NORTHERN TERRITORY LAW REFORM COMMITTEE

Report on the Interaction between people with Mental Health Issues and the Criminal Justice System

Report No. 42
May 2016

MEMBERS OF THE NORTHERN TERRITORY LAW REFORM COMMITTEE

The Hon Austin Asche AC QC

Mr Peter Shoyer

Ms Megan Lawton

Ms Peggy Cheong

Mr Russell Goldflam

Superintendent Richard Bryson

Michael Grant QC SG (Ex-officio)

Professor Les McCrimmon

Dr John Lowndes CSM

Mr Tass Liveris

Mr Jared Sharp

Mr Ron Levy

Mr Tom Anderson

Ms Adele Bogard

MEMBERS OF THE MENTAL HEALTH ISSUES SUB-COMMITTEE

The Hon Austin Asche AC QC

Mr Peter Shoyer

Mr Russell Goldflam

Dr John Lowndes CSM

Mr Tass Liveris

Ms Adele Bogard

ABBREVIATIONS

CHO	Chief Health Officer under the *Mental Health and Related Services Act*
M'Naghten Rules	The common law test for 'insanity' established in M'Naghten's Case (1843) 8 ER 718 at 722
MHRSA	*Mental Health and Related Services Act* (NT)
MHRT	Mental Health Review Tribunal
NSWLRC	New South Wales Law Reform Commission
NT	Northern Territory
NTLRC	Northern Territory Law Reform Committee
The Sub-committee	Mental Health Issues Sub-committee
VLRC	Victorian Law Reform Commission
VLRC Report	Review of the *Crimes (Mental Impairment and Unfitness to be Tried Act 1997*: Report June 2014: Victorian Law Reform Commission

TABLE OF CONTENTS

1.0 TERMS OF REFERENCE

I, JOHAN WESSEL ELFERINK, Attorney-General and Minister for Justice, ask the Northern Territory Law Reform Committee (the Committee) to investigate, examine and report on law reform in relation to the interactions between people with mental health issues and the justice system, and ways that this interaction, as well as outcomes for both the individual and society, might be improved.

Matters for the Committee to Consider

1. What measures might be taken to improve the interaction that people experiencing mental health issues have with the justice system? In particular, what steps might be taken to ensure that the first point of contact for a person experiencing mental health issues after arrest is with the mental health system and not the justice system? In its assessment of this matter, the Committee should consider:

   (a) whether a court based mental health clinician, would assist and how this might function in practice. In considering this matter, the Committee should have regard to schemes of this nature that exist in other jurisdictions, such as the Mental Health Court Liaison Service in Victoria; and

   (b) whether a medical examination should occur if the police suspect that an arrested person has mental health issues and, if so, where this assessment should occur.

2. In particular, whether a better outcome might be achieved by amending section 77(4) to provide a court exercising summary jurisdiction with options other than a mandatory dismissal of the charge if the matters set out in section 77(4) are satisfied and a defence of mental illness or mental disturbance is established. In addition to any other options, the Committee should consider whether it might be appropriate to:

   (a) provide a court exercising summary jurisdiction with powers under Part 4 of the Sentencing Act (Community Treatment Orders); and/or
   (b) provide the court with powers similar to those given under Part IIA of the Criminal Code to the Supreme Court when a finding of not guilty by reason of mental impairment is made (custodial and non-custodial supervision orders, in addition to unconditional release).

   In considering section 77 o1 the *Mental Health and Related Services Act*, I refer the Committee to O'Neill v Lockyer [2012] NTSC 10.

   The Committee should also consider any relevant reviews conducted in other jurisdictions. Without limiting the Committee's consideration of reviews conducted in other jurisdictions, I refer the Committee to the Victorian Law Reform Commission review of the *Crimes (Mental Impairment and Unfitness to be Tried) Act* 1997 (Vic). In particular, chapter five of the June 2014 report may be of assistance. It considers whether the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) should permit the Magistrates' Court to make a supervision order or other orders appropriate to the jurisdiction, rather than being required to discharge the accused if they are found not guilty because of a mental impairment.

