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Mental Health and Related Services Act 1998 Review

Danila Dilba Health Service

Submission

31 May 2021

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Executive Summary

Danila Dilba Health Service (**DDHS**) is grateful for the opportunity to provide feedback to the *Mental Health and Related Services Act 1988 Review*. We support the NT Government's commitment to reform and modernise the *Mental Health and the Related Services Act 1988* (NT) (**the Act**), to improve the design, implementation and delivery of the NT's mental health sector.

The focus of this submission is on the importance of embedding a human rights framework and person-centred approach within the Act, and the pragmatic ways in which the legislation can be amended to reflect this. In particular, our submission focusses on the ways in which the legislative regime can be strengthened to improve the cultural safety and treatment efficacy for Aboriginal and Torres Strait Islander people.

Throughout the submission, we make the following recommendations:

1. DDHS supports the inclusion of a recovery-oriented framework. The Act should provide practical guidance on its application, while remaining broad and flexible enough to respond to clients' needs. Recovery should be a holistic concept that focuses on personal recovery rather than simply centre clinical recovery.
2. DDHS recommends that the criterion of 'unreasonable refusal' for involuntary admission be clarified and defined to ensure that it is only used when the harm or deterioration, or likely harm or deterioration, of a person is of such a serious nature that it outweighs the person's right to refuse to consent.
3. DDHS recommends the insertion of a provision that sets out criteria that practitioners must use to determine whether a person has capacity to provide informed consent. DDHS recommends the adoption of the criteria provided under s 7 of the *Mental Health Act 2015* (ACT).
4. DDHS recommends the insertion of a provision that stipulates principles that must be considered in determining a person's capacity to provide informed consent. This provision should be similar to s 8 of the *Mental Health Act 2015* (ACT).
5. DDHS is supportive of ascertaining the wills and preferences of a client as part of their treatment plan and recommends adopting the legislative provisions under the *Mental Health Act 2016* (QLD) relating to consumer participation, namely under ss 5(b) and s 25, combined with the active promotion of 'advance health directives'.

6. DDHS is supportive of legislating to allow a client to nominate a nominated support person in the event that a client becomes an involuntary patient. Clients should be able to choose up to two nominated support persons. Where two nominated support persons are nominated, one must delegated as the 'primary' position, and the other the 'secondary' position. A nominated support person should not be a role confined to certain people in relation to the client.
7. DDHS recommends repealing s 11 of the Act, and instead inserting the following:
   (1) Where a court, tribunal or person exercises a power or conducts proceedings under this Act in respect of a person of Aboriginal or Torres Strait Islander background, the power must be exercised or the proceedings must be conducted –
       a. with proper recognition of the importance and significance to the person of the person's connection to family, kinship, culture, land, sea, spirituality and ancestry; and
       b. with proper recognition of the contribution those connections make to the person's social and emotional wellbeing; and
       c. with proper respect for the person's cultural and ethnic identity, language, and religious or ethical beliefs.
   (2) When providing treatment and care to a person of Aboriginal and Torres Strait Islander background, the following principles apply:
       a. The assessment, treatment and care of the person must be conducted according to the requirements under s 11(1).
       b. The person's treatment and care are to be appropriate to and consistent with the person's cultural beliefs, practices and mores, taking into account the views of the person's family and community.
       c. Where appropriate, cultural and traditional remedies and treatments are to be facilitated as far as practicable.
       d. The assessment, treatment and care of a person is, where possible, to be provided in collaboration with an Aboriginal and Torres Strait Islander health practitioner.
8. DDHS recommends that a provision should be inserted in the Act that provides:
   When conducting an assessment for the involuntary admission of a person of Aboriginal or Torres Strait Islander background, the assessing practitioner must either:
   a. be an Aboriginal health practitioner;
   b. consult with an Aboriginal health practitioner; or
   c. consult with the proposed patient or patient's family.
9. DDHS recommends that the Act include stronger legislative requirements for a qualified interpreter during assessments for involuntary admissions of clients that are unable to communicate adequately in English. We also recommend greater investment in the NT's interpreting services and robust oversite over the provision and utilisation of such services.
10. DDHS recommends that the provisions that allow for involuntary admission on the grounds of mental disturbance be repealed in their entirety.
11. DDHS recommends that the provisions that allow for involuntary admission on the grounds of complex cognitive impairment be repealed in their entirety.
12. DDHS recommends that the Act legislate the Gillick competency test so that a person is not considered incapable of providing information consent because of their age. This should be incorporated as part of principles to consider when determining if a person is capable of providing informed consent.
13. DDHS recommends the insertion of s 32(8) which would provide: 'Where the use of force is necessary to apprehend a person under this section, a police officer must use the least amount of force necessary to achieve the apprehension.'

14. DDHS is supportive of the Chief Psychiatrist being afforded greater responsibility and power through legislative incorporation and endorses the recommendations outlined in the Discussion Paper as identified in the 'Chief Psychiatrist Review'.
15. DDHS recommends that there be legislative provision that the Chief Psychiatrist is responsible for the delivery of a mental health and wellbeing system that responds to the needs of Northern Territory's diverse communities and promotes access and equity of outcomes, with particular reference to oversight of cultural safety regarding services for Aboriginal and Torres Strait Islander people.
16. DDHS endorses the recommendations made by the Northern Territory Law Reform Committee's Report on the Interaction between people with Mental Health Issues and the Criminal Justice System (May 2016). In particular, we support recommendations 18, 19 and 20, which were identified in the Discussion Paper in relation to this issue.
17. DDHS recommends that s 43ZC be amended such that supervision orders are required to have an actual term of cessation which do not exceed 12 months.
18. DDHS strongly urges the NT government to create and invest in secure therapeutic residential facilities.
19. DDHS supports the McGrath Report's recommendation for 'a clear clinical pathway of care with stepped resource model for persons subject to Part IIA orders and others in contact with the criminal justice system'. In particular, we recommend that the NT government commit further investment in mental health services and therapeutic supports in NT jails and detention centres.
20. DDHS endorses the recommendations made in the McGrath Report in relation to system delivery and management oversight of the NT's mental health sector.

