North Australian Aboriginal Justice Agency

Submission on the 'Discussion Paper for the Mental Health and Related Services Act 1998 Review'

Northern Territory Government, Department of Health

June 2021

About NAAJA

The North Australian Aboriginal Justice Agency (NAAJA) provides high quality, culturally appropriate legal aid services for Aboriginal people in the northern and central region of the Northern Territory in the areas of criminal, civil and family law, prison support and through-care services. NAAJA is active in systemic advocacy and law reform in areas impacting on Aboriginal peoples' legal rights and access to justice. NAAJA travels to remote communities across the Northern Territory to provide legal advice, legal representation, justice agency services and advocacy.

Priscilla Atkins

Chief Executive Officer, NAAJA

1. PART ONE: PRINCIPLES AND RIGHTS OF THE PATIENT

1.1 *How can we use the legislation to promote the rights of the voluntary consumer or involuntary patient when they are receiving care?*

NAAJA supports efforts to promote the rights of the voluntary consumer and involuntary patient in order to strengthen mental health related legislation.

A human rights based approach can give clearer guidance and direction across the service system and can serve as an incentive for improved compliance. This will also improve the health outcomes of the people of the Northern Territory.

(a) Strengthening the rights of the voluntary consumer and involuntary patient

At a broad level, NAAJA proposes the following principles to inform the process of legislative reform (these principles are not exhaustive, however present as a reference point for the process itself):

- Strengthen access to justice and accountability mechanisms within the system. In complex areas such as mental health and where diverse language and cultural factors are significant it is important to develop a robust system with built in accountability mechanisms. These mechanisms do not need to serve as a threat to the authority of authorised practitioners. Rather, they can serve to assist and support practice. Examples of doing this include involving Aboriginal Community Controlled organisations in delivering certain services (and in agreement with them), empowering Social Work roles with clearly defined rights and responsibilities, legislating recognition of the proposals we make under part 7 of this submission, ensuring Health Justice Partnerships or voluntary consumers and involuntary patients have access to legal aid services in relation to a range of issues that are also impacting their mental health (such as housing, Centrelink, etc.).

- Legislate for appropriate support mechanisms that centre Aboriginal people in relation to services for Aboriginal people. We have made proposals under part 7 of this submission.

- We acknowledge the work done to date including the inquiries and reports listed in the Discussion paper particularly as it relates to forensic mental health. This work provides for recommendations that should be implemented. Whilst we acknowledge and value the opportunity to make a submission in relation to a review of mental health legislation, it is important we use this opportunity to put in place reforms reflective of the work and recommendations done previously.

- Recognise and respond to the nuanced nature of mental health in the Northern Territory. The *Discussion Paper for the Mental Health and Related Services Act 1998 Review* provides a highly valuable analysis including legislation across States and Territories. Given our unique demographics and cultural characteristics across the Territory, there is a need to develop an enhanced and more robust legislative framework taking into account our unique circumstances. Particularly as it relates to treatment and care for voluntary consumers and involuntary patients who have an Aboriginal and/or Torres Strait Islander background, we should be going further than any other State or Territory in developing modern legislation suited to our unique needs.

- Develop legislation with clearly defined rights. Legislation that includes terms such 'as far as practical' etc. often provides sufficient scope and flexibility to deny a person their basic human right (such as accessing information in a language they understand and when an interpreter is not available). Terms or rights that are

broad or can be interpreted in many different ways can be subject to manipulation. Areas of mental health are more sensitive due to the inherent nature of considering the state of the mind at the time of the voluntary consumer or involuntary patient interacting with the system. Language barriers can add to vulnerabilities. People who work within the mental health system require the supports, training and clarity that clearly defined laws and regulations provide.

- Build the case for systemic reform as this also impacts mental health. Factors such as the lack of availability of a suitably qualified workforce willing to take up vacancies across the service system and particularly regional and remote areas can serve a significant role in the level and quality of care provided. In some areas there is a high turnover, and because knowledge that relates to a place and particularly relationships and history and people is so valuable, this high turnover can significantly impact the level of services provided. Other factors such as the lack of available and suitable accommodation options for people affected by mental health and questions such as whether accommodation genuinely meets the needs of the individual can also impact the level and quality of care provided. Historically, legislation that provides a framework for mental health is often not effective in responding directly to these systemic factors.

(b) Nuanced nature of mental health in the Northern Territory

Of itself, mental health is a highly complex area. Whilst significant advances have been made in recent decades in understanding mental health, the nuanced nature of the Northern Territory including different worldviews informed by significant cultural diversity adds to this complexity. A lack of research and genuine, evidence-based explorations particular to the nuanced circumstances of the Northern Territory limits our own assumptions and understandings.

An example of this is during consultations to develop the submission:

> *[feedback from a community member] for our mob in urban areas, it's more ok. But for people in community there is a strong belief in being "sung" and in magic. From this perspective we need traditional doctors to be involved.*

This feedback is broadly reflective of many communities across the Northern Territory. Its meaning and implications would require significant work to properly unpack and understand. Readers of this submission will be informed by their own worldviews and so properly understanding the context of this feedback is limited.

The feedback also connects to other factors that impact mental health and effective service delivery such as the intersection of interpersonal discrimination and also systemic and institutionalised discrimination and colonialism. An example is the prevalence of the criminal justice system on the lives of many Aboriginal Territorians and their families and how the prison and youth detention system in the Northern Territory is based on an approach of confinement (lockdown in areas and in small cells) and places where there have been deaths in custody. In many instances these events can led traumatising events for Aboriginal prisoners affecting their mental health.

Another example is when the COVID-19 pandemic hit. During that time there were calls from many Aboriginal led lobby groups for prisons to de-incarcerate. This was on the basis of the poorer health and vulnerabilities including mental health impacts during a major pandemic on a population confined in small prison cells and spaces, staffing issues and regular lockdowns, and also the mental health stressors for family in community who avoided major population centres to be on country (and were worried about family in prison).

Whilst the *Mental Health and Related Services Act* requires reform and can build on the developments and lessons of other jurisdictions and Subject Matter Experts, when it is done

in isolation to other core parts of government and related legislation that impacts Aboriginal people of the Northern Territory significantly – and when mental health requires a holistic approach – the potential for wider reforms that impact mental health is not realised.

(c) Section 8 of the Act

To inform this submission NAAJA received pro bono assistance from a national law firm to consult across NAAJA's staff base including frontline services and Subject Matter Experts to inform our submission. This feedback is referred to across this submission.

Feedback from a consultation is:

> The current Act has reference to the United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care. However Australia is also a signatory to the Convention on the Rights of Persons with Disabilities ("CRPD"). This document also provides guidance to the rights that should be enjoyed by those with a disability. A large part of the CRPD is to promote autonomy and personal independence, part of the NT Working Group definition. By using terminology from the CRPD and referring to it in the objects of the Act, this would help provide further overarching principles to guide the interpretation of the Act.
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> Specifically, CRPD Article 25 regarding health and Article 13 on legal rights are important as we are seeking to bring our experiences from the Tribunal and the importance that a person should be given every opportunity to participate in the Tribunal proceedings.
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> Further, in line with the Act there should be principles that note a person with a mental illness should have:
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> - a say in their recovery;
> - the right to consent or not consent to treatment; and be told about the risks of doing so; and
> - not be discriminated against and be supported in their decision making.

We consider there is an inherent tension between the concepts of mental health care (being more individualistic) and traditional values (being more holistic and community focussed). Despite the ontological divergence in these concepts, it is possible to achieve a balance and embed more of these traditional values in the legislation.

Rights of the patient in view of traditional values should be included in the legislation through provisions which support access to traditional healers. Such provisions could be incorporated in sections 9 (Principles relating to provision of treatment and care), and 11 (Principles related to admission, care and treatment of Aboriginal and Torres Strait Islander persons).

Generally, the Act, or if appropriate, policy directives to mental health care workers, should require consideration of social and wellbeing principles as overarching principles to be incorporated into the design and provision of a patient's care. This could be incorporated into section 8 of the Act.

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

Incorporating the word 'recovery' into legislation should be assisted by more robust frameworks to guide its application as it relates to the particular circumstances of the individual.

