who are in an approved mental health facility.

The purpose of the provisions in Part 11 is to maintain a safe environment for everyone at an approved mental health facility, including persons receiving treatment and care, staff and visitors. Safety is the primary concern, but this needs to be achieved in a way that acknowledges the rights of a person who may be searched, particularly their right to privacy and to dignity.

Searches are carried out in approved treatment facilities in the Territory in accordance with procedures approved by the CEO of NT Health under section 18 of the MHRSA. There are no express 'security' powers in the MHRSA.

The Consultation Report recommended (recommendation 14) that:

- search and seizure powers be included in the new mental health act,
- the provisions contain human rights protections, and
- monitoring the use of the powers be included as a function of the Community Visitor Program.

Including these powers and procedures in the Exposure Draft Bill provides clarity and transparency about their use.

Division 2 is about searches of persons detained at or admitted to an approved mental health facility.

The purpose of a search is to detect if the person is carrying or is in possession of a thing that may be a serious risk to the health or safety of the person or anyone else at the approved mental health facility. Division 2 includes corresponding powers and requirements about seizing such things.

A search may only be carried out by authorised staff members (**clause 251** and **clause 252**) at an approved mental health facility.

There are detailed requirements about how a search is to be conducted, to ensure the minimum intrusion of the person's privacy and dignity.

There are additional requirements if the search involves any touching of the person.

A search that involves the removal of a person's clothing (other than hats, jackets etc) can only be conducted in a high dependency unit of an approved mental health facility.

Clause 262 sets out information that must be recorded about a search and anything seized. The person in charge of an approved mental health facility must keep a register of this information. The principal community visitor must ensure that the register is inspected at least every 6 months by a community visitor or a community visitors panel.

Division 3 is about the search of visitors' possessions. The purpose of searching a visitor's possessions is to promote the health and safety of persons at an approved mental health facility.

If a visitor has something that may be a risk to the health or safety of a person at the approved mental health facility, an authorised staff member may ask the visitor to leave the thing with the authorised staff member until the visit is over. The thing must be returned to the visitor when they leave.

If a visitor does not agree to a search of their possessions or does not agree to leave a thing that may be a risk to health or safety, they may not be allowed to enter the approved mental health facility or may be asked to leave.

Division 4 sets out the circumstances when the person in charge of an approved mental health facility or an authorised staff member may search and seize mail or other things sent to a person who is detained at or admitted to an approved mental health facility. Although there is a right to receive mail or other things (**Part 3**), a search is justifiable if the mail or thing may pose a serious risk to the person receiving it or to another person.

Part 12 Disclosure of health information

Part 12 sets out the circumstances under which health information about a person, held by an approved mental health facility or an approved mental health service, may be disclosed.

Clause 277 proposes a definition of *health information*. It is a modernised version of the type of information covered by section 91(1) of the MHRSA. It is a specific definition that applies only in the Exposure Draft Bill. It does not have the same (wider) meaning of 'health information' in the *Information Act 2002*.

Health information means a document held by an approved mental health facility or an approved mental health service that:

- (a) identifies a person to whom an assessment order applies or has applied,
- (b) identifies a person who has received or is receiving treatment and care at an approved mental health facility or an approved mental health service,
- (c) relates to any treatment and care received by a person at an approved mental health facility or an approved mental health service, or
- (d) relates to the mental health, safety or wellbeing of a person who has received or is receiving treatment and care at an approved mental health facility or an approved mental health service.

Section 91 of the MHRSA deals with the disclosure of information that identifies that a person has been admitted to an approved treatment facility or has received treatment from an approved treatment agency, or provides information about treatment, by creating an offence and then listing, in section 91(2)(a) to (n), the circumstances when information may be disclosed.

The approach in the Exposure Draft Bill is to set out clear permissive provisions explaining the circumstances under which health information may be disclosed. Promoting the autonomy and agency of the person about their own health information, the starting point regarding disclosure is disclosure by consent (**clause 280**).