Introduction

DDHS was established in 1991 as an Aboriginal Community Controlled Health Service. Our aim is to improve the physical, mental, spiritual, cultural and social wellbeing of Biluru (and Torres Strait Islander) people in the Yilli Rreung (greater Darwin) region. We provide services from nine locations, reaching more than 15,000 people; approximately 80 per cent of the Aboriginal population residing in the Darwin/Palmerston region.

The DDHS vision is outlined in our strategic plan 2017-22; 'that the health, well-being and quality of life of Aboriginal and Torres Strait Islander Australians equals that of non-Indigenous Australians.' To achieve this, DDHS has adopted a comprehensive approach to the delivery of primary health care with integrated services.

Comprehensive primary health care encompasses the range of health care generally offered by general practice but extends beyond that to provide specialist and allied health professionals; health promotion and education; care coordination for clients with complex health needs; social emotional wellbeing and alcohol other drugs services.

Since July 2016, DDHS has been involved in supporting the social and emotional wellbeing of young people at Don Dale Youth Detention Centre (**DDYDC**) which has now developed into a program known as the Youth Social Support Program. On 1 July 2020, DDHS took over the delivery of primary health care at DDYDC with a full-time general practitioner, allied health/mental health practitioner and registered nurse, and an after-hours on-call service.

This submission was compiled by the DDHS policy team with input from staff across our organisation, including the Social and Emotional Wellbeing Team and the in-reach child and adolescent forensic psychiatrist to DDYDC, Dr Brendan Daugherty.

Background

DDHS's aspiration is for a robust, efficient and modern mental health and wellbeing system, where Aboriginal and Torres Strait Islander self-determination, culture and dignity are respected and upheld in the design and delivery of treatment, care and support. Aboriginal and Torres Strait Islander people, alongside all Territorians, should be able to access safe, inclusive, and respectful services that are responsive to community and individual needs. While there have been many recent investments and encouraging initiatives to improve the NT's mental health sector, there remains significant deficiencies that require addressing to achieve the vision outlined above.

Aboriginal and Torres Strait Islander people access medical and mental health services at markedly lower rates than non-Indigenous Australians. For example, Aboriginal and Torres Strait Islander young people experience higher rates of mental health issues and are more likely to end their life by suicide than non-Indigenous youth, yet under-utilise mental health services and engage in healthcare at more advanced stages of illness and for shorter periods.[1] Similarly, despite being hospitalised at over twice the rate of non-Indigenous men, a third of Aboriginal and Torres Strait Islander men did not access health care when they needed it in the past 12 months.[2]

Key factors that influence engagement and health outcomes for Aboriginal and Torres Strait Islander communities include the quality, capacity and cultural appropriateness of health services, as well as differences in emotional health literacy, language and worldview.[3] One major contributing factor to this is the lack of availability and utilisation of interpreting services. This is compounded by issues of mistrust of service providers in the context of historical and contemporary discrimination in health services, paternalistic policy and culturally unsafe or inappropriate services.

In particular, the NT has unique challenges that affect the provision and utilisation of mental health services. This includes the large populations in rural and remote settings, thin markets and workforce issues, and the high level of disadvantage and trauma experienced by many people, but particularly Aboriginal and Torres Strait Islander people, in the NT.

As acknowledged in the Discussion Paper, Aboriginal and Torres Strait Islander people experience markedly higher rates of mental illness and emotional ill-health. The reported rate of suicide, hospitalisations for diagnosed emotional disorders and emergency department attendances for emotional health-related issues are two to three times greater for Aboriginal and Torres Strait Islander people than non-Indigenous Australians.[4]

This is often explained due to a higher prevalence of stressful life events and psychological distress, including death of a family member or close friend, overcrowding at home and alcohol and drug-

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[1] Puszka, S., Nagel, T., Matthews, V. et al. Monitoring and assessing the quality of care for youth: developing an audit tool using an expert consensus approach. *Int J Ment Health Syst* 9, 28 (2015). https://doi.org/10.1186/s13033-015-0019-5, 2; Write, M. et al. "If you don't speak from the heart, the young mob aren't going to listen at all": An invitation for youth mental health services to engage in new ways of working, 3.

[2] Snodgrass et al. (2020) 'Evaluation of a culturally sensitive social and emotional well-being program for Aboriginal and Torres Strait Islanders' *Aust J Rural Health* 28, 328.

[3] Ibid.

[4] Ibid.

related problems.[5] Approximately a third of Aboriginal and Torres Strait Islander people experience high or very high levels of psychological distress, which is about 2.5 times the non-Indigenous rate.[6] These stressors often stem from the inequality experienced by Aboriginal and Torres Strait Islander people across the social determinants of health - a legacy of colonisation, intergenerational trauma, cultural dislocation and discriminatory political interventions.[7]

In the face of these challenges, Aboriginal and Torres Strait Islander communities remain resilient and strong, steeped in the cultural traditions and knowledges that have sustained these communities for thousands of years. Indeed, many of the solutions needed to redress these systemic challenges are known and advocated within Aboriginal and Torres Strait Islander communities, and are being practiced by Aboriginal community controlled health organisations and Aboriginal health practitioners.

The issues identified require systemic reform of the mental health sector. While it is just one piece of a larger system reform, legislation plays a pivotal role in effecting this reform by embedding a cultural shift from the top down, creating direction and accountability for practitioners, and providing more suitable practices and remedies for Aboriginal and Torres Strait Islander clients suffering mental health issues. Understanding these issues highlights the importance and urgency of enacting reform and underpins much of the discussion that occurs within this Submission.

Feedback in relation to matters raised in the discussion paper

Part One: Principles and Rights of the Patient

Recovery

DDHS is supportive of incorporating a recovery-oriented model of care into the Act. Doing so signifies a shift towards a more client-focused approach underpinned by principles of hope and resilience, which are fundamental to a person's wellbeing. It also better aligns with the *NT Mental Health Strategic Plan 2019-2025*, which adopts a strengths-based and recovery-oriented approach that promotes resilience, independence and self-management across the lifespan.