As one NAAJA staff member states:

> Recovery is a difficult concept to put into legislation. It should not be a defined term, particularly as recovery for one mental health consumer may look wildly different to how recovery may look for another person. However, as the legislation currently indicates at 9(h) treatment should not be provided for the convenience of others or as punishment.
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> In the realm of the Tribunal, having a legislative framework, either through the objects or interpretation, can allow for greater questioning by advocates or Tribunal members on how the treatment plan proposed will promote the recovery of a patient. This provides a level of oversight that would hopefully permeate through to ensure that when a medical practitioner is applying for involuntary treatment, there is an eye towards promoting recovery.

As a general principle, NAAJA supports inclusion of the word 'recovery' into legislation provided there is a robust framework to guide its application and that is flexible and responsive to the particular needs of the individual. To this end, we propose the recommendations outlined in part 7 of this submission.

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

The concept of recovery can be included by making reference to it at a principle level in the objects of the act and by ensuring a broader, contextual framework for its application.

Feedback through internal NAAJA consultation revealed a proposed object:

> To promote the recovery of people with a mental illness in order to achieve and maintain that person's maximum independence and autonomy, and ensure their participation in that recovery as far as possible.

We understand the challenge of defining recovery specifically in legislation and how this might impact the way services and treatment is provided.

The discussion paper refers to the *NT Mental Health Strategic Plan 2019 – 2025* explanation as:

> Recovery means gaining and retaining hope, understanding abilities and disabilities, engagement in an active life, personal autonomy, social identity, meaning and purpose in life and a positive sense of self.

The challenge with including a definition such as this in a legal framework is the subjective nature of its interpretation and the difficulties associated with applying broad terms such as the 'meaning and purpose in life and a positive sense of self' in the context of understanding another person's situation.

The discussion paper rightly points out the argument that 'an absence of a definition leaves the term open to interpretation by decision makers, and leaves potentially uncertainty for consumers, their families/carers and other supporters, and clinicians administering treatment and care for the purposes of "recovery"'.

At a foundation level, there is also some utility in including recovery as a concept. When delivering services and providing treatment and particularly in complex areas such as mental health there can be a tendency to use complicated language that is not easily understood by the voluntary consumer or involuntary patient, or their families and supports. The word 'recovery' – and its association to 'recover' – has utility because its foundation meaning of having an injury and then 'recovering' from that injury to pre-injury state can be applied across a range of injuries including physical. This concept is generally understood

regardless of a person's cultural background. Extending this concept to understandings of the brain and what is going on with mental health, at its face value, seems logical. From a legislative standpoint, it makes sense to include this word broadly in the objectives and for it to extend across treatment and care including the way services are delivered and understood.

In addition, further feedback from NAAJA's frontline services is:

> It is important that recovery is seen as an individual assessment designed to ensure that they are able to achieve independence and live and contribute in society in the same way that any able person can. This is reflected in the CRPD and it would be appropriate for the MHRS Act to refer to the CRPD in the objects.

Feedback from one staff member referred to the importance of also considering wording consistent with Article 26 of the CRPD:

> Article 26 Habilitation and rehabilitation
>
> States Parties shall take effective and appropriate measures, including through peer support, to enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life. To that end, States Parties shall organize, strengthen and extend comprehensive habilitation and rehabilitation services and programmes, particularly in the areas of health, employment, education and social services, in such a way that these services and programmes:
>
> (a) Begin at the earliest possible stage, and are based on the multidisciplinary assessment of individual needs and strengths;
>
> (b) Support participation and inclusion in the community and all aspects of society, are voluntary, and are available to persons with disabilities as close as possible to their own communities, including in rural areas.
>
> States Parties shall promote the development of initial and continuing training for professionals and staff working in habilitation and rehabilitation services.
>
> States Parties shall promote the availability, knowledge and use of assistive devices and technologies, designed for persons with disabilities, as they relate to habilitation and rehabilitation.

Noting in the interpretation of the Act at 8(c)

a. the objective of treatment is directed towards the purpose of recovery, and preserving and enhancing personal autonomy.

We also recognise complex areas such as these as opportunities for a more robust, Aboriginal led framework integrated into the health service system response. At a principle level, we support inclusion of the concept of recovery. At an operational level, understanding and applying the concept of recovery requires a balance between clinical and non-clinical approaches and within contexts and environments that are suitable from a clinical perspective and also in terms of Aboriginal cultural security and safety. To work towards this, we acknowledge the work including commissioned reports and reform efforts underway. We are also of the view that given the complexity and sensitivities involved in seeking to develop and apply the concept of 'recovery' within a mental health service system,

that a more robust Aboriginal-led framework can be established and as a mechanism with authority and a legislative mandate to serve a key role driving this work.

NAAJA recommends inclusion of the concept of recovery with the condition that the mechanism outlined in part 7 of this submission is legislated in a way to provide autonomy and independence for an Aboriginal-led meaning, context and framework supported by relevant policy directives.

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

In response to this question we defer to the Aboriginal Community Controlled health sector.

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

Feedback from NAAJA's internal consultations is:

> If anything the current framework around informed consent (section 7 of the Act) is quite cumbersome, and should be simplified to help promote a person's autonomy. There should be an overarching principle that a person has the ability to provide informed consent until otherwise shown. The NT is the only jurisdiction other than NSW to not explicitly say this (whether in relation to informed consent or decision making capacity). A statement in the Act as part of the section on informed consent would help to achieve many of the principles around personal autonomy and would ensure that a rebuttable presumption is created before involuntary treatment can be administered.
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> - The fact the NT legislation does not contain a rebuttable presumption should be remedied.
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> - NSW also does not have a definition of informed consent/decision making capacity outside of the context of ECT nor does it appear to be a relevant consideration in the determination of whether or not a person should be detained for involuntary treatment. As a result, its legislation should not necessarily be looked to as one to emulate considering it is out of step with the other legislation.
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> Further it would be worthwhile for the legislation to note that informed consent is decision specific (similar to the ACT) and that a person's ability to give informed consent can fluctuate (similar to SA, Vic, ACT).
>
> The list of requirements before informed consent can be given is highly onerous, with many requirements seemingly above even what a person with the ability to provide informed consent may ultimately need.
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> A simpler process in line with other jurisdictions would be more appropriate. The danger of a highly prescriptive definition is that it may create a bar too high for a person to be able to provide informed consent. The SA definition has useful points around the fact that simply because someone doesn't understand a technical or trivial point doesn't mean a person can't have decision making capacity/provide informed consent. This is crucial as it comes back to the points surrounding the fact that a person should be supported in making a decision. The relevant sections that go to informed consent or decision making capacity in the other jurisdictions are:
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> - Section 5A *Mental Health Act 2009* (SA), s7 *Mental Health Act 2013* (Tas) s18 *Mental Health Act 2014* (WA), s 69 *Mental Health Act 2014* (Vic), s 7 *Mental Health Act 2015* (ACT), s 14 *Mental Health Act 2016* (Qld).

- Section 91 *Mental Health Act 2007* (NSW) in the context of ECT – quite prescriptive, however this is in line with how many legislative frameworks which see ECT as a far more serious treatment than providing medication under involuntary treatment. Of course whether or not this is particularly true is up for debate.

It would be appropriate to look at the ACT, SA, Qld and WA definitions. They are simple definitions for informed consent or decision making capacity that share the following aspects:

- understanding that the person has an illness/a decision to make about treatment;
- understanding the relevant information about treatment proposed;
- retaining that information;
- weighing up the factors (pros and cons, particularly the effects of not having treatment); and
- communicate that decision.

The crucial elements that should be part of the definition are – receiving the information, retaining the information, weighing up the information and acting on the information.

Both the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care and CRPD provide that person with a mental illness should be able to refuse or stop treatment (provided the person has the capacity to do so). As a result it should be made clear that a refusal to receive treatment does not in of itself indicate a person lacks capacity to make decisions about their treatment or provide informed consent. The ACT, SA and Qld Acts all note that simply because a person makes an unwise decision, a decision that is adverse to them, or that they refuse treatment does not mean a person does not have capacity.

If the Act is attempting to enhance personal autonomy and promote recovery, the definition around informed consent should place a person's autonomy front and centre. It should note that a person has a right to make decisions about their treatment even if they may be considered unwise.

In addition, in order to provide informed consent the legal and health profession is guided by the Aboriginal Interpreter Services and established protocols in relation to assessing whether a person requires an interpreter. This is very important for professions where more complex and technical language is used. The nature of mental health and its impact on the brain and understanding adds to the importance of involving qualified interpreters.

As feedback in internal NAAJA consultations showed:

> Interpreters should be used so there is no room for miscommunication regarding informed consent.