In undertaking this reference, the Committee should consult with relevant professionals and agencies in both the Northern Territory and in other jurisdictions and invite written submissions.

The Committee should consider the legislative and policy approaches taken in other jurisdictions but have regard to the unique Northern Territory context in making recommendations. The Committee should also have general regard to the cost implications of recommendations.

I request the Committee present to me a completed report by 30 November 2015 [*].

[* Due to the significant issues to be considered and scale of consultation to be undertaken, on 22 September 2015 the Northern Territory Law Reform Committee was granted an extension to 31 March 2016 to complete their Report]

2.0 RECOMMENDATIONS

Recommendation 1

'Mental disturbance' should be added as one of the inclusions under the definition of 'mental impairment' in section 43A of the Criminal Code.

Recommendation 2

The definition of 'mental illness' under section 43A of the Criminal Code should be replaced with reference to section 6 of the *Mental Health and Related Services Act*.

Recommendation 3

Section 43C(1)(b) of the NT Criminal Code should not be amended to replace '(that is that he or she could not reason with a moderate of sense and composure about whether the conduct is perceived by reasonable people was wrong)' with '(that is, he or she did not have the capacity to think rationally about whether the conduct as perceived by reasonable people was wrong)'.

Recommendation 4

The assessment and diversion of individuals prior to a matter being brought before the court should remain a matter for the NT Police.

Recommendation 5

There should be established a specialist Mental Health Court or Mental Health Diversion List constituted by an appropriately qualified Magistrate to which persons with possible mental health issues (including cognitive impairment), who have been charged with the commission of a criminal offence in the Court of Summary Jurisdiction, would be referred, and thereby diverted from the regular criminal justice system and into a forum better equipped to deal with defendants who may have mental health issues or a cognitive impairment.

Recommendation 6

If it appears that a defendant may have mental health issues, including cognitive impairment, the Court of Summary Jurisdiction should refer such person's matter/s to the Mental Health Court or Mental Health Diversion List.

Recommendation 7

The following persons should be able to report concerns regarding a defendant's mental health to the Court of Summary Jurisdiction:

(a) Members of the police force;
(b) Legal representatives of such person;
(c) Those involved in the prosecution of such persons;
(d) Community Corrections Officer;
(e) The family or family carers, or other persons involved in the care of such persons;
(f) Any member of the public having a connection with and sufficient knowledge of such person to give relevant information about such persons.

The means for making and receiving a 'report' will be managed by the Court.

Recommendation 8

The jurisdiction of the Mental Health Court or Mental Health Diversion List should include, but not be limited to:

(a) Assessment of a defendant's bail application;
(b) Assessment and admission of a defendant, under Part 10, Division1 of the MHRSA;
(c) Consideration of applications for dismissal of a charge on the basis of mental illness or mental disturbance, under section 77 of the MHRSA;
(d) Making voluntary treatment plans, under section 78 of the MHRSA;
(e) Making orders for and consideration of pre-sentence reports requiring psychiatric or psychological examinations; and
(f) Making Mental Health Orders, under Part 4 of the *Sentencing Act*.

Recommendation 9

The Mental Health Court or Mental Health Diversion List should have all powers of the Court of Summary Jurisdiction, including but not limited to:

(a) Hearing such evidence and examining such reports as it considers necessary and, hearing all arguments and submissions as may be addressed to it by legal representatives or mental health professionals, including Mental Health Clinicians and the Chief Health Officer;

(b) Ordering the provision of reports from an expert as necessary;

(c) Ordering the defendant attend for examination, for the purpose of preparation of such a report as necessary.

Recommendation 10

The Mental Health Court or Mental Health Diversion List should consider any referred matter in its entirety, including any examination of the defendant's fitness to stand trial, defence of mental impairment or, finding none of these, the defendant's sentence and plea of Guilty.