To strengthen this framework, we believe it is also necessary to fully integrate a human rights framework that recognises the client's inherent dignity, freedom and right to achieve their full potential in all aspects of life by obtaining the highest attainable standard of mental health.

DDHS practitioners have expressed the importance of providing practical definitions and guidance within the legislation on what recovery is and how it can be supported and achieved. This will ensure greater understanding of and compliance with this conceptual framework. However, we recognise the utility of retaining a definition that is broad enough to allow for a subjective, client-determined definition of recovery, which has been acknowledged as being "a deeply personal, unique process".[8]

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[5] Nagel T, Thompson C (2009) The Central role of Aboriginal families in motivational counselling: family support and family 'humbug'. *Australian Indigenous Health Bulletin* 10(1). < http://healthbulletin.org.au/articles/the-central-role-of-aboriginal-families-in-motivational-counselling-family-support-and-family-humbug/>.
[6] Royal Commission into Victoria's Mental Health System, Volume 3, p 144.
[7] Ibid; Commonwealth of Australia (2017) National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing. Canberra: Department of the Prime Minister and Cabinet, 7.
[8] Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal, 16*(4), 11–23.

We emphasise the need to move beyond the primary goal of 'clinical recovery' to one that focuses on 'personal recovery', which allows for a person to lead a meaningful and contributing life, with or without mental health challenges.[9]

1. DDHS supports the inclusion of a recovery-oriented framework within the Act. The Act should provide practical guidance on its application, while remaining broad and flexible enough to respond to clients' needs. Recovery should be a holistic concept that focuses on personal recovery rather than simply centre clinical recovery.

Capacity and informed consent

Unreasonable refusal

Under Part 3 of the Act, a criterion for involuntary admission is that "the person is not capable of giving informed consent to the treatment or has unreasonably refused to consent to the treatment". This empowers practitioners to admit a person against their will who has the capacity to provide consent but, in the opinion of the clinician, unreasonably refuses to provide it. Admitting a client in such circumstances appears to conflict with principles of self-determination and autonomy, and is incongruent with a person-centred and human rights approach.

Notwithstanding this, DDHS mental health practitioners have recognised that in rare and specific situations, this function may play a necessary role in safeguarding clients, as well as their families and communities, from imminent harm due to their mental illness. Removing the unreasonable refusal criteria could also undermine effective treatment and ethical practice in certain circumstances. For example, a depressive episode and severe suicidal ideation may be a temporary state for a client who, with the appropriate treatments and supports, is able to recover shortly afterwards. Indeed, nine out of ten people who attempt suicide and survive do not end up dying by suicide.[10]

In order to address the competing priorities of client safety and a client's rights, DDHS recommends that the Act incorporate a provision that provides greater guidance on what is considered 'unreasonable refusal' under Part 3 of the Act to ensure that this criterion is only used when the harm or deterioration, or likely harm or deterioration, of a person is of such a serious nature that it outweighs the person's right to refuse to consent.[11] What is considered 'unreasonable' should be determined objectively, to negate the potential of subjective personal judgement or opinion of the clinician.

Capacity to provide informed consent

DDHS notes that the Act provides little guidance to practitioners on assessing a person's ability to provide informed consent. A clearer framework for this would ensure more accurate assessments of decision-making capacity and better practice of involuntary admissions.

Clearer guidelines and more accurate assessments may also lead to less use of the 'unreasonable refusal' criterion. For example, clients that experience major depressive episodes and severe suicidal

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[9] State of Victoria, Royal Commission into Victoria's Mental Health System, Final Report, Summary and recommendations, Parl Paper No. 202, Session 2018-21 (document 1 of 6), 12.

[10] Owens D, Horrocks J, and House A. Fatal and non-fatal repetition of self-harm: systematic review. British Journal of Psychiatry. 2002;181:193-199.

[11] This criterion was adapted from s 66(2)(d) of the *Mental Health Act 2015* (ACT).

ideation may appear to be rational in their decision-making capacity and able to provide informed consent. Where such clients do not consent to treatment, clinicians therefore often involuntarily admit them on the basis of 'unreasonable refusal' to prevent the client from attempting suicide.

However, research shows that depression can indeed impair a client's decision-making capacity, especially if severe, despite the client being considered autonomous and coherent.[12] Such clients should be deemed 'unable to provide informed consent', however it is unclear whether these findings are widely known and utilised by clinicians in assessing clients with depression, and what decision-making capacity model is used in the NT. Creating a uniform assessment model that incorporates criteria that reflects these considerations will ensure more accurate findings of a client's ability to provide informed consent and ensure that the 'unreasonable refusal' criterion is limited to very rare and specific circumstances.

DDHS recommends the insertion of a provision that sets out criteria that practitioners must use to determine whether a person has capacity to provide informed consent. DDHS recommends the adoption of the criteria provided under s 7 of the *Mental Health Act 2015* (ACT), which provides comprehensive yet straightforward criteria:

> For this Act, a person has capacity to make a decision in relation to the person's treatment, care or support for a mental disorder or mental illness (decision-making capacity) if the person can, with assistance if needed—
>
> (a) understand when a decision about treatment, care or support for the person needs to be made; and
>
> (b) understand the facts that relate to the decision; and
>
> (c) understand the main choices available to the person in relation to the decision; and
>
> (d) weigh up the consequences of the main choices; and
>
> (e) understand how the consequences affect the person; and
>
> (f) on the basis of paragraphs (a) to (e), make the decision; and
>
> (g) communicate the decision in whatever way the person can.

DDHS also recommends the insertion of a provision that stipulates principles that must be considered in determining a person's capacity to provide informed consent. We recommend adopting the principles provided under s 8 of the *Mental Health Act 2015* (ACT), noting that there needs to be additional principles in relation to youth, as set out below.

Other than the addition of these sections, DDHS is supportive of retaining the current s 7 of the Act, which provides importance guidance to practitioners about the way in which informed consent must be obtained.

2. DDHS recommends that the criterion of 'unreasonable refusal' for involuntary admission be clarified and defined within the Act to ensure that it is only used when the harm or deterioration, or likely harm or deterioration, of a person is of such a serious nature that it outweighs the person's right to refuse to consent.