We are aware of challenges associated with accessing interpreters and especially at short notice. Mental health matters can arise at any time and for any person. The many languages of the Northern Territory and a shortage of qualified interpreters is a significant challenge. Accessing a suitably qualified interpreter at short notice can be a challenge. However, the importance of accessing information in a language that the person adequately understands, and the particular sensitivities and nature of mental health, means access to an interpreter should be essential. The protocols for determining whether a person requires

an interpreter is an assessment process that could be integrated into practice. By putting in place legislative protections, this will establish a lever for meaningful reform and the right investments and systemic supports to improve access to interpreters.

In relation to informed consent, NAAJA recommends:

1. A simplified process with clear steps as outlined above.

2. Legislative recognition and application of protocols to assess whether a person requires an interpreter and, in circumstances where this assessment supports the use of an interpreter, a requirement that an interpreter is used.

1.6 ***What is your opinion about introducing the concept of investigating the 'will and preference' of someone to help make decisions about mental health treatment and care?***

Similar to NAAJA's response to 1.3 (including the concept of recovery), we are of the view that the introduction of this concept can potentially be an important reform effort to improve mental health services. An investigation of a person's 'will and preference' can work alongside the concept of 'recovery'. Our responses to 1.3 and in the context of referencing part 7 of this submission also apply to this question.

NAAJA recommends in principle support of introducing the concept of investigating the 'will and preference' of someone to help make decisions about mental health treatment and care. We do so on the basis that the mechanism outlined in part 7 is established in legislation and with the authority to be responsible for this work but also the ways and means it is developed, strengthened, communicated and applied across the mental health service system.

1.7 ***What steps should be taken to find out someone's will and preference?***

We have reviewed the discussion paper and appreciate the comparative analysis provided. We note that in some instances, legislation can refer to the will and preference of the voluntary consumer or involuntary patient and includes terms such as 'as far as practical'. In our experience, these terms are often designed to be broad enough so that they can be applied flexibly including to a point of not providing the 'will and preference' reference with any substantive weight. As a general guide, these terms should be avoided.

Determining the 'will and preference' of an individual and in the context of mental health is also a highly complex area. The effectiveness of legislation and the service system will depend largely on the quality improvement measures and also the robustness and effectiveness of accountability mechanisms built into the service system.

NAAJA submits that referring to will and preference within legislation alone will be insufficient without having robust, Aboriginal-led and integrated supports across the service system design. We recommend the proposals in part 7 of this submission as part of the steps to identify someone's 'will and preference'.

2. STAGE TWO: PERSON-CENTRED APPROACH

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

Feedback obtained by internal NAAJA consultations and with staff with direct experience in these matters is:

> NAAJA supports the inclusion of a 'nominated support person' in the MHRSA, bringing the Northern Territory in line with other jurisdictions in Australia (Queensland, South Australia, Victoria, Western Australia) and overseas (Scotland, England, Sweden). It

would also align Australia more closely with its ratified obligation under article 12(3) of the Convention on the Rights of Persons with Disabilities:

> *"States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity."*

Inclusion of a 'nominated support person' in MHRSA must go beyond inserting such a role in the extant compulsory notification sections of the MHRSA (ss 41, 43, 44D, 47 and 50A). The role's enumeration should take the form and function of that set out in the Mental Health Act 2016 (Qld). Importantly, the nomination of a support person should not be mandatory (as was the primary experience in Scotland with the *Mental Health (Care and Treatment)* (Scotland) Act 2003).

The carve out included in the Western Australian legislation should not be included. Section 269(2) of the *Mental Health Act* 2014 (WA) states that a:

> *"…nominated person is not entitled to be provided with particular information or involved in a particular matter if the patient's psychiatrist reasonably believes that it is not in the best interests of the patient…*"

The adoption of a best interests test is reasonable when it concerns the provision of a patient's information to their primary carer (see ss 41, 43, 44D, 47 and 50A of the MHRSA). However, a 'nominated support person' and a primary carer are intrinsically different roles – the latter may be acting with self-interest and may remain involved despite the patient's wishes; whilst the former is a person freely chosen by the patient to support them. These considerations are especially so in the context of Central Australian Aboriginal familial structures, where a patient's primary carer and the person that a patient wants to support them may be very different (and the latter may be well outside of the nuclear family structure more present in non-Aboriginal families).

The Queensland experience of 'nominated support persons' shows that the legislative provision of this role is an effective way of empowering patients. As such, the MHRSA should be amended to allow nominated support persons, by right, to act in the ways set out in s 25 of the Mental Health Act 2016 (Qld).

Another staff member noted that a lot of Aboriginal people across the mental health service system serve multiple roles, and that there are cases of involuntary patients 'being unaccompanied with no idea of what is going on'. Feedback was that many individuals have a sense of 'people talking about them but not to them' and this can disempowering.

NAAJA supports the inclusion of a nominated support person in legislation.

2.2 ***What kind of roles should the nominated support person have?***

We note the discussion paper refers to different jurisdictions and that the roles of the nominated support person vary.

At a foundational level, the nominated support person should be selected by the patient and can act in the 'best interests' of the patient.

Where the person admitted is an Aboriginal person, reference in the legislation should be made to the nominated support person and also to the service support system referred to in part 7 of this submission. By doing so, the support system can serve to complement the role of the nominated support person by providing support to that person and also serving a role within the service system (and, for example, can monitor the supports and serve as a support for the patient in circumstances where it is not appropriate for the nominated support person to be informed).

In some instance, it might be appropriate for a role within the mechanisms proposed in part 7 to be the nominated support person. That is, it could be that an Aboriginal person in a formal role within the health system should be the nominated support person for the individual. This could be in circumstances where the person nominated by the involuntary patient is unable to perform the role, or if the involuntary patient would like to nominate that person.

NAAJA recommends legislation refer to the roles of the nominated support person in relation to the principal role of serving the 'best interests' of the involuntary patient and other roles as set out in legislation (and drawing on the experience in other jurisdictions).

These roles will include certain occasions when the nominated support person is to receive information and, in circumstances where the psychiatrist believes it is not appropriate to do so, that this information is made available to an internal advocacy function within Health plus the Aboriginal support service system explained in part 7 of this submission.

NAAJA further recommends that the list of roles are expansive in that they will include a broad range of roles such as that in Victorian legislation plus other examples such as in South Australia and receiving 'a copy of the statement of the patient's rights'.

2.3 ***How many nominated support persons should a voluntary consumer or involuntary patient have?***

Feedback from internal NAAJA consultations is that the nominated support person should be centred on 'cultural authority', and that there needs to be someone with cultural authority relevant to the voluntary consumer or involuntary patient for 'any form of commitment'. Further, feedback is the cultural authority can also serve as the support network that might be an important aspect of treatment and care, and that if this is tied into the nominated support person role then this can help facilitate the development and strengthening of this network. The feedback is that in some situations it might be appropriate to have more than 2 so that the nominated support persons can serve a role suited to the nature of their family and cultural connections.

In relation to whether there should be one or more 'nominated support persons', and circumstances where multiple people are making enquiries and receiving information as they are entitled to as a nominated support person, then this can potentially create confusion and miscommunication. Services likely require clear and consistent feedback and a central point of call in relation to receiving and assessing information from the nominated support person. This could be addressed by having a primary nominated support person where legislation sets out the circumstances that they will receive information (as set out in our response to 2.2), and then secondary nominated support persons who will have the right to meet or contact staff within the mental health system to represent the 'best interests' of the patient.

The nominated support person therefore needs to serve as a conduit to the broader cultural authority of the voluntary consumer or involuntary patient. Provided the voluntary consumer or involuntary patient has input into who the primary nominated support person is, this should be sufficient to allay any concerns in relation to potential disputes or actions or influences of the broader cultural authority and its impact on treatment and care.

NAAJA recommends legislation provide for a primary nominated support person with clearly defined circumstances set out in NAAJA's response to part 2.2, and secondary support persons (where it could be more than 1) who have the right to meet or contact staff within the mental health system to represent the 'best interests' of the patient.

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

We respectfully submit the current provisions relating to the use of interpreters is inadequate. Whilst they make a positive commitment, the legislation is not as robust as is required. It is a fundamental human right that an Aboriginal person should have access to their condition, treatment and consent in their own language.

The current approach as outlined in the discussion paper refers to section 8 (g) of the Act providing that "the assessment, care, treatment and protection of an Aboriginal person …who has a mental illness is appropriate to, and consistent with, the person's cultural beliefs, practices and mores."