Recommendation 11

The Mental Health Court or Mental Health Diversion List should only refer a matter back to the Court of Summary Jurisdiction if it determines:

(a) there is no mental impairment; and

(b) the defendant is fit to stand trial; and

(c) the defendant wishes to plead Not Guilty.

Such a hearing is then to be conducted in the ordinary criminal justice stream of the Court of Summary Jurisdiction.

Recommendation 12

The Chief Magistrate may at any time, and in his complete discretion, give such directions as to the procedures to be adopted in the Mental Health Court or Mental Health Diversion List as he considers will be conducive to the more efficient operation of the Court.

Recommendation 13

Mental Health Clinicians should be appointed to assist the Court of Summary Jurisdiction and specialist Mental Health Court or Mental Health Diversion List in all matters which may arise in relation to the mental health of a defendant, including but not limited to:

(a) making an initial assessment of persons appearing before the Court of Summary Jurisdiction and accused of a criminal offence and report to the court if it appears that such persons may be suffering from mental illness;
(b) reporting and seeking immediate assistance from appropriate authorities under the *Mental Health and Related Services Act* if it appears that such persons may be in immediate danger of self-harm or harming others;
(c) assisting the Mental Health Court or Mental Health Diversion List to consider whether a person appearing before that Court, may be suffering from a mental illness;
(d) linking such persons with such services as may be of help in their condition and, if necessary, to seek immediate assistance from such services.
(e) carrying out such functions or make such reports as the Chief Magistrate may direct;
(f) being aware of and applying, where appropriate, the objects of the *Mental Health and Related Services Act* as set out in section 3;
(g) coordinating and assisting with preparation of assessments, treatment plans and communication of the same to the Court, under Part 10 of the *Mental Health and Related Services Act*; and
(h) the monitoring of the person's progress while on the treatment plan and reporting to the court on the person's progress at periodic court reviews.

Recommendation 14

The appointment of Mental Health Clinicians should be up to the Chief Magistrate, however, considerations regarding the minimum qualifications of such Clinicians should be given, including but not restricted to:

(a) Holding qualifications in nursing, social work, psychology or psychiatry;
(b) Having a post graduate certificate in mental health; or
(c) Having forensic mental health experience in courts, prison or the community.

Recommendation 15

The Mental Health Court or Mental Health Diversion List should have jurisdiction to hear all matters currently falling within section 77 of the *Mental Health and Related Services Act*.

Recommendation 16

The requirement for a Certificate to be furnished by the Chief Health Officer under section 77 of the *Mental Health and Related Services Act* should be removed and replaced with the requirement for a comprehensive report to be completed by the Chief Health Officer or an 'authorised psychiatric practitioner' or 'designated mental health practitioner' as defined in *Mental Health and Related Services Act*.

Recommendation 17

The Report referred to in recommendation 16 should address the defendant's mental impairment and provide recommendations regarding the defendant's ongoing supervision and treatment.

Matters to be considered in the report need to reflect the matters set out in section 77(4) of the *Mental Health and Related Services Act*.

Recommendation 18

The Mental Health Court or Mental Health Diversion List should be provided with the power to make therapeutic supervisory orders in the form of Part IIA, Division 5 of the Criminal Code, but with variation to ensure that processes are simplified as far as practical to align with the practice and conduct of the Court of Summary Jurisdiction including – the limitation that supervision orders be made for a specific period of time, no longer than 12 months, having regard to the therapeutic needs of the person.

Recommendation 19

In relation to all matters that the Court of Summary Jurisdiction would have jurisdiction to hear summarily (including minor indictable offences), all questions relating to a defendant's fitness to stand trial should be dealt with by the Mental Health Court or Mental Health Diversion List.

Recommendation 20

The process and matters to be considered by the Mental Health Court or Mental Health Diversion List in determining the defendant's fitness should be adapted from those under Part IIA of the Criminal Code, simplified as far as practical to align with the practice and conduct of the Court of Summary Jurisdiction.

Recommendation 21

The exchange of information between the Department of Health, Mental Health Review Tribunal, court clinicians and the Court should be formalised so as to ensure workable information sharing arrangements and compliance with the *Information Act*.