[12]Hindmarch et al. (2013) 'Depression and decision-making capacity for treatment or research: a systematic review' *BMC Medical Ethics* 14:54.

3. DDHS recommends the insertion of a provision that sets out criteria that practitioners must use to determine whether a person has capacity to provide informed consent. DDHS recommends the adoption of the criteria provided under s 7 of the *Mental Health Act 2015* (ACT).
4. DDHS recommends the insertion of a provision that stipulates principles that must be considered in determining a person's capacity to provide informed consent. This provision should be similar to s 8 of the *Mental Health Act 2015* (ACT).

Part Two: Person centred approach

Wills and Preference

DDHS is supportive of ascertaining the wills and preferences of a client as part of their treatment plan. This promotes client participation and engagement in their care and treatment, which is fundamental to quality mental health services and to recovery. It is also in line with a client-centred and recovery-oriented approach by promoting principles of self-determination and autonomy.

DDHS believes that the legislative provisions under the *Mental Health Act 2016* (QLD) relating to consumer participation, namely under ss 5(b) and s 25, combined with the active promotion of 'advance health directives' are an exemplary model that should be adopted by the NT.

5. DDHS is supportive of ascertaining the wills and preferences of a client as part of their treatment plan and that the Act should adopt the legislative provisions under the *Mental Health Act 2016* (QLD) relating to consumer participation, namely under ss 5(b) and s 25, combined with the active promotion of 'advance health directives'.

Nominated support person

DDHS is supportive of incorporating a nominated support person where a client becomes an involuntary patient. This represents a shift from a paternalistic 'best interests' approach, to one that promotes greater advocacy for the client's wills, preferences and rights.

We believe this would work most effectively by allowing a client to choose up to two nominated support persons, as is the model under the *Mental Health Act 2016* (QLD). To avoid situations of dispute between the nominated support persons, the client should be required to delegate a 'primary' and 'secondary' position if they choose to nominate two support persons.

DDHS believes that nominated support persons should not be a role confined to certain people, such as relatives or partners. Any person should be able to be nominated provided they are willing to do so and are able to fulfil the functions and responsibilities of the role (as is the case under sections 24-27 of the *Mental Health Act 2014* (Vic)).

Within many Aboriginal cultures there are important kinship relationships that govern who has responsibility for and power over another person. For example, many Aboriginal people use the term 'jungai' which refers to the 'boss for that person', someone within the kinship network with cultural authority and decision-making responsibility for, and power over that person. These relationships and kinship structures are not uniformly acknowledged and respected within the healthcare system. Allowing the client to nominate any nominated support person will allow for greater recognition of these kinship structures within the mental health sector.

6. DDHS is supportive of legislating to allow a client to nominate a nominated support person in the event that a client becomes an involuntary patient. Clients should be able to choose up to two nominated support persons. Where two nominated support persons are nominated, one must delegated as the 'primary' position, and the other the 'secondary' position. A nominated support person should not be a role confined to certain people in relation to the client.

Cultural Security

Embedding cultural security in the legislation goes beyond ensuring basic cultural awareness. It necessitates minimum standards of practice to ensure that processes and services are culturally safe for Aboriginal and Torres Strait Islander clients at an operational level. DDHS believes that cultural security within the Act could be improved in the following domains:

Amendments to section 11

We recommend that s 11 of the Act be repealed and replaced with the following provision:

S 11 Principles related to admission, care and treatment of Aboriginal and Torres Strait Islander persons

(1) Where a court, tribunal or person exercises a power or conducts proceedings under this Act in respect of a person of Aboriginal or Torres Strait Islander background, the power must be exercised or the proceedings must be conducted –

a. with proper recognition of the importance and significance to the person of the person's connection to family, kinship, culture, land, sea, spirituality and ancestry; and

b. with proper recognition of the contribution those connections make to the person's social and emotional wellbeing; and

c. with proper respect for the person's cultural and ethnic identity, language, and religious or ethical beliefs.

(2) When providing treatment and care to a person of Aboriginal and Torres Strait Islander background, the following principles apply:

a. The assessment, treatment and care of the person must be conducted according to the requirements under s 11(1).

b. The person's treatment and care are to be appropriate to and consistent with the person's cultural beliefs, practices and mores, taking into account the views of the person's family and community.

c. Where appropriate, cultural and traditional remedies and treatments are to be facilitated as far as practicable.

d. The assessment, treatment and care of a person is, where possible, to be provided in collaboration with an Aboriginal and Torres Strait Islander health practitioner.

This suggested provision affords greater recognition of Aboriginal understandings of mental health through a 'social and emotional wellbeing' framework. Such understandings provide effective,

culturally-safe guidance on recovery-oriented practice for the admission, assessment, treatment and care of Aboriginal and Torres Strait Islander people.

Social and emotional wellbeing is a holistic view of health that includes the social, emotional, cultural, and spiritual wellbeing of a person. It recognises that mental health is shaped by connections to kinship and community, land and sea, culture and spirituality, and is influenced not only by the social determinants of health, but also by historical, political and cultural determinants.[13] It acknowledges that the factors that influence a person's wellbeing are also capable of providing a protective and pivotal role in the care, treatment and support of a person.[14]

Given that approximately a third of the NT's population is Aboriginal or Torres Strait Islander, it is appropriate and necessary to provide such understandings of mental health within legislation to better guide practitioners on proper and culturally safe practice. Incorporation of this epistemological framework departs from the imposition of a Western paradigm on people of non-Western cultural backgrounds where such treatment would be culturally inappropriate, unsafe or ineffective. This holistic understanding of social and emotional wellbeing sits well within the broader goals of recovery mentioned above and is based on the corresponding cultural provision of s 5 under the *Mental Health (Compulsory Assessment and Treatment) Act 1992* (NZ).

In addition, the suggested provision also expands s 11 to apply to a court, tribunal and person exercising power under the Act, and not just practitioners that conduct assessments and provide care and treatment during involuntary admission.