Section 87 applies to information given in relation to the involuntary patient or a community management order:

> (2) As far as possible, information given under subsection (1):
>
> (a) must be given both orally and in writing, in a language and form in which the person to whom it is given is used to communicating in and in a culturally appropriate manner including, where necessary, through the use of interpreters;

The effect of the qualifier 'as far as possible' often means that there can be attempts to secure an interpreter and if an interpreter is not available then the communication takes place without an interpreter.

NAAJA's submission in response to the question relating to informed consent (question 1.5) refers to protocols to assess whether an interpreter is required and, in circumstances where this is so, that legislation makes clear that an interpreter must be used.

In our response we said:

> We are aware of challenges associated with accessing interpreters and especially at short notice. Mental health matters can arise at any time and for any person. The many languages of the Northern Territory and a shortage of qualified interpreters is a significant challenge. Accessing a suitably qualified interpreter at short notice can be a challenge. However, the importance of accessing information in a language that the person adequately understands, and the particular sensitivities and nature of mental health, means access to an interpreter should be essential. The protocols for determining whether a person requires an interpreter is an assessment process that could be integrated into practice. By putting in place legislative protections, this will establish a lever for meaningful reform and the right investments and systemic supports to improve access to interpreters.

Further, internal feedback from NAAJA is:

> There must be rights to the use of a patient's first language – this treatment honours basic human rights.

And:

> The use of interpreters needs to be ensured in context of cultural security. It does not normally happen but is necessary to make sure that will/preference/consent is communicated.

We respectfully submit that putting in place legislative protections will establish a lever for meaningful reform and the right investments and systemic supports to improve access to interpreters. It will create the context for meetings to take place where government will be bound to deliver an interpreter and this will lead to different responses and measures in order to deliver a solution. For other, essential parts of the health system when there is a

shortage or issues in relation to access these are solvable with the right level of commitment, an adaptive response and resources. The involvement of interpreters should be seen as essential.

For critical points such as the time when involuntary admission occurs, the legislation can provide a short period of time for when an interpreter is required (such as 24 hours from the point of admission), and a reassessment can take place for involuntary admission with the interpreter present.

NAAJA recommends legislative recognition and application of protocols to assess whether a person requires an interpreter and, in circumstances where this assessment supports the use of an interpreter, a requirement that an interpreter is used.

This should extend to the current provisions under section 87 of the Act (or, in the event an interpreter cannot be secured at the time of when involuntary admission to an approved treatment facility is made or when a community management order is made, within the next 24 hours of either of these events).

Legislation should be clear that when it is established that an interpreter is required, that an interpreter is utilized for specific interactions as set out in legislation (for example, when an assessment by a psychiatrist is performed, etc.).

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

Feedback from a NAAJA staff member is:

> In short, yes; the legislation needs amendment in this area. Currently, pursuant to section 25, a person over 14 may apply to be admitted as an involuntary patient, and a parent or guardian of someone under 18 may apply to have the person admitted as a voluntary patient. If the person under 18 is admitted upon application of their parent and does not wish to be admitted, this is effectively an involuntary admission.
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> In allowing a person over 14 years old to apply for voluntary admission, the Act appears to admit that it is possible for a person of that age, or older, to have the requisite understanding of their condition and the required treatment such that they meet the common law *Gillick* competency. It would seem to make sense, then, that a person between 14 and 18's capacity and decision-making ability should be assessed on a case-by-case basis, and not, in effect, delegated to their parent.
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> We believe that section 25(2) should be removed, and the MHRS Act should instead create a rebuttable presumption of decision-making capacity from age 14 years, similar to in South Australia. Children under 14 years should be presumed not to have capacity unless, the child is shown to have capacity, similarly to the West Australian legislation.
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> The fundamental principles of the MHRS Act, articulated in Part 2, should be amended to include principles to include a principle that the care and treatment for a child should be tailored to recognise the different developmental stages of each child, akin to Mental Health Act 2009 (SA) s 7(1)(e).

NAAJA recommends the Act create a rebuttable presumption of decision-making capacity from age 14 years, similar to in South Australia. Children under 14 years should be presumed not to have capacity unless, the child is shown to have capacity (similar to the West Australian legislation).

3. PART THREE: ADMISSION AND TREATMENT

3.1 *What do you think about the current process of assessment and examination for involuntary admissions?*

In response to this question we defer to the Aboriginal Community Controlled health sector.

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

Feedback through internal NAAJA consultations is:

> The criteria for involuntary treatment (either via an admission to an approved facility or in the community) are found in ss 14, 15, 15A and 16 of the MHRSA. A common element for all grounds of involuntary treatment is a test to determine whether the person receiving treatment will, if the treatment is not administered, cause harm to themselves or to others.
>
> In ss 14 and 16, the test is expressed as such (emphasis added):
>
> > "(b)(ii) without the treatment [or care], the person is likely to:
> >
> > (A) cause serious harm to himself or herself or to someone else; or
> >
> > (B) suffer serious mental or physical deterioration."
>
> In ss 15 and 15A, the test is expressed as such (emphasis added):
>
> > "(c) unless the person receives treatment and care at an approved treatment facility, the person:
> >
> > (i) is likely to cause serious harm to himself or herself or to someone else; or
> >
> > (ii) will represent a substantial danger to the general community; or
> >
> > (iii) is likely to suffer serious mental or physical deterioration."
>
> In essence, the decision for the Tribunal is, whether on the evidence provided by the treating team, the patient would be likely to cause harm to themselves or someone else if they did not receive the proposed treatment. As is made clear by the words emphasised above, the legislative test is couched in prospective terms. It requires the Tribunal to form an opinion on the present condition of the patient the subject of the proceedings and to infer from that present condition whether there is any risk in the immediate future. In *KMD v The Mental Health Review Tribunal & Anor* [2020] NTSC 13 at [31], Barr J noted the temporal nature of the Tribunal's enquiry:
>
> > *"In my opinion, the use of the present tense in the expression "is likely to" suggests that the focus of the risk assessment should be on the present, or at least the short term*".
>
> Importantly, the tests outlined above are to be proved with reference to what Blokland J called the "enhanced civil standard derived from *Briginshaw v Briginshaw*" (*JXC v Mental Health Review Tribunal & Anor* [2018] NTSC 62 at [30]). It was found that given the grave and adverse consequences of a positive finding (namely, involuntary state-sanctioned medical treatment), the Tribunal must be satisfied on the balance of probabilities by compelling proofs with high probative value, not merely inexact or speculative evidence.

Despite the prospective nature of the Tribunal's enquiry and the high evidentiary onus placed on the treating team, in practice the Mental Health Review Tribunal is far less stringent. Applications made by the treating team are not written afresh – they are built one layer at a time. The most pertinent information about a patient's condition is added to the already-compiled narrative of a patient's medical history. Occasionally, the only difference between a written application made 6 months prior and a written application the subject of the proceedings will be a matter of one or two sentences.

The Tribunal will then be asked to consider whether the patient meets one of the tests outlined above. However, in doing so they are forced to consider a list of that patient's (potentially extensive) mental health history as the backdrop to the application. What frequently results is exactly what the case law mentioned above attempts to guard against: the consideration of historical incidents with limited (if any) probative value when the legislative enquiry is inherently forward looking and the outcome of a positive finding is the curtailment of a person's liberty.

NAAJA submits that the legislation should be amended to strongly emphasize the temporality of the enquiry at hand. Whilst this is not featured in any other state or territory's mental health legislation, such an amendment would be consistent with the common law and with the primary object of the MHRSA, that being the provision of care and protection for those with mental illness whilst balancing their civil rights. For example, the following possible amendments to s 16(b)(ii) would achieve this goal:

> "(b)(ii) without the treatment [or care], the person, **in their present condition**, is likely to"

"(b)(ii) without the treatment [or care], the person is **immediately** likely to"

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

In response to this question we defer to the Aboriginal Community Controlled health sector.

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

NAAJA understands and appreciates that people with mental health issues that require an immediate service response can be a danger to themselves or others and therefore agencies such as Police can be required to ensure community safety. We also understand the overwhelming majority of callouts for people affected by mental health issues are of people who require some level of assistance but are not a threat of danger to themselves or the community. The point of making an assessment in relation to this is by a suitably qualified heath practitioner and, whilst resources such as St. John's Ambulance are often highly utilised and stretched, in many instances Police are often the first responders.