Clause 281 to clause 293 set out when disclosure is permitted without needing consent. Each permitted circumstance for disclosing health information is set out in its own clause. This makes the provisions easier to find and to read. They provide clear permission to disclose health information.

It remains an offence (**clause 279**) to disclose information other than under one of the permissive provisions or as otherwise allowed under **clause 279**.

The disclosure provisions in **Part 12** are not the only information sharing provisions in the Exposure Draft Bill. Throughout the Exposure Draft Bill there are provisions that require health practitioners to communicate about a person with family, carers and supporters [at defined points of care. These provisions apply unless the person says they do not want the communication to happen (**clause 44**) or, for communication to a parent about a child, it is not in the best interests of the child (**clause 45**).

The Exposure Draft Bill does not include a statutory scheme for access to health information.

The MHRSA requires a person to apply to an authorised psychiatric practitioner for access to information about themselves in records kept by an approved treatment facility or an approved treatment agency. The inclusion of access provisions in the MHRSA may be because the MHRSA was enacted before the *Information Act 2002*. The *Information Act 2002* provides an access scheme of general application.

The main reasons that an access scheme has not been included in the Exposure Draft Bill are that:

- it may lead to inequity of access to health information (in the wider, *Information Act 2002*, sense) if an access scheme in the Exposure Draft Bill for information about a person's treatment and care for a mental illness or mental disorder had different access provisions to the general provisions in the *Information Act 2002* that relate to access to any other health information. If the access provisions were the same as in the *Information Act 2002*, they would be redundant, and
- from a practical perspective there would be difficulties of operating two systems and, for the person to whom the information relates, of negotiating them.

Instead, it is proposed to rely on administrative access to health information from NT Health and, if access is refused at an agency level, rely on the *Information Act 2002*.

Part 13 Administration

Part 13 deals with how the proposed legislation is to be administered, including provisions for –

- the appointment, powers and functions of the Chief Psychiatrist,
- the approval and declaration of mental health facilities (including high dependency units) and mental health services,
- the appointment of –
 - persons in charge of an approved mental health facility or an approved mental health service,
 - authorised psychiatrists,
 - authorised psychiatric practitioners,
 - authorised mental health practitioners, and
 - authorised officers, and
- monitoring compliance with the proposed legislation and investigating clinical events.

Chief Psychiatrist

The Exposure Draft Bill establishes the role of the Chief Psychiatrist. The Territory and New South Wales are the only jurisdictions in Australia where the Chief Psychiatrist is not a statutory position. Functions that a Chief Psychiatrist has in other jurisdictions are, in the MHRSA, performed by the CEO of NT Health or the Chief Health Officer.

During the MHRSA Review, stakeholders were unanimous in supporting the establishment of the Chief Psychiatrist as a statutory position. The Consultation Report made recommendations (recommendation 15 and recommendations 5(c), 17(d) and 18(c)) about what powers and functions the Chief Psychiatrist should have.

Clear provisions setting out the role, functions and responsibilities of the Chief Psychiatrist will:

- strengthen clinical governance,
- protect the rights of people receiving treatment and care under the proposed legislation, and
- enhance transparency and accountability in the provision of treatment and care.

The role of the Chief Psychiatrist extends to all persons receiving treatment and care in an approved mental health facility and persons receiving treatment and care in the community under a temporary community treatment order or a community treatment order.

The Exposure Draft Bill provides that the Chief Psychiatrist is responsible for the administration of the proposed legislation and for monitoring compliance with it.

Some functions of the Chief Psychiatrist have already been mentioned in this guide. They are the requirements to:

- prepare and publish a statement of rights (**clause 33**),
- make and publish a policy about the use and recording of information about restrictive interventions (**clause 248**), and
- make and publish a policy or guideline about the circumstances in which it may not be appropriate to give treatment and care to a person in accordance with an advance personal plan (**clause 303(1)(b)**).