Further, the proposed s 11(2)(c) provides that cultural remedies are to be facilitated and provided where appropriate. There is growing recognition of the importance of recognising culture bound syndromes and treating them with traditional cultural interventions in order to ensure cultural and clinical competence, especially in the context of escalating rates of Aboriginal and Torres Strait Islander suicide and mental health.[15] Common culture bound syndromes include being 'sung' or cursed, longing for country, and 'sorry time'. These syndromes are often misdiagnosed as psychosis, as the symptoms share similar traits to that contained in the DSM-IV. This may be a contributing factor as to why Aboriginal people have the highest rates of psychotic illness in Australia, reportedly experience psychosis at 1.8 times the rate of non-Indigenous people and are hospitalised at 2.4 times the rate.[16]

It is crucial to treatment efficacy that assessments are accurate and rigorous, which necessitates greater awareness of culture-bound syndromes and effective cultural treatments. Western treatment of patients tends to focus on individual intrapsychic experience or individual pathology, while effective Indigenous practices are often based on more group-based interventions and

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[13] Witness Statement of Dr Graham Gee to *Royal Commission into Victoria's Mental Health Sector*, 10 July 2019, paras. 6–7

[14] See, for example, ___ which found that 'family' is the key precipitant and perpetuating factor for illness in Aboriginal and Torres Strait Islander people, as well as a key protective factor.

[15] Tracy Westerman (2021): Culture-bound syndromes in Aboriginal Australian populations, Clinical Psychologist, DOI: 10.1080/13284207.2020.184396, 1.

[16] Ibid, 3.

community processes.[17] The important role that cultural healers, Elders and others play in maintaining and healing social and emotional wellbeing is being increasingly acknowledged within health services and literature.[18] This underpins the rationale behind the inclusion of s 11(2)(c).

<u>Involuntary treatment</u>

DDHS recommends that a provision should be inserted in the Act that provides:

> When conducting an assessment for the involuntary admission of a person of Aboriginal or Torres Strait Islander background, the assessing practitioner must either:
>
> (a) be an Aboriginal health practitioner;
>
> (b) consult with an Aboriginal health practitioner; or
>
> (c) consult with a proposed patient or patient's family.

Mandating consultation with a patient or patient's family mirrors the requirement in the *Mental Health (Compulsory Assessment and Treatment) Act 1992* (NZ) in which a health practitioner must consult with a patient or their family or whanau when conducting a preliminary assessment or providing treatment under a compulsory treatment order, unless the consultation is not reasonably practicable or in the patient's best interests.

Requiring the assessment to be conducted by or in consultation with an Aboriginal health practitioner recognises that Indigenous patients receive better health outcomes where Indigenous clinicians are utilised in the decision-making process. This also serves to better address the need for greater understanding of culture-bound syndromes while conducting assessments, forming a diagnosis and providing effective treatment, as explained above. Given that Aboriginal people are hospitalised at over twice the rate of non-Indigenous people, culturally safe and competent assessments are crucial in addressing these rates.

<u>Use of interpreters</u>

DDHS mental health practitioners have reported that in the vast majority of cases, interpreters are not being used or are not available where necessary. One clinician reported that approximately 70 per cent of clients in need of interpreting services do not regularly have access to them. The under-utilisation and difficulty accessing interpreters clearly compromises the efficacy of any consent given by such clients and raises concerns in relation to clients' understanding of their admission, treatment and legal rights. DDHS believes this to be particularly important during the stage of assessment for involuntary admission, and so recommends the strengthening of legislative requirements for a qualified interpreter during client assessment.

DDHS practitioners have also reiterated the inherent challenges in identifying and using interpreters in the NT, and the complex cultural issues that often arise. A situation that was reported to be particularly common was where the interpreter cannot provide interpreting services because it would be a transgression of kinship lore. This is particularly challenging where the community of a specific Aboriginal language is considerably small, and thus kinship dynamics are fraught and there

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[17] Tribe R. The mental health needs of refugees and asylum seekers. Mental Health Rev. (2005) 10, 8. doi: 10.1108/13619322200500033

[18] See, for example, the National Strategic Framework for ATSI People's Mental Health and Social and Emotional Wellbeing (2017-2023), 7 and 17.

are a small number of qualified interpreters. Mandating that interpreters be strictly used in all circumstances, without the proviso of ‘as far as practicable’, would therefore not be culturally safe or indeed practical in the current circumstances.

This significant issue in the provision of interpreting services does not appear to be one that can be solved through legislation alone. It requires greater investment in interpreting services and training in order to increase the amount of accredited interpreters available in the NT and improve the accessibility and capacity of such interpreters.

7. DDHS recommends repealing s 11 of the Act, and instead inserting the following:

(1) Where a court, tribunal or person exercises a power or conducts proceedings under this Act in respect of a person of Aboriginal or Torres Strait Islander background, the power must be exercised or the proceedings must be conducted –

   a. with proper recognition of the importance and significance to the person of the person’s connection to family, kinship, culture, land, sea, spirituality and ancestry; and
   b. with proper recognition of the contribution those connections make to the person’s social and emotional wellbeing; and
   c. with proper respect for the person’s cultural and ethnic identity, language, and religious or ethical beliefs.

(2) When providing treatment and care to a person of Aboriginal and Torres Strait Islander background, the following principles apply:

   a. The assessment, treatment and care of the person must be conducted according to the requirements under s 11(1).
   b. The person's treatment and care are to be appropriate to and consistent with the person's cultural beliefs, practices and mores, taking into account the views of the person's family and community.
   c. Where appropriate, cultural and traditional remedies and treatments are to be facilitated as far as practicable.
   d. The assessment, treatment and care of a person is, where possible, to be provided in collaboration with an Aboriginal and Torres Strait Islander health practitioner.

8. DDHS recommends that a provision should be inserted in the Act that provides:

When conducting an assessment for the involuntary admission of a person of Aboriginal or Torres Strait Islander background, the assessing practitioner must either:

(a) be an Aboriginal health practitioner;
(b) consult with an Aboriginal health practitioner; or
(c) consult with a proposed patient or patient’s family.