Recommendation 22

Ensuring that the victim of an offence remains informed throughout the process and is provided the opportunity to express their views, should be a priority. Counselling services should also be made available to the victim.

3.0 INTRODUCTION

The reference by the Attorney-General asks:

> What measures might be taken to improve the interaction that people experiencing mental health issues have with the justice system.

(The reference continues with particular comments and suggestions relevant to the basic question set out above.)

Far greater recognition exists today of the concept of what can broadly be described as 'mental illness'. The fact is that the concept itself is not confined to one particular set of symptoms, but can be manifest in various ways not necessarily connected, but nevertheless all falling within the description of 'mental illness' or 'mental impairment'. The definition of mental impairment in section 43A of the Criminal Code 'includes' senility, intellectual disability, mental illness, brain damage and involuntary intoxication. Any one of these conditions differs quite radically from any other in symptoms, recognition and treatment; yet all can be accepted as excusing a person suffering from such a condition from criminal liability if an action clearly contrary to the criminal law is committed without the mind which goes with it.

The inclusion of 'mental illness' within the term 'mental impairment' in section 43A widens the scope of the expression far beyond those specific examples named. The definition of 'mental illness' in the Code and the differing definition in section 6 of the *Mental Health and Related Services Act* both indicate a far more comprehensive view of 'mental impairment'. The intention of the legislation seems clearly to allow the courts a wide discretion in accepting psychiatric or specialist evidence of 'mental impairment' even if the particular condition is not 'included' in the definition.

But, whatever professional designation is given to the condition as an indicator of mental impairment, a person proved to be suffering from that condition is not thereby entitled to be acquitted of the criminal offence for which the person has been charged unless they also prove on the balance of probabilities (the onus being on the person) that, at the time of committing the offence alleged, they did not know what they were doing or, if they did know, they did not know that what they were doing was wrong. This is the M'Naghten Test, discussed further in this Report in section 4.0, which, for the reasons given, is not likely to be repealed. For the purposes of the criminal law, the M'Naghten Test marks out the borderline between those responsible for their own actions, and therefore subject to criminal law, and those not so responsible and therefore not within the sanctions of the criminal law.

The rapidly increasing knowledge of and research into mental illness; and, happily, the increasing success of various forms of treatment, raises a sort of no-mans-land between those who can successfully 'pass' the M'Naghten Test and those who cannot, but would still be 'mentally ill' in the medical or psychiatric sense. Thus, to refer back to some of the conditions named in section 43A of the Criminal Code, a person suffering 'brain damage' or 'intellectual disability' might still be

capable of forming the requisite intention to commit a crime and to know that the action was wrong.

It could be argued that the answer to a criminal charge in which the defendant has failed to convince the court to acquit under the M'Naghten Rules, but does show signs of mental illness, is to make appropriate allowances in sentencing.

Sections 79 and 80 of the *Sentencing Act* (NT) give the court power to make various orders for the welfare and treatment of a person if the court is of the opinion that the person appears to be mentally ill, or mentally disturbed. But this power operates only if the person 'is found guilty of an offence'. Similarly, the Court of Summary Jurisdiction may request a certificate from the Chief Health Officer as to whether a defendant was suffering from mental illness or mental disturbance at the time of the alleged offence; but can only dismiss the charge if the M'Naghten Rules apply.[1]

Under section 78 of the *Mental Health and Related Services Act* the court may seek the assistance of the Chief Health Officer and direct treatment; but only if the defendant has pleaded guilty or been found guilty.[2]

The problem for a better informed society is that persons suffering a mental illness, but who cannot pass the M'Naghten Test must necessarily be convicted of a crime before the court can act to bring about necessary treatment.

Most Australian citizens these days would feel if a mentally ill person was convicted for an act substantially related to, or caused by their illness, this would be an unjust result unfairly stigmatising a person for something over which he had little control. On the other hand, the situation could be reached that, taking an overgenerous view, some form of mental illness or disturbance might be found to explain practically any behaviour of a defendant which, in normal circumstances, would constitute a criminal act. Modern psychiatry can give reasons why a person commits a crime, and such reasons may invite sympathy and a desire to deal leniently with a person so badly treated by destiny. Yet the person does not come within the M'Naghten Rules if they knew what they were doing and that it was wrong.