Clause 303 sets out matters about which the Chief Psychiatrist must make policies and guidelines. These include policies or guidelines about:

- making decisions about whether a temporary treatment order should be made,
- the management of complaints,
- (as mentioned above) the circumstances in which it may not be appropriate to give treatment and care to a person in accordance with an advance personal plan, for example –
 - the decision not to give treatment and care in the less restrictive way of being in accordance with an advance consent decision and instead give treatment and care under a temporary treatment order, and
 - a treatment decision not to follow an advance personal plan once a temporary treatment order has been made,
- the administration of electroconvulsive therapy, and
- the searching of rooms at an approved mental health facility to prevent risks to health and safety.

The Chief Psychiatrist may also make guidelines and policies about other matters relating to treatment and care of persons under the proposed legislation.

People working in approved mental health facilities and approved mental health services must comply with these policies and guidelines (**clause 303(3)**).

Clause 304 requires the Chief Psychiatrist to make and publish standards about the treatment and care of persons at an approved mental health facility or an approved mental health service. The person in charge of the facility or the service must ensure compliance with the standards.

The requirements in the Exposure Draft Bill for the Chief Psychiatrist to make and publish policies, guidelines and standards provides a level of transparency and accountability that is not found in the MHRSA. The relevant power in the MHRSA is section 18, which provides that the CEO *may* approve procedures, not inconsistent with the MHRSA.

Advisory committees

The Chief Psychiatrist will be responsible under the proposed legislation for making and publishing clinical policies and guidelines. As mentioned above, this means there will be greater transparency and accountability than under the MHRSA.

The Consultation Report recommended (recommendation 15(l)) that the powers and functions of the Chief Psychiatrist subsume the role of the Approved Procedures and Quality Assurance Committee (**APQAC**) and that the Chief Psychiatrist have the power to establish advisory panels.

The Exposure Draft Bill proposes that the Chief Psychiatrist may establish advisory committees (**Division 2 subdivision 5**). An advisory committee is a more flexible approach than the APQAC in the MHRSA. An advisory committee may, for example, be of limited duration, to address a particular issue, or may be established with terms of reference to give ongoing advice.

Monitoring compliance and investigation of clinical events

The Chief Psychiatrist will have the function of monitoring compliance with the proposed legislation. This includes the function of conducting independent audits where the Chief Psychiatrist considers it necessary, for example in response to complaints, concerning trends, or for monitoring the efficacy of new initiatives.

The Chief Psychiatrist will also have the power to conduct investigations into clinical events (**Division 6**). A clinical event could be any matter relating to the treatment and care of:

- a person admitted to an approved mental health facility,
- a person to whom a temporary community treatment order or a community treatment order applies, or
- a person detained at an approved mental health facility or another place under an assessment order.

As part of the function of monitoring compliance with the proposed legislation and conducting investigations into clinical events, the Chief Psychiatrist may appoint authorised officers (**Division 5**) to assist the Chief Psychiatrist in performing those functions.

The powers that the Chief Psychiatrist and an authorised officer may use when carrying out these functions are set out in **Division 7**. They are the power to:

- enter and inspect an approved mental health facility or the premises of an approved mental health service. Consent of the person in charge must be sought but is not required to allow entry.
- take actions, such inspecting and taking copies of documents and making inquiries are set out in **clause 329(4)**, and
- require, by written direction, that a member of staff (including the person in charge) of an approved mental health facility or and approved mental health service produce a document or answer questions.

Part 14 Community visitors

The Community Visitor Program in the Territory provides an important safety and quality oversight function for people receiving treatment and care under the MHRSA. There are separate framework provisions in the *Disability Services Act 1993*.

Part 14 of the Exposure Draft Bill replaces Part 14 of the MHRSA. It sets out the framework for the appointment, role and functions of the principal community visitor, community visitors, community visitors panels and special community visitors panels.

The Consultation Report recommended that the Community Visitor Program be retained (recommendation 16) and expanded (recommendations 14(c) and 16) to include monitoring compliance with the new search and seizure powers in **Part 11**.