9. DDHS recommends that the Act include stronger legislative requirements for a qualified interpreter during assessments for involuntary admissions of clients that are unable to communicate adequately in English. We also recommend greater investment in the NT’s interpreting services and robust oversite over the provision and utilisation of such services.

Part Three: Admission and Treatment

Involuntary admission

Involuntarily admitting a person for treatment has significant repercussions on the individual. The deprivation of their liberty and autonomy, as well as the risk of traumatisation, needs to be balanced against the necessity of such treatment and the likelihood that treatment will have a positive impact. The severity of involuntary admission orders is recognised throughout the legislation, in which criteria repeatedly requires that "there is no less restrictive means of ensuring that the person receives the treatment and care". However, there are provisions in the Act that allow for the involuntary admission of persons where it may be overwhelmingly detrimental and unnecessary in the circumstances.

Involuntary admission on the grounds of mental disturbance

DDHS recommends that the provisions that allow for involuntary admission on the grounds of mental disturbance, namely sections 15, 42, 43 and 44, be repealed in their entirety.

The term 'mentally disturbed' is defined under section 4 as 'behaviour of a person that is so irrational as to justify the person being temporarily detained under this Act'. A person does not have to have a mental illness in order to justify involuntary admission on the grounds of mental disturbance. In the absence of a requirement of mental illness, these provisions appear to address behavioural issues of 'abnormally aggressive behaviour' and 'seriously irresponsible conduct' rather than any underling infirmity of the mind that requires treatment.

The implications are that violent and hostile patients are 'detained' in hospital wards, where this is often an inappropriate setting for them. Their admission also has significant implications on the treatment they are able to access in the future and often results in prolonged periods of detainment until the behavioural issues have subsided. Such admissions can also impact negatively on the patient's education, employment and personal relationships. Removing this ground for involuntary admission will bring the NT in line with every other jurisdiction in Australia (aside from NSW that allows for involuntary admission for the 'mentally disordered').

Involuntary admission on the grounds of complex cognitive impairments

DDHS recommends that the provisions that allow for involuntary admission on the grounds of complex cognitive impairment, namely sections 15A, 44B, 44C and all related provisions, be repealed in their entirety.

The term 'complex cognitive impairment' under s 6A is defined as a cognitive impairment with a behavioural disturbance; that is, the person is behaving in an aggressive manner or is engaging in seriously irresponsible conduct. Similar to 'mental disturbance', the involuntary admission of a person with complex cognitive impairment appears to target the problematic behavioural issues of the person rather than mental health issues.

In these circumstances, we are concerned that detaining the person is not therapeutically sound, as it may serve to escalate the behavioural, resulting in police apprehension and even more restrictive measures to maintain compliance. The involuntary admission of a person, which essentially serves as a method of detainment, should not be a response to violent or challenging behaviour. There is no other jurisdiction in Australia that allows for the involuntary admission of a person on the grounds of complex cognitive impairment.

Youth

DDHS believes that greater clarity is needed in the Act regarding the capacity of a young person to provide consent. DDHS is supportive of legislating the common law 'Gillick competency' principle as outlined in the Discussion Paper and that capacity to consent should not be a set principle of age.

This test recognises that maturity, intelligence and comprehension are not qualities instantly acquired at a certain age, and that the capacity to consent should be assessed for each individual client. In line with this, we believe that the role of the parent or guardian's capacity to consent on behalf of the young person should be reduced as the young person's capacity and maturity grows.

DDHS recommends that this be included as part of the provision of 'principles' relating to a person's capacity to provide informed consent, which was recommended to be included above. The principles should stipulate that a person must not be treated as being unable to provide informed consent only because of their age.

Young people should also be screened for markers of developmental delay to determine whether further assessment (FASD, cognitive or functional assessment) is required. This assessment process should help clinicians to determine whether the young person has capacity to consent to admission and treatments.

Apprehension by Police

DDHS believes that where it is necessary to involve police to apprehend a person, apprehension must be conducted in a way that respects the dignity and rights of the person and uses the least amount of force necessary. As such, DDHS recommends the insertion of s 32(8) which would provide: 'Where the use of force is necessary to apprehend a person under this section, a police officer must use the least amount of force necessary to achieve the apprehension.'

To ensure that s 10(b) is effectively adhered to so that police officers are genuinely used as a method of last resort, DDHS echoes Recommendation 10 of the *Royal Commission into Victoria's Mental Health System* (albeit applied to the NT). Recommendation 10 recommends that the Victorian government:

1. ensure that, wherever possible, emergency services' responses to people experiencing time-critical mental health crises are led by health professionals rather than police.
2. support Ambulance Victoria, Victoria Police and the Emergency Services Telecommunications Authority to work together to revise current protocols and practices such that, wherever possible and safe:
    a. Triple Zero (000) calls concerning mental health crises are diverted to Ambulance Victoria rather than Victoria Police; and
    b. responses to mental health crises requiring the attendance of both ambulance and police are led by paramedics (with support from mental health clinicians where required).
3. ensure that mental health clinical assistance is available to ambulance and police via:
    a. 24-hours-a-day telehealth consultation systems for officers responding to mental health crises;
    b. in-person co-responders in high-volume areas and time periods; and
    c. diversion secondary triage and referral services for Triple Zero (000) callers who do not require a police or ambulance dispatch.

Further, to maintain consistency with s 8(b) of the Act, we strongly urge that police do not use a paddy wagon in the apprehension of a person under s 10(b) and that further policy be developed to deter such methods of apprehension.

DDHS is aware of the current NT Department of Health initiative to implement a Mental Health Co-Response team to acute mental health crises in the Darwin region through the coordination of services between NT police, St Johns Hospital and NT health clinicians. A purported aim of the initiative is to improve early intervention in mental health crises and avoid potentially inappropriate delays and restrictions of freedom (including avoidance of police custody).[19] While we are yet to see an evaluation of the project, DDHS is, in principle, supportive of this multi-disciplinary approach.