The courts must therefore be alert to the question as to what extent a defendant may genuinely rely upon a condition which excuses the person from punishment or whether the court can insist that the defendant must take responsibility for their own actions.

The Recommendations in this Report are directed to a speedy recognition of mental illness, and the process which diverts a person suffering from such to a forum better equipped to make orders or directions appropriate to the situation.

Obviously, the earlier the recognition of a mental health issue, the better for the person involved and for the community. In this respect the police are the front line and this Report acknowledges their importance (Recommendation 4).

---

[1] sections 77(2) and (4)(b), *Mental Health and Related Services Act*.
[2] Section 78(1)(a), *Mental Health and Related Services Act*.

Likewise, other members of the public with knowledge of a person's condition (e.g. family) should be encouraged to report their knowledge or concerns to the Court of Summary Jurisdiction (Recommendation 7).

The Court of Summary Jurisdiction should have permanently attached to it Mental Health Clinicians to assess possible mental health issues and report to and assist the court (Recommendations 13-14).

If it appears that a defendant is in difficulties apparently caused by mental illness, the Court of Summary Jurisdiction may refer the matter to a Mental Health Court or Mental Health Diversion List presided over by a Magistrate with experience in such cases, assisted by persons qualified in mental health care.

(Detailed discussion of the powers and procedures of the Mental Health Court or Mental Health Diversion List are contained in those parts of this Report which refer to Recommendations 5-12 and 15).

Without limiting the above, the effect should be that, in appropriate cases, persons before the Mental Health Court or Mental Health Diversion List would be discharged if their condition is genuinely one of mental illness and they comply with such directions as the Mental Health Court or Mental Health Diversion List requires. The court may also seek a comprehensive report from the Chief Health Officer or other mental health care providers (Recommendations 8, 9 and 16).

For convenience and expedition, it is also recommended that where practicable and if within the jurisdiction of the Court of Summary Jurisdiction, the question relating to a defendant's fitness to stand trial be dealt with by the Mental Health Court or Mental Health Diversion List (Recommendations 15-20).

In effect this Report makes a series of Recommendations which it considers will allow persons suffering mental illness who come into contact with the Criminal Law to be promptly recognised and treated and in appropriate cases, discharged. But it may well be the case that some will remain a threat to the public because of their mental illness and the Mental Health Court or Mental Health Diversion List must be alert to these situations. In addition it will be expected of the Mental Health Court or Mental Health Diversion List that, in discharging a defendant whose conduct has appeared dangerous in the past, the Court clearly explain its reasons for the benefit of the public who may have serious concerns about what they would otherwise regard as unduly lenient orders.

NOTE: In preparing this Report, the Northern Territory Law Reform Committee, conducted a series of Round Table discussions with a number of stakeholders. Formal written submissions were also received by the Chief Health Officer, Professor Dinesh Arya and the Chief Psychiatrist, Dr Peggy Brown. The Committee is grateful for the submissions made by all involved. A full list of stakeholders who participated is contained at Appendix A and a copy of Professor Arya and Dr Brown's formal submissions is at Appendix B.

4.0 OVERARCHING PRINCIPLES

While undertaking their inquiry, the NTLRC has formulated a number of overarching principles that should apply to proceedings involving a defendant's mental health:

1. Every effort should be made to afford a defendant whose capacity may be in doubt such adjustments as he or she reasonably requires to be able to participate in a full criminal process and to maintain that capacity for the whole of the process;

2. The provision of equitable and improved access to justice for mentally ill or disturbed persons within the criminal justice system;

3. Those unable to engage in a full trial process but who have sufficient understanding and decision-making capacity to plead guilty should be able to do so;

4. Wherever possible, orders should favour treatment in a therapeutic environment rather than a correctional environment;

5. If an individual is not guilty by way of mental impairment, their condition is clearly serious enough that it is best met by the health care system;

6. The improvement of community safety and reduction of recidivism by the diversion of mentally ill persons from the criminal justice system and into appropriate treatment and support;

7. Consistent with the principles of the *Mental Health and Related Services Act*, involuntary detention and treatment should be a last resort;

8. There is a need for appropriate resourcing, training and materials to be provided to staff working in the field so that they can adequately explain the process to victims and the community.