The current situation of Police often being the first responders can compound the pressures associated with mental health because of a range of factors, including:

- past experiences of being confined in small spaces including in paddy wagons or prison cells
- the lack of systemic reform to the justice system as outlined in this submission and known generally in the context of recommendations in a series of reports and inquiries not being followed, and over many years
- escalation of a law and justice system to respond to many of the social issues
- intergenerational trauma and past trauma
- past negative experiences with Police

- black deaths in custody

These systemic factors can mean that even the most suitably qualified and respected Police Officer with good relationships and a positive rapport with an Aboriginal family or community can be in a situation where mental health issues, often at a serious stage, can be escalated, and especially if the Police Officer faces pressure to detain a person.

NAAJA submits that resources should be made available to draw on the recommendations of an Aboriginal led process, preferably from the Aboriginal Community Control Health Organisation sector if agreeable, to establish a mental health service that can work alongside Ambulance and the Police as the first responders to issues of mental health concern and where a person does not present as a danger to themselves or the community. This service could also be the first point of call in circumstances where the Police are the first responders and it is assessed that the situation is safe. A service system model with the agreement of the ACCHO sector and with resources made available to ensure that a combined clinical and Aboriginal-led approach is integrated is necessary to alleviate the factors identified above.

Whilst we understand legislative reform may not be possible without the resources being made available to put this service in place, we recommend legislative reform as part of a review of the Mental Health and Related Services Act to necessitate a process to take place to establish this service. In the first instance, such a service is foreseeable at least in the large population centres of the Northern Territory.

NAAJA recommends legislative reform to ensure an Aboriginal-led service is the first responder to mental health issues where a person does present as a danger to themselves or community, and that a service system model is established to work alongside Ambulance and Police and relevant services to respond to community need.

3.5 ***What do you think about the current approach under the MHRS Act that grants leave to involuntary patients?***

The granting of leave for a person involuntary admitted to an approved treatment facility is an important and valued aspect for any person regardless of their background.

For Aboriginal people of the Northern Territory, connection to country and to environments that are therapeutic and suited to the particular needs and circumstances of that person can be highly valuable, and potentially necessary to their recovery.

For many Aboriginal people the factors of power, authority and control, of confinement within a small space (such as prison or the back of a paddy wagon), of matters arising from multiple Royal Commissions and Inquiries concerning law and justice (and of recommendations that have often been ignored), of interpersonal discrimination and also systemic and institutionalised discrimination, are relevant to the need for treatment and care to take place in a therapeutic environment. A therapeutic environment for many Aboriginal people will likely require connection to country.

Whilst reform efforts are taking place to make approved treatment facilities more appropriate, our understanding is there is still a long way to go.

We also acknowledge each person is different, and the particular state that a person is in should be assessed by a suitably qualified psychiatric practitioner. This is an essential pillar to the mental health system, and should remain so.

The current legislation at section 166 provides the following for leave for involuntary patients:

(3) Leave of absence:

(a) must not be granted except in accordance with approved procedures; and

(b) must be recorded in the approved form; and

(c) is subject to the conditions determined by the practitioner.

We respectfully submit that the above legislation is too broad and puts too much flexibility and reliance on internal departmental forms and procedures in respect of the sensitive matter of leave for a person involuntary admitted.

Whilst a decision to grant leave should be with an authorised psychiatric practitioner, there should be legislative guidance and a process that makes clear the factors that an authorised psychiatric practitioner should take into account when granting leave.

Feedback in relation to this question and as part of NAAJA's internal consultations is:

> There are two recent Coronial findings that related to the deaths of people on leave from their admission as involuntary patients at mental health facilities: *Inquest into the findings of Linden Alan Kunoth* ("*Kunoth*") and *Inquest into the death of Jordan Gregory Allen*.
>
> Currently the MHRS Act only regulates how leave is granted, but does not regulate why leave may be granted or mention supervision. It refers to 'Approved Procedures' that it is on the mental health facility to create and follow, but in the case of *Kunoth* these did not exist.

Further:

> We believe the legislative scheme for leave similar should be similar to that of Victoria, with some changes to reflect the cultural needs of those involuntarily admitted to the Territory.
>
> If s 64 of the *Mental Health Act* 2014 (Vic) were replicated in the MHRS Act, we suggest that an additional reason for leave to be granted should be added that, such as:
>
> - The purpose of cultural and familial support, connection, treatment or care.

In relation to leave generally including the factors taken into account and the information that the approved psychiatric practitioner has access to in order to make a decision, we support legislative recognition of the mechanism outlined in part 7 of this submission.

NAAJA recommends clear guidance for the approved psychiatric practitioner to consider in relation to the granting of leave, such as the legislation in Victoria. This should include a provision where the authorised psychiatrist, 'when determining whether to grant leave, must have regard to: the purpose of leave; and, if satisfied on the evidence available that the health and safety of the person or the safety of another person will not be seriously endangered as a result'.

We recommend further that the legislation specify factors for the approved psychiatric practitioner to have regard to when determining whether to grant leave, and that this reference legislative recognition of the mechanism outlined in part 7 of this submission.

3.6 ***What do you think about including the granting of leave for voluntary patients in the legislation?***

The discussion paper refers to the annual reports of the NT Community Visitor Program raising 'concerns about the ability for a voluntary consumer to go on a period of leave whilst being admitted, and it has been raised that voluntary consumers "report frustration or

confusion about their ability to have leave (2018-2019, p 24)" and the rules being administered to approve leave "are based on legislation for voluntary consumer but have been applied to voluntary consumers (2018-2019, p 25)"' (p 70).

People who require support with their mental health and are within the environment of a treatment facility are vulnerable in relation to their levels of awareness and understanding. This can be even more so where language and cultural factors are relevant.

Legislative direction that makes clear the status of a voluntary consumer or involuntary patient and as it relates to their rights of leave will assist people responsible with oversight for these facilities to adhere to strict protocols. Compliance with protocols can involve many people who work across these facilities, and so reference to legislation creates a clearer and more direct impression of the need to ensure the correct protocols are followed.

The discussion paper refers to the South Australian provision section 8 (2) which states that 'a person admitted as a voluntary inpatient at the treatment centre may leave the centre at any time unless an inpatient treatment order then applied to the person'. This section provides a clear right for the voluntary inpatient and provides direction to centre management to ensure an inpatient treatment order is applied if required.

We support the Statement of Rights in South Australia (where leave is encouraged and supported as part of your treatment and care plan). This could also reference the concept of recovery.

Of concern is that treatment facilities are often not culturally safe and this can adversely impact the voluntary consumer or involuntary patient. We recognise the reform efforts underway to address this, however it is important to emphasise and acknowledge this in an open way and in relation to any discussion concerning the granting of leave.

We are concerned that people who leave treatment facilities can have family and cultural obligations such as funerals and where they can be discharged including self-discharge from hospital settings. This goes to the core issue of the need for wrap around services that are Aboriginal led and can support people both within treatment facilities but also in community and post their time in a treatment facility. To help address this, and as one example of an area where this support is needed, we emphasise the importance of a legislative framework consistent with part 7 of this submission that also links into this part of legislation.

NAAJA recommends legislation refer to the granting of leave for voluntary patients similar to section 8(2) of the Mental Health Act 2009 (South Australia).

We recommend and emphasise the importance of a legislative framework consistent with part 7 of this framework, and that Aboriginal people who are voluntary consumers or involuntary patients receive wrap around and continuous, direct support both within the treatment facility but also in community and post their time in a treatment facility. This part can link into the legislation that refers to leave.

3.7 ***What do you think about regulating the power to search someone and seize property under the MHRS Act?***

Voluntary consumers and involuntary patients are often highly vulnerable and their past adverse experiences can impact their mental health. A past adverse experience can be triggered by an action that involves searching the body. This is because the body is private and an action that involves another person searching a part of the body, particularly a search that is more than a 'general search' or a 'scan search' (as defined in page 73 of the discussion paper), can be intrusive and can infringe the privacy and power that a person has over their own body.

Voluntary consumers and involuntary patients are vulnerable because of the connection between past trauma or intergenerational trauma and the searching of the body. Aboriginal

voluntary consumers and involuntary patients are vulnerable because they also can have these experiences, but also language or cultural differences that can serve to elevate the power imbalances in a way that makes them more susceptible to a process where they clearly do not have a context or environment that is culturally secure and safe. At an operational level the priority of ensuring a treatment facility does not include items that can be harmful carries with it broad search powers that allow for intrusive searches on the body. The search powers are justified by this priority. The search powers can also be a trigger that can adversely affect mental health on many different levels.