10. DDHS recommends that the provisions that allow for involuntary admission on the grounds of mental disturbance be repealed in their entirety.
11. DDHS recommends that the provisions that allow for involuntary admission on the grounds of complex cognitive impairment be repealed in their entirety.
12. DDHS recommends that the Act legislate the Gillick competency test so that a person is not considered incapable of providing information consent because of their age. This should be incorporated as part of principles to consider when determining if a person is capable of providing informed consent.
13. DDHS recommends the insertion of s 32(8) which would provide: 'Where the use of force is necessary to apprehend a person under this section, a police officer must use the least amount of force necessary to achieve the apprehension.'

Part Four: Monitoring

Chief Psychiatrist

DDHS is supportive of the Chief Psychiatrist being afforded greater responsibility and power through legislative provisions. DDHS endorses the recommendations outlined in the Discussion Paper as identified in the 'Chief Psychiatrist Review'. In addition, we recommend that there be legislative provision that the Chief Psychiatrist is responsible for the delivery of a mental health and wellbeing system that responds to the needs of Northern Territory's diverse communities and promotes access and equity of outcomes.[20] This should be with particular reference to oversight of Aboriginal and Torres Strait Islander cultural safety, including the strengthening of interpreting services, the facilitation of cultural and traditional medicines, and promotion of cultural and health literacy.

Regulating Restrictive Practices

DDHS strongly supports further clarification and regulation regarding the use of chemical restraint within the Act. Practitioners have reported many stories in which they have witnessed that chemical restraint has been used as a method of convenience to manage difficult behaviour, rather than being used only where it is immediately necessary to prevent harm to the patient. We believe this to be unacceptable.

We endorse the recommendation made by the Health and Community Services Complaints Commission, in which the Act "should include a clear definition of chemical restraint and provision of

[19] NT Government, Public Inquiry into Mental Health, Submission 1220 (23 January 2020), 7.

[20] This is based off of recommendation 34(2) of the *Royal Commission into the Victorian Mental Health System*.

appropriate safeguards, including oversight and record keeping; and be consistent with existing disability legislation. This should be accompanied by clear policy guidance and training for professionals involved in administration of chemical restraint".[21]

A definition similar to that provided under the *Mental Health Act 2013* (Tas) in relation to chemical restraint should be adopted, that is: "medication given primarily to control a person's behaviour, not to treat a mental illness or physical condition".

14. DDHS is supportive of the Chief Psychiatrist being afforded greater responsibility and power through legislative incorporation and endorses the recommendations outlined in the Discussion Paper as identified in the 'Chief Psychiatrist Review'.
15. DDHS recommends that there be legislative provision that the Chief Psychiatrist is responsible for the delivery of a mental health and wellbeing system that responds to the needs of Northern Territory's diverse communities and promotes access and equity of outcomes, with particular reference to oversight of cultural safety regarding services for Aboriginal and Torres Strait Islander people.

Part Five: Forensic Provisions

Fitness to Stand Trial

As the Discussion Paper identifies, a 'significant deficiency' within the Act is that the Local Court does not have the power to determine fitness to stand trial. To resolve this, DDHS endorses the recommendations made by the Northern Territory Law Reform Committee's *Report on the Interaction between people with Mental Health Issues and the Criminal Justice System* (May 2016). In particular, we support recommendations 18, 19 and 20, which were identified in the Discussion Paper in relation to this issue. These recommendations empower the Mental Health Diversion List to make therapeutic supervisory orders and deal with questions relating to a defendant's fitness to stand trial, and that these process and matters be simplified as far as practical to align with the practice and conduct of the Court of Summary Jurisdiction.

Indefinite Term for Supervision Orders

The Discussion Paper also identifies the issue of an 'indefinite term' that arises under s 43ZC of the Criminal Code. Subjecting a person to an indefinite term in which their liberty is confined is an abrogation of human rights and likely inconsistent with Australia's international obligations not to subject any person to torture or to cruel, inhuman or degrading treatment or punishment.

As such, we believe it is imperative to amend s 43ZC such that supervision orders are required to have an actual term of cessation. As recommended in the NT Law Reform Committee's Report, we believe the supervision order should be for no longer than 12 months, having regard to the therapeutic needs of the person.

Availability of appropriate facilities for persons on supervised orders

For many years advocacy groups have highlighted concerns regarding the indefinite detention of people sentenced under Part IIA of the NT *Criminal Code*, that is persons found 'not fit to plead' or

[21] NT Health and Community Services Complaints Commission, 8 August 2019, De-Identified Investigation Report, 61.

'not fit to stand trial' due to mental impairment.[22] Part IIA provides for these people to be accommodated in an 'appropriate place', namely a therapeutic facility other than a correctional facility.[23] However, the NT does not currently have a facility of this nature.

At present, there are no secure therapeutic residential facilities for people found not guilty due to mental impairment, and so people with complex health and mental health needs are effectively kept indefinitely in designated sections of adult correctional facilities (prisons), until a judge determines that they are no longer a risk to the community.[24]

A report on the review of Forensic Mental Health and Disability Services within the Northern Territory prepared by David McGrath in January 2019 ('the McGrath Report'), noted the prevalence of forensic mental health orders in the NT is higher than in other jurisdictions.[25] This report also noted the inadequacy of existing facilities to cater to these complex needs, recommending:

- that the NT Government develop "as a matter of urgency, a territory wide services plan for clients of forensic mental health and forensic disability services that incorporates secure inpatient or residential care, secure supported accommodation and access to community based forensic supports at a minimum. The role and responsibility of, and interface with, the National Disability Insurance Scheme should be made clear in the plan" (recommendation 3)
- that the Northern Territory Government shift "operational authority for the Complex Behavioural Unit at the Darwin (Holtz) Correctional Complex to NT Health, and degazettes the facility as a correctional unit in favour of changing the legal status to a health facility, approved as a treatment facility within the meaning of the Mental Health and Related Services Act. Appropriate changes to the existing security arrangements, staffing and physical asset should be made to allow this change to occur" (recommendation 4).