The provisions in the Exposure Draft Bill are comparable to the MHRSA with the following changes.

The provisions have been redrafted to reflect modern drafting style and to be easier to read,

It is proposed that the appointment of community visitors will be made by the principal community visitor rather than the Minister. This same amendment is included in the *Monitoring of Places of Detention (OPCAT) Amendment Act 2022*, which has not yet commenced.

The power of community visitors and members of community visitors panels to inspect a person's medical record has been drafted so that inspection requires the consent of the person (**clause 342(d)** and **clause 350(e)**). These provisions are modelled on the equivalent provision in the *Mental Health and Wellbeing Act 2022* (VIC). They align with the rights-based, person-centred ethos of Exposure Draft Bill and are consistent with the concern expressed by SALRI about community visitors having access to patient records without consent.

Giving effect to the recommendations in the Consultation Report, community visitors and community visitors panels are given the new function of monitoring compliance with the search and seizure powers in **Part 11**; and the principal community visitor must ensure that search and seizure register required to be kept by the person in charge of an approved mental health facility is inspected at least every 6 months by a community visitor or a community visitors panel (**clause 262(3)**).

Community visitors and community visitors panels will continue to monitor the use of restrictive interventions, as they currently monitor the use of mechanical restraints and seclusion under the MHRSA. As discussed above, the provisions about the use of restrictive interventions in **Part 10** are clearer and wider than the provisions in the MHRSA. Therefore, in addition to monitoring the use of mechanical and physical restraints, community visitors and community visitors panels will monitor the use of chemical and physical restraints.

Part 15 NTCAT

Part 15 sets out the jurisdiction, constitution and procedures of NTCAT. NTCAT performs the role that in some other Australian jurisdictions is performed by a mental health review tribunal. NTCAT provides an essential safeguard to protect the rights of people with a mental illness or mental disorder.

In 2020, amendments were made to Part 15 of the MHRSA, abolishing the Mental Health Review Tribunal and giving its functions to NTCAT. Some procedural provisions which were no longer required due to provisions in the *Northern Territory Civil and Administrative Tribunal Act 2014* (**NTCAT Act**) were removed but no other substantive changes were made to Part 15.

The Consultation Report recommended (recommendation 6) that the role, functions and powers of NTCAT be retained.

NT Health has worked in consultation with NTCAT to streamline and modernise the provisions that relate to its jurisdiction and procedures. Provisions in the MHRSA that are not used have not been included in the Exposure Draft Bill. Provisions that are not needed because NTCAT can rely on procedures in the NTCAT Act have also not been included.

The main function of NTCAT is to determine whether the compulsory treatment criteria (**clause 23**) apply to a person. NTCAT may make a treatment order if those criteria apply. NTCAT's powers and functions in making treatment orders are dealt with in **Part 5 Division 3**.

Provisions about making electroconvulsive therapy orders and neurosurgery orders are in **Part 9**.

Provisions about making an order for compulsory examination are in **Part 4 Division 3**.

NTCAT will hold a hearing:

- automatically if a temporary treatment order or a treatment order is about to expire or a temporary community treatment order or community treatment order is varied to a temporary inpatient treatment order or an inpatient treatment order,
- on application by an authorised psychiatrist, for example for an electroconvulsive therapy order,
- on application by the person to whom an order applies, such as an application for revocation of a temporary treatment order or a treatment order, and
- on application by a medical practitioner or authorised mental health practitioner for an order for compulsory examination.

Part 16 Appeal to Supreme Court

Part 16 provides for appeals to the Supreme Court from decisions made by NTCAT.

The provisions in Part 16 are comparable to those in Part 16 of the MHRSA.

Part 17 Interstate transfer

Part 17 enables a person on a treatment order in the Territory to transfer to another state or territory in Australia and a person on a similar order in another state or territory to transfer to the Territory.