The discussion paper refers to the different types of searches that can take place, and the interstate comparison offers a useful analysis.

NAAJA recommends the power to search someone and seize property is detailed in legislation and include reference to:

a) The different types of searches that can take place; and

b) Regulations for how these searches can take place including searches performed by a person of the will and preference of the voluntary consumer or involuntary patient (unless inappropriate), strong protections for young people under 18, input by the mechanism recommended in part 7 of this submission.

c) Regulations for the basis of these searches. For example, the more intrusive types of searches should have a stronger status of belief on the part of the decision-maker in relation to their views of the necessity for a particular search.

d) Regulations for clinical input into decisions concerning searches based on the individual circumstances (for example, if an individualised plan notes concerns about the connection between actions that are intrusive to the body with the traumatic experiences of the individual then there should be clinical input and, where relevant, input from the mechanism recommended in part 7 of this submission, into the type of searches but also any relevant circumstance that relates to the searches).

e) Reports tabled in a public way or more detailed information made available to the mechanism recommended in part 7 of this submission.

NAAJA recommends a legislative framework for searches incorporating the points made above.

4. PART FOUR: MONITORING

4.1 *What do you think of the current approach to regulating the use of restrictive practices under the MHRS Act?*

The current legislative test provides that, where necessary to be carried out for a purpose under s 61(3) or 62(3) (and where other relevant elements are met), mechanical restraint or seclusion may be used if "no less restrictive method of control is applicable or appropriate". Broadly, there should be a higher threshold for use of restraints in the legislation. This can preserve the option to use restraints where necessary, that being, where there is an immediate risk of harm, and at the same time ensure this practice is limited.

We consider the Victorian model in the *Mental Health Act 2014* (Vic) provides an appropriate cross-jurisdictional example for an improved framework for the Northern Territory. In Victoria, restrictive practices are only used after all reasonable and less restrictive options have been tried or considered, and where necessary to prevent serious and imminent harm to the person or another person. The Victorian model also includes notification requirements

to the person's key support people when restrictive practices are used, as well as a report provided to the Chief Psychiatrist.

The New South Wales model provides for policy directives related to restrictive practices to support the principle of Trauma Informed Care. It specifically recognises and requires consideration of the following in design and provision of care:

> "many Aboriginal people have experienced and continue to experience significant intergenerational and other trauma…[NSW Health Services] consider cultural obligations (e.g. Aboriginal family and community roles) and personal backgrounds of staff when allocating roles during a seclusion or restraint episode."[1]

We consider another effective model to increase oversight and reduce instances of restrictive practices is the "reduction and elimination plan" in *Queensland's Mental Health Act 2016* (Qld). This requires a plan developed for the relevant patient, by an authorised doctor, providing information on previous use of mechanical restraint or seclusion on that patient, strategies previously used or proposed to use to reduce or eliminate the use of restrictive practices on that patient in the future. Broader than the legislative provision in Queensland, we consider this plan should include information on any chemical restraint used.

We support the Health and Community Services Complaints Commission's recommendation that the MHRS Act include a clear definition of chemical restraint and related safeguards, namely oversight and record keeping, in order to achieve clarity and effective oversight of this practice.[2] Similar to records for mechanical restraint and seclusion, recording requirements should require this data to be transparent and accessible to the public.

We recommend legislation reflect the Victorian model where restrictive practices are only used after all reasonable and less restrictive options have been tried or considered, and where necessary to prevent serious and imminent harm to the person or another person. The Victorian model also includes notification requirements to the person's key support people when restrictive practices are used, as well as a report provided to the Chief Psychiatrist. The Victorian model also includes notification requirements to the person's key support people when restrictive practices are used, as well as a report provided to the Chief Psychiatrist.

We recommend further the inclusion of the mechanism in part 7 of this submission be included as it relates to reports that are provided to the Chief Psychiatrist.

4.2 ***How do you think the legislation can further promote the elimination of restrictive practices?***

See [4.1] above.

4.3 ***The Discussion Paper proposes existing legislative functions to transfer to the Chief Psychiatrist, what do you think about these proposals?***

NAAJA supports legislative functions to transfer to the Chief Psychiatrist where it is appropriate. This should align with legislative recognition of mechanisms to support cultural safety in line with our response in part 7 in this submission.

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[1] New South Wales Health, *Seclusion and Restraint in NSW Health Settings* (Policy Directive) 14 <https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2020_004.pdf>.

[2] Northern Territory Health and Community Services Complaints Commission, *De-Identified Investigation Report* (Report, 8 August 2019) <https://www.hcscc.nt.gov.au/wp-content/uploads/2019/08/FINAL-INVESTIGATION-REPORT-DE-IDENTIFIED-2018-00066-67_13B49.pdf>.

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

NAAJA supports the submission of Danila Dilba Health Service in relation to this aspect.

5. PART FIVE: FORENSIC PROVISIONS

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

The discussion paper properly refers to reviews and independent reports relating to this part and since 2016. These reviews and reports have been developed by appropriately qualified and experienced people, and NAAJA has provided submissions as part of this work. We support the thrust of the findings of these and acknowledge that whilst some reform measures and investments made recently will seek to improve the forensic mental health system, there is some way to go to realising the full extent of what should be acceptable. We also recognise Aboriginal people affected by mental health issues are highly vulnerable and often lack the resources and access to services that could otherwise assist and respond appropriately to their needs.

NAAJA's 2016 submission to the NTG Department of Health NT Forensic Health Services Review of September 2018 (referred to as NAAJA's 2018 submission) said at page 3:

> The biggest hold up for NAAJA's clients on custodial and non-custodial orders is the availability of appropriately supported, community-based accommodation and support in Darwin and remotely. People with complex needs who would otherwise be in the community are instead kept in custody.
>
> On paper, the provisions contained in Part IIA seem reasonable. Although the legislation is clear in its intention that jail be a last resort, 8 the reality is often different. A major issue with the practical application of the legislation is the lack of designated housing for mentally impaired people on supervision orders, preventing a person from being appropriately supervised in a non-custodial setting. Often, clients are kept in prison as a consequence of their disability, rather than their offending. This has a major impact on NAAJA's clients, many of whom are mentally ill and cognitively impaired Aboriginal persons, already over-represented in the criminal justice system.

We recommend a separate piece of legislation as per below, however if there are amendments to existing legislation we recommend amendments emphasise a human rights based approach to forensic mental health. This would prompt action on the part of governments to provide resources to support clients in community (or, where appropriate, secure and culturally appropriate accommodation) rather than prison, and to support individuals to address their mental health needs rather than exacerbate issues. The culturally appropriate support should also be legislated and as recommended in part 7 of this submission.

5.2 ***Should forensic provisions be contained it its own piece of legislation?***

NAAJA's 2018 submission recommended the establishment of a specialised Mental Health Court. This submission supported extending part IIA to the Local Court on the proviso that such matters included the introduction of 'limiting terms' and as a replacement to indefinite detention. The concern raised was that individuals with serious mental health issues can be in contact with the criminal justice system however if they are minor matters then the client's mental health circumstances are not necessarily made available to the court. A specialised Mental Health Court with its own legislation could seek to address this in an appropriate way and if co-designed with relevant stakeholders including NAAJA and mental health and Aboriginal Community Controlled Health Services. It could also seek to address

the issues and findings raised in the various reviews and independent reports relating to forensic mental health.

We recommend forensic provisions are contained within its own piece of legislation and that a specialised Mental Health Court is established and in co-design with relevant stakeholders.

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

NAAJA's 2018 submission provides case studies illustrating NAAJA's clients impacted by forensic mental health and inadequate clinical pathways. The case studies inform the content and recommendations of submissions. Many of these case studies reveal no clear pathway suited to the needs of the individual and a sense of being 'stuck' or at a 'standstill' as it relates to their matter and circumstances within the prison environment.

At a broader level, whilst some improvements have been made to the type, availability and quality of services (such as that offered by the Complex Behaviour Unit at the Darwin Correctional Precinct as a replacement for the old Berrimah prison), and whilst current reform efforts and services such as the Adult Mental Health Centre currently underway reflect progress, the most effective way to improve and implement appropriate clinical pathways is to implement the findings of specialised reports into forensic mental health.