This situation is even worse for children and young people. At present there are no secure residential facilities that a young person under a supervision order can be admitted to. The lack of alternatives to custodial correctional facilities fetters the jurisdiction of the court to commit a young person who has not been found guilty of a crime to a detention centre without the proper therapeutic facilities necessary to provide adequate treatment.

The following observation was made by Grant CJ in the case of *The Queen v KG* [2020] NTSC 24, in which his Honour committed a young person who was found unfit to stand trial due to severe cognitive impairments and liable to a supervision order, to custody in a custodial correctional facility under s 43ZA:

> "The Court is entirely reliant on the Executive to make appropriate facilities and services available for the custody, care or treatment of accused people who continue to present the relevant level of risk to either themselves or the community. There is in this jurisdiction a

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[22] Senate Standing Committee on Community Affairs. Report on the Inquiry into 'Indefinite Detention of People with Cognitive and Psychiatric Impairment in Australia.' Chapter 2.

[23] See s 43ZA(2A) Criminal Code

[24] See discussion of this in https://www.abc.net.au/news/2019-02-10/justin-walker-indefinite-detention-prison-mentally-unfit-guilty/10796740; see also criticism of this situation in Supreme Court decisions: R v KMD [No 2] [2017] NTSC 18 and *R v Ebatarintja* [2010] NTSC 6

[25] https://www.alrc.gov.au/sites/default/files/subs/118._nt_government.pdf.

> dearth, or at least a shortage, of appropriate secure accommodation outside the custodial correctional context to house supervised persons subject to custodial supervision orders.
>
> **In the absence of those facilities or services in some other appropriate place, an accused person who does present that form of risk must necessarily be committed to a custodial correctional facility. As this Court has observed on many previous occasions, that situation is far from ideal**." (emphasis added)

DDHS strongly urges the NT government to create and invest in secure therapeutic residential facilities for children and adults to rectify this pressing issue.

Clinical pathways for forensic clients

DDHS supports *the McGrath Report's* recommendation for 'a clear clinical pathway of care with stepped resource model for persons subject to Part IIA orders and others in contact with the criminal justice system'. In particular, DDHS practitioners have identified the need for more explicit pathways for young people to be diverted to community sentencing options and to have greater access to culturally appropriate organisations for the creation and implementation of their treatment plans.

Our experience delivering primary health care at DDYDC has highlighted the high prevalence of complex health and mental health needs of people in the justice system. A recent study at Banksia Hill Detention Centre in Western Australia found that 89 per cent of young people in detention have a severe neurodevelopmental impairment, and 39 per cent were diagnosed with Fetal Alcohol Spectrum Disorder (FASD). Whilst we cannot yet provide rigorous estimates of the prevalence of FASD or neurodevelopmental impairment at DDYDC, early indications are that it is at least as high as that found in the Banksia Hill study.

There is currently no therapeutic model of care in place within detention centres in the NT, and a significant lack of mental health supports and therapeutic interventions. This is due to limited governmental resources and a lack of medicare funding, which prevents health services from delivering comprehensive primary health care in detention.

Given the high prevalence of neurodevelopmental impairments and mental health issues among adults and children in the justice system, there is a clear need for accessibility of multidisciplinary and functional assessments to identify and understand these complex needs and ensure timely access to supports. Currently, diagnostic assessments can often take months or even years to finalise and progress.

We are also concerned about the lack of appropriate therapy or support for people with FASD or other neurodevelopmental impairments, such as Autism Spectrum Disorder, Attention Deficit Hyperactivity Disorder and Intellectual Disability, while in detention and upon release. People with neurodevelopmental impairment in the justice system require specialised services and supports, including for example communication intermediaries that can support effective communication with service providers and detention staff. We have observed that such essential therapeutic services are not being provided in a timely and regular manner.

DDHS emphasises the need for a comprehensive and holistic approach to health care – one that aims to prevent developmentally vulnerable young people from entering detention, caters to young people while in detention, and continues to support and care for them post release. This requires a multi-disciplinary team and wraparound service model, equipped with culturally appropriate

services that integrates early assessment, multi-disciplinary and specialist treatment and therapeutic interventions.[26]

The Senate's FASD Report noted that some ACCHS are already delivering effective programs which prevent, diagnose and manage FASD in Aboriginal communities, citing Congress Child and Youth Assessment and Treatment Service (CYATS) in Alice Springs as an example of such a successful program. The report noted with concern that that CYATS funding is ad hoc, fragmented and uncertain in the long term,[27] and concluded that similar clinics should be set up in other locations 'where there is an identified need for such services'. This service cannot be properly accommodated through the current funding model without additional funding and Medicare subsidy.

DDHS strongly recommends that the NT Government provide greater investment in mental health services and therapeutic supports available for people in detention and jail, with a focus on culturally safe services that integrate early assessment, multi-disciplinary and specialist treatments.

System Delivery and Management Oversight

DDHS endorses the recommendations made in the *McGrath Report* in relation to system delivery and management oversight of the NT's mental health sector. We consider the implementation of these recommendations to be a matter of importance and urgency.

16. DDHS endorses the recommendations made by the Northern Territory Law Reform Committee's *Report on the Interaction between people with Mental Health Issues and the Criminal Justice System* (May 2016). In particular, we support recommendations 18, 19 and 20, which were identified in the Discussion Paper in relation to this issue.
17. DDHS recommends that s 43ZC be amended such that supervision orders are required to have an actual term of cessation which do not exceed 12 months.
18. DDHS strongly urges the NT government to create and invest in secure therapeutic residential facilities.
19. DDHS supports *the McGrath Report's* recommendation for 'a clear clinical pathway of care with stepped resource model for persons subject to Part IIA orders and others in contact with the criminal justice system'. In particular, we recommend that the NT government commit further investment in mental health services and therapeutic supports in NT jails and detention centres.
20. DDHS endorses the recommendations made in the *McGrath Report* in relation to system delivery and management oversight of the NT's mental health sector.

[26] See Senate FASD Inquiry Final Report, at 4.6] – 4.8]; see also Professor Carol Bower and Professor J Eliot AM, Australian guide to the diagnosis of FASD, 2016, p.4, FASD Research Australia, Submission 42, p8.

[27] At [6.80]