5.0 M'NAGHTEN RULES: INDICTABLE OFFENCES

> [T]o establish a defence on the ground of insanity it must be clearly proved that, at the time of committing the act, the accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or, if he did know it, that he did not know he was doing what was wrong.[3]

This test, propounded by the judges of England in 1843, was generally accepted in common law countries throughout the world including the Northern Territory under South Australian jurisdiction and, after 1911, under federal jurisdiction, and from 1978 and thereafter, under self-government.

If sufficiently proved, the verdict in such a case was 'not guilty on the grounds of insanity' (save for a period in England when, apparently at the urging of Queen Victoria, the verdict was 'guilty but insane').

In the NT in 2002 the term 'mental impairment was substituted for the term 'insanity'.[4]

The defence of mental impairment is contained in section 43C of the Criminal Code (NT) provides:

> **43C Defence of mental impairment**
>
> *(1) The defence of mental impairment is established if the court finds that a person charged with an offence was, at the time of carrying out the conduct constituting the offence, suffering from a mental impairment and as a consequence of that impairment:*
>
> *(a) he or she did not know the nature and quality of the conduct;*
>
> *(b) he or she did not know that the conduct was wrong (that is he or she could not reason with a moderate degree of sense and composure about whether the conduct, as perceived by reasonable people, was wrong); or*
>
> *(c) he or she was not able to control his or her actions.*
>
> *(2) If the defence of mental impairment is established, the person must be found not guilty because of mental impairment.*

In accordance with sections 43D and 43E of the Criminal Code, the onus of proof is on the accused to prove that they were suffering from a mental impairment at the time of engaging in the impugned conduct, on the balance of probabilities.

Note that section 43C(1)(a) and (b) are in the same terms, and therefore adopt the M'Naghten Rules. Subsection (c) is a defence now generally accepted in both Australian and American jurisdictions.

---

[3] M'Naghten's Case (1843) 8 ER 718 at 722

[4] *Criminal Code Amendment (Mental Impairment and Unfitness to be Tried) Act 2002.*

5.1 Has the substitution of the term 'mental impairment' for the term 'insanity' widened the scope of the defence?

As noted, the test remains the same as in the M'Naghten Rules. Thus in whatever psychiatric category the accused may be placed, it must still be shown on the balance of probabilities, that the accused did not know the nature and quality of their conduct, or did not know that this conduct was wrong.

'Mental impairment' is not defined in the Criminal Code (NT). At most, section 43A of the Criminal Code states that the term 'includes' senility, intellectual disability, mental illness, brain damage and involuntary intoxication. This is not a definition, merely a list of certain conditions which may be included in the definition. The word 'includes' necessarily implies that the list is not closed.

It would seem that the expression 'mental impairment' is an attempt to expand or clarify the concept of 'disease of the mind' in the M'Naghten Rules. Even so, it is fair to say that:

> A great deal of the old common law relating to insanity is therefore still relevant to the new defence.[5]

The NT Criminal Code, section 43A, does contain a definition of the term 'mental illness':

> ***mental illness*** *means an underlying pathological infirmity of the mind; whether of long or short duration and whether permanent or temporary, but does not include a condition that results from the reaction of a healthy mind to extraordinary stimuli (although such a condition may be evidence of a mental illness if it involves some abnormality and is prone to recur).*

Since the terms 'mental impairment' and 'mental illness' appear as separate terms in section 43A they cannot be equated together, and it appears that the latter term is merely a specific instance of the former.