6. GENERAL MATTERS

6.1 ***Do you think the current legislation is effective in regulating mental health treatment and care?***

In developing this submission NAAJA consulted across our frontline services and across the Northern Territory to seek the views of people with direct experiences supporting community members who experience mental health conditions.

The following is a range of opinions to be considered:

> In the European settlers context, it is difficult for some men to actually understand why they are in prison in the first place. There are cases of indifference, but then there are also cases of genuine misunderstanding. In some cases the mental health of men in prison so bad that they do not know where they are or why they are there.

In our view, this also goes to the need for a comprehensive and integrated primary health care service and a properly functioning disability support and National Disability Insurance Scheme. Recent indications of young people diagnosed with Foetal Alcohol Spectrum Disorder shows the likely rate amongst the adult population to be significant, yet there are not the resources or access to services to properly diagnose and support. Some of these matters have been identified in the multiple inquiries and reports including those referred to in the discussion paper. The Northern Territory context also forms part of the Disability Royal Commission currently taking place.

Further:

> The structures and systems are so colonial; systems do not promote foundational human rights/spirituality. What is seen with mental health issues leads to mandatory sentencing/detention – the person is so unwell in custody, then (based on the lack of resources and infrastructure), people remain in custody for years - sees people criminalised purely for their mental health issues.

Further:

> The mental health paradigm is completely medication driven. It is not culturally appropriate - There is currently no discussion of spirituality, belonging, healing etc.

In relation to a person-centred approach:

> Police involvement, arrest and court process when dealing with First Nations young people - limited understanding from people in those roles; default use of English when it may not be their first language; issues of cognitive impairments; needs to be a greater understanding of these things.

In relation to young people in detention:

> At risk policies in youth detention facilities for young people facing mental health issues are problematic.
>
> Language used around young people in a distressed place - self harm; suicide; questioning whether it was an "actual attempt" (questions of legitimacy); questioning whether actions are taken to get out of detention and go to hospital to see family. Positioning by adults about children/ adults giving children language to use to speak about what happened to them.
>
> Access to mental health services for young people in detention is difficult as the Child and Youth team won't get involved in detention as not enough capacity. When young people are leaving detention, the mental health support in that area is very limited and is a very Western model for predominantly First Nations young people that does not work for the needs of First Nations young people.
>
> There is a real lack of coordination, empathy and care towards some of the young people that are experiencing significant mental health responses to the world and what is going on around them.

In further feedback frontline services identified the absence of a designated forensic mental health service in youth justice, at risk frameworks lacking in an evidence base (ie trauma-informed practice), a workforce that could be strengthened significantly in relation to being culturally informed and a lack of training and specialised skill, and a lack of understanding in relation to complex co-morbidity in a detention environment that is not fit for purpose.

In relation to funding:

> Mental Health Services are currently travelling to community every 1-2 months, which is insufficient. More funding is required for mental health services.

And:

> Limited funding is available to assist in the diagnosis of young people.

In relation to Community Mental Health Orders:

> Currently, it is sometimes impossible to obtain instructions from clients prior to hearing of interim CMO but also not possible to obtain an adjournment of an interim CMO under s 129A. The only option is a one week or two week order and the client must meet the criteria for this interim order to be granted, which makes it harder to prove/disprove client meets criteria later. Should amend legislation to allow adjournment of interim CMO to allow for ability to obtain instructions. Formalisation of process and time limits should also be set out in legislation.

And:

> CMOs are not available to many First Nations people in the NT as require a fixed address and many have no fixed address/are transient. CMO might be good to reduce recidivism but not available to people who are transient.

In relation to the National Disability Insurance Scheme:

> NDIS applications within the [correctional centre context] are getting better, but are still not useful for long term prisoners with cognitive conditions. No funding to pay for cognitive or other reports for prisoners. NDIS applications can delay release to those seeking parole. Need NDIS support prior to re-entering community otherwise will be recidivism.
>
> …
>
> [disability support] is an area that requires an entirely separate approach. Mental health and disability assistance are totally different areas and this should be reflected in any reforms.

Further:

> There is a lack of clarity around young people receiving NDIS payments and still being able to access them in detention. Cognitive impairments are included in this review, but it does not appreciate the entire need for disability services while in custody. Cannot get NDIS to deliver services in prison.
>
> **…**
>
> There is confusion surrounding young people in detention receiving NDIS payments:
>
> - It is a huge "win" for a young person to get an NDIS payment.
> - There was one case of a young man who got NDIS support while in detention and then lost it.
> - There are a number of youth with NDIS packages not being utilised.
> - Engaging in recidivist behaviour which makes it difficult to maintain contact with supports, which makes it difficult to obtain and maintain NDIS plan.
> - Especially difficult with remote locations and cultural appropriateness.
> - An overall trend of NDIS funded services popping up without much sense of what is needed.
> - Predominantly dealing with Aboriginal young men.

In relation to timeframes in Tribunal proceedings

> It is common for NTCAT to send NAAJA the name and medical paperwork for the client one or two days before the Tribunal. For involuntary patients, this is less of an issue – they are (most of the time) at the mental health ward and therefore it is more straightforward to seek instructions from (except where an interpreter is required, see below).
>
> If the application is for a Community Management Order this presents several hurdles to gaining instructions as we have to track down the client in town or out bush. If the client is in town, and has a fixed address, most of the time they can be found there. If the client is in town and is sleeping rough or with family, it often takes a few hours to track them down. If the client is located in a remote community, we often have to seek assistance from the local health service and/or the police to locate the client and (if they don't have a phone) speak to them about their matter. This often takes a few days. Often we are unable to find and speak to a client in time for Tribunal and have to seek

an adjournment. Due to the wording of s129A, where a client isn't already on a CMO, the Tribunal will grant the CMO for a few weeks to enable contact. In my view, this makes it more difficult for us to argue against the Tribunal granting a CMO later on, if that is the client instructs they do not want the order at the 'adjourned' hearing.

If we require an interpreter to speak to our clients on the ward or in the community, one or two days is simply not enough time to book an interpreter. The Aboriginal Interpreter Service usually needs at least 24 hours' notice, and even then it can be difficult to lock in particular language with longer lead times.

…

The last-minute paperwork from the Tribunal is particularly frustrating where our client is on a 6 month Community Management Order and the application before the Tribunal is for another 6-month Community Management Order; the community mental health team had sufficient notice to file their new application paperwork.

In relation to Community Member Involvement and Co-Design

Community members do not currently make many comments and there could be scope for a community member to play a greater role. Could also be scope for community member to be First Nations person if a First Nations person is appearing before the Tribunal. Currently about 80% of people going through the Mental Health Tribunal are First Nations and it is a very white proceeding. First Nations community members could be good to assist with cultural safety.

…

Any mental health reform needs to be co-designed with Aboriginal people and organisations.

In relation to the importance of ensuring ancillary matters such as the prison environment are addressed:

Is a maximum security prison the best place to put someone with mental health issues? Prison system promotes mental unhealth. Prison system conflates mental health with suicide.

…

There are concerns regarding the mental health of women in prison. Example of women in Sector 4 prison - limited support; women have to walk past the men at the prison - this is a cultural issue. Also far less mental health support for women in prison. [note, in addition to this comment from staff we emphasise that many Aboriginal women in prison have associated past trauma including serious experiences and the need for substantial reform that takes into account health based approaches is needed in order to more effectively address and improve mental health service system responses.]

Any reform needs to look at whether changing legislation is going to change practices in places like prisons, schools, communities. Can change the legislation, but is it going to actually be implemented on the ground and impact on the environments e.g. prisons, schools, community. There are poor mental health practices in prison not based on legislation e.g. strip someone down, putting in hospital gown, cameras watching. Prisons often fail to provide mental health treatment to prisoners e.g. stopping anti-depressants

6.2 ***Do you think the MHRS Act needs amendments, or does the Northern Territory need to make an entire new Act for mental health?***

The development of a new Act starting from a blank canvass will likely lead to a more creative, innovative and effective outcome. Our circumstances are unique in the Northern Territory when compared to other jurisdictions and we should be more creative and innovative when it comes to developing legislation of this kind.

We are aware legislation drafted in the Northern Territory can actively include key agencies such as Police in the drafting process itself and when legislation relates to their powers and functions.