There are interstate transfer provisions in Part 18 of the MHRSA. The provisions to enable a person to transfer to the Territory are inefficient and have not been used. The provisions to enable a person in the Territory to transfer to another state or territory require intergovernmental agreements with other jurisdictions to be made. An intergovernmental agreement is an agreement made between Ministers of each participating jurisdiction. It is not a practical mechanism for enabling a person receiving compulsory treatment to move to another state or territory in Australia and continue receiving treatment.

Instead of replicating the provisions in Part 18 of the MHRSA, the provisions in the Exposure Draft Bill are modelled on more practical provisions in Chapter 11 Part 5 Division 4 of the *Mental Health Act 2016* (QLD).

Part 18 General matters

Part 18 contains the miscellaneous provisions that are standard in legislation, including protection against individual liability for persons acting in good faith, confidentiality and misleading information offences, powers to delegate and the power to make regulations.

The Exposure Draft Bill includes two provisions for protection against individual liability. **Clause 394** provides immunity for the Chief Psychiatrist and specified health care providers who administer treatment and care in good faith and without negligence. This provision is consistent with the protection against individual liability provision for health care providers in the *Health Care Decision Making Act 2023*. **Clause 395** is the standard protection against individual liability provision that primarily covers administrative actions, rather than clinical ones.

Clause 402 is a review clause. It requires a review of the first five years of operation of the new act and requires that the Minister make sure a report of the review is tabled in the Legislative Assembly no later than 7 years after the new act commences. Mental health laws have significant impact on human rights, autonomy, and dignity. Review is important to make sure the legislation is working as it is intended, that it stays up to date and that it is responsive to the needs to Territorians.

Part 19 Repeals and transitional provisions

Part 19 includes standard provisions repealing the MHRSA (and acts that have amended it) and a regulation making power for transitional regulations.

When the final Bill is introduced in the Legislative Assembly it will include savings and transitional provisions to make sure that matters such as the appointment of persons, declaration of places, actions and decisions made, and NTCAT orders made under the MHRSA continue to have effect when the MHRSA is repealed, and the new act commences.

The power to make transitional regulations will only be used if absolutely necessary. **Clause 405** allows regulations to be made up to 12 months after commencement of the new act, to facilitate the establishment of the new legislative framework, in case unanticipated matters arise. To limit the incursion into parliamentary sovereignty, this clause, and any regulations made under it, will expire 12 months after commencement.

Part 20 Consequential amendments

Consequential amendments to other Territory legislation need to be included when the final Bill is introduced in the Legislative Assembly. Often, such amendments are minor and technical.

Proposed consequential amendments to the *Health Care Decision Making Act 2023* and the *Disability Services Act 1993* have been included in Part 20 of the Exposure Draft Bill.

Health Care Decision Making Act 2023 – Division 1

The proposed amendments to the *Health Care Decision Making Act 2023* are included to:

- ensure that a person’s adult guardian (under the *Guardianship of Adults Act 2016*) or decision maker (under the *Advance Personal Planning Act 2013*) can consent to treatment for mental illness or mental disorder on their behalf,
- clarify that the provisions in the *Health Care Decision Making Act 2023* which deal with consent to, approval of, or directions about the use of restrictive interventions do not apply to the use of restrictive interventions under the proposed mental health act, and
- clarify that if there is any inconsistency between the proposed mental health act and the *Health Care Decision Making Act 2023*, the proposed mental health act prevails.

The consequential amendments to the *Health Care Decision Making Act 2023* are necessary to give effect to the principle of least restriction in the Exposure Draft Bill, in particular **clause 11(4)**, and to ensure that the highly regulated framework in the Exposure Draft Bill for the use of restrictive interventions is distinct and separate from the more generalised framework in the *Health Care Decision Making Act 2023*.

Disability Services Act 1993 – Division 2

The proposed amendments to the *Disability Services Act 1993* are included to show that a definition of complex cognitive impairment needs to be included in the *Disability Services Act 1993*. Currently, the *Disability Services Act 1993* relies on the definition of complex cognitive impairment in the MHRSA. Complex cognitive impairment will not fall within the scope of the proposed legislation, so there will not be a definition in it.