If Aboriginal people of the Northern Territory are affected significantly by mental health issues not just in terms of the conditions and circumstances that arise, but by the nature and function of mental health services, it makes sense to be deliberate and open about involving Aboriginal-led Subject Matter Experts in the actual legislative drafting process. This could serve to complement the Legislative Assembly committee process. It will also place Aboriginal-led Subject Matter Experts in a more inclusive and influencing position rather than just being consulted on the development of legislation.

NAAJA recommends the development of a new Act and with Aboriginal-led Subject Matter Experts actively involved and empowered in the drafting process.

6.3 ***Does another Australian jurisdiction have laws about mental health that you think the Northern Territory should look at?***

In developing this submission we were not in a position to thoroughly research other jurisdictions. We also appreciate the analysis provided in the discussion paper, particularly as it relates to other jurisdictions.

With a high Aboriginal population as a proportion to the total population (and when compared to all other States and Territories), and a unique historical, language and cultural circumstance, we are of the view that Northern Territory legislation should be at the forefront of recognising and adapting to the needs and circumstances of the Aboriginal population. This is not to detract from the unique needs of any person who is a voluntary consumer or involuntary patient, but to say that legislative recognition and protection is important if we are to develop an integrated and adaptable overarching framework.

7. LEGISLATIVE RECOGNITION OF A MECHANISM TO OVERSEE ABORIGINAL CULTURAL SECURITY

7.1 ***Legislative recognition of a mechanism to oversee Aboriginal Cultural Security***

The discussion paper refers briefly to the *Northern Territory Health Aboriginal Cultural Security Framework 2016 – 2026* (Framework). The question in the discussion paper that relates to this framework is in relation to interpreters (although many other questions are broad enough to include matters concerning the framework if the submitter would like to include).

We have included an additional part 7 to our submission to provide recommendations specific to strengthening Aboriginal Cultural Security. In our view, there should be legislative recognition of a mechanism to oversee this aspect of the health service system. Legislative recognition will build on the work done to date and strengthen the potential to deliver on the vision and outcomes intended in the Framework. It will also enhance the prominence and value of the Aboriginal-led service system at an operational level in terms of a dual role: (1) delivering a service to voluntary consumers and involuntary patients (and families and community) and across the service system, and (2) aligning work focus with the intent that the system as a whole is appropriately culturally secure. By building this

into, and across, the service system there can be an appropriate balance between ensuring key decisions in relation to treatment and care are made by suitably qualified practitioners and professionals (such as psychiatrists), and also the transparency and accountability required to ensure practitioners and professionals feel safe and supported.

As stated previously, with our unique demographics and language and cultural characteristics, we have an opportunity to lead the nation in the recognition and development of this work.

Other key points to share in relation to this proposal:

- Legislative recognition of a cultural safety service system will clarify and enhance authority in relation to the development of research and evidence. There is significant work taking place in relation to data sovereignty and particularly for data that is of Aboriginal and/or Torres Strait Islander people. By providing legislative recognition of an Aboriginal-led structure within the service system, there is an opportunity to be clear in relation the direction and responsibility of data sovereignty and the development of principles or guidelines to balance a range of factors required for effective data management. There is also a need to ensure all parts of the health system provide data and information to mechanisms with adequate Aboriginal-led direction. Specific legislation can provide clear guidance and authority for this. Whilst some of this work has been taking place at an operational and policy level, legislative recognition will provide a mandate and clear direction and authority. Existing operational authority sits within a broader Executive level government and this detracts from the principle of data sovereignty which is for Aboriginal control and direction of Aboriginal related data. Legislative recognition and direction will provide clarity and a framework that the operational level must comply with.

- Legislation can provide scope for the responsibility and structure of specific programs. For example, an Elders on Residence program (or other name) where senior Aboriginal persons are employed to provide support in relation to the treatment and care of voluntary consumers and involuntary patients should be available at each treatment facility. Legislation can refer to this when a treatment facility is gazetted or recognised (in other words, it should include reference to such a program). This program should sit separate to the Department of Health, or report to a mechanism recognised in legislation where the key role is an Aboriginal and/or Torres Strait Islander person with statutory recognition. The principal reason for this is so the Elders have autonomy. This autonomy is important in terms of enabling the Elders to develop, operationalise and implement their own community-of-practice separate to the authority of a Department. Legislation can provide guidelines around this to ensure it is safe and appropriate within a service setting. Overall, whilst it may be unusual to recognise such roles in legislation this can be important for the genuine development of an Elder-led practice reflective of the authority Elders hold as Aboriginal people of the Northern Territory (and whose laws and sovereignty still exist).

- Similar to above, legislation can refer to a range of roles that may be referred to at certain points and as required for Aboriginal people who are voluntary consumers or involuntary patients. Roles such as Elders, Aboriginal Health Practitioners, Interpreters, Aboriginal Social Workers (or Support or other name), Cultural Supervision (where supervision is provided to consumer or patient interactions and feedback is provided to the health professional in a safe way) all provide different services however they may be more appropriate for certain points of the mental health service system. It may be necessary for a certain point to require consultation between the health professional and a certain role.

By legislating in this way it will create a mandate and this will assist with a clear understanding to avoid doubt.

NAAJA recommends an Aboriginal led co-design process to explore options of enhancing the *Northern Territory Health Aboriginal Cultural Security Framework 2016 – 2026* with the goal of developing a legislative framework.

This recommendation is consistent with NAAJA's 2018 submission stating, at page 14:

> NAAJA recommends that the Northern Territory Government establish an independent oversight body to act as a robust accountability mechanism by ensuring that mental health and disability treatment plans for Aboriginal clients are individually tailored and culturally appropriate.
>
> Culturally appropriate services can be interpreted broadly and can easily be manipulated or deficient to the detriment of the person. Appropriate cultural understanding should guide the provision of forensic mental health and disability services to Aboriginal clients. More importantly, in order to effectively address the mental health and disability issues of Aboriginal people in the NT, there needs to be culturally appropriate programs specifically designed to meet their needs and robust accountability mechanisms in place to ensure appropriate provision. This can occur with the linking of suitable networks and family supports but also in the provision of services. At an optimum level, Aboriginal led authority or the active involvement of Aboriginal practitioners or Aboriginal community controlled organisations are examples of moving towards mechanisms of accountability. When considering the broad scope of people in contact with the criminal justice system who have varying levels of mental health conditions or cognitive disabilities the lack of robust accountability mechanisms is of significant concern.
>
> NAAJA also stresses the importance of offering appropriate support and education to Aboriginal communities. Information and resources should be made available to communities, families and carers in a culturally informed and accessible way to aid understandings of disability and mental illness. The views of the Aboriginal community controlled health sector are highly relevant in this context.

Further, feedback received from internal NAAJA consultations is:

> At present, section 8(g) MHRSA states that the Act is to be interpreted so that: "the assessment, care, treatment and protection of an Aboriginal person …who has a mental illness is appropriate to, and consistent with, the person's cultural beliefs, practices and mores."
>
> The Northern Territory Health Aboriginal Cultural Security Framework 2016 – 2026 and the National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social Wellbeing 2017 – 2023 have both elaborated on the concept of Cultural Security. Together, they refer to the creation of a system where "Aboriginal people feel safe, secure and able to participate" and where "embedded structures" are reformed so "culturally valid understandings…shape the provision of services". These Frameworks make it clear that the attainment of cultural security goes beyond the reconciliation of "Western" medicine with "Non-Western" medicine. It goes beyond making currently embedded medical practice "appropriate to" or "consistent with" Aboriginal cultural practice. It involves the insertion of Aboriginal cultural practice in the provision of mental health services and the legitimate of that practice. This is the only way to create holistic and multicultural service delivery.

In relation to recognition of 'traditional healers', in one internal NAAJA consultation we received the following feedback:

1. The amendment of s 11(b) of the MHRSA to include "traditional healer" in the obligation to, "where possible" provide involuntary treatment "in collaboration with an Aboriginal and Torres Strait Islander health practitioner". Traditional healers, known as "Ngangkari" in the Ngaanyatjarra, Pitjantjatjara and Yankunytjatjara language groups or "Angangkere" in the various Arrernte language groups, play a crucial role in the cultural security and holistic treatment of Aboriginal mental health patients of Central Australia. They ensure that service delivery is not mono-cultural and is adept to the needs of the patient. Traditional Healers have already been afforded a place in sections 4, 50, 81 and 189 of the Mental Health Act 2014 (WA). This is despite Western Australia having an Aboriginal and Torres Strait Islander population that is almost 1/10th of the Northern Territory population.