Part IIA of the Criminal Code relevantly only applies to the Supreme Court; for a court exercising Summary Jurisdiction the expression 'mental illness' is much more precisely defined in section 6 of the *Mental Health and Related Services Act* as follows:

> *(1) A* ***mental illness*** *is a condition that seriously impairs, either temporarily or permanently, the mental functioning of a person in one or more of the areas of thought, mood, volition, perception, orientation or memory and is characterised:*
>
> *(a) by the presence of at least one of the following symptoms:*
>
> *(i) delusions;*
>
> *(ii) hallucinations;*
>
> *(iii) serious disorders of the stream of thought;*

[5] Grey, S. Blokland, J. (2012) *Criminal Laws Northern Territory*. Second Edition. Sydney: The Federation Press.

(iv) serious disorders of thought form;

(v) serious disturbances of mood; or

(b) by sustained or repeated irrational behaviour that may be taken to indicate the presence of at least one of the symptoms referred to in paragraph (a).

(2) A determination that a person has a mental illness is only to be made in accordance with internationally accepted clinical standards.

(3) A person is not to be considered to have a mental illness merely because he or she:

(a) expresses or refuses or fails to express a particular political or religious opinion or belief, a particular philosophy or a particular sexual preference or sexual orientation; or

(b) engages, or refuses or fails to engage, in a particular political, religious or cultural activity; or

(c) engages, or has engaged, in sexual promiscuity, immoral or illegal conduct or anti-social behaviour; or

(d) has a sexual disorder; or

(e) is intellectually disabled; or

(f) uses alcohol or other drugs; or

(g) has a personality disorder or a habit or impulse disorder; or

(h) has, or has not, a particular political, economic or social status; or

(j) communicates, or refuses or fails to communicate, or behaves or refuses or fails to behave, in a manner consistent with his or her cultural beliefs, practices or mores; or

(k) is, or is not, a member of a particular cultural, racial or religious group; or

(m) is involved, or has been involved, in family or professional conflict; or

(n) has been treated for mental illness or has been detained in a hospital that provides treatment of mental illness; or

(p) has been admitted as an involuntary patient on the grounds of mental disturbance or complex cognitive impairment; or

(q) has acquired brain damage.

Whether there is any practical difference in the two definitions is unclear.

It would seem that this definition of mental impairment in section 43A of the Criminal Code is so defined to allow specific expressions to be added, from time to time. The definition of mental

illness is wide enough to allow the court to adopt various aspects of mental impairment. Accordingly, the definition of mental impairment should remain open to include any further conditions as necessary.

However, consistent with section 77 of the *Mental Health and Related Services Act*, mental disturbance should be added as one of the inclusions under the definition of mental impairment under the Criminal Code.

Further, for consistency and precision, the definition of mental illness under section 6 of the *Mental Health and Related Services Act* should be preferred to that under the Criminal Code. The NTLRC further understands that the definition of mental illness under section 77 of the MHRSA is more closely aligned with the tenets of modern psychiatry.

5.2 Should the M'Naghten Rules be changed?

In broad terms, the consensus seems to be 'No'.

The Victorian Law Reform Commission Report, Review of the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*, comments on the earlier NSWLRC Report, People with cognitive and mental health impairments in the criminal justice system: Criminal responsibility and consequences,[6] and noted 'in its recent review the NSWLRC recommended retaining both elements of the McNaghten test'. Section 20 of the Victorian *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* is in precisely the same terms as section 43C(a) and (b) of the NT Criminal Code. The VLRC examined those provisions and reported:

> The Commission does not recommend any changes to the essential elements of the two limbs of the mental impairment defence but recommends changes to the test for assessing whether a person knows their conduct is wrong.
>
> The Commission agrees with the view expressed by clinicians in submissions and consultations that the phrase 'to reason with a moderate degree of sense and composure' requires clarification. The Commission's recommendation therefore seeks to clarify the meaning of the second limb of the defence of mental impairment only.

Accordingly, recommendation 25 of the VLRC Report was as follows:

> Section 20(1)(b) of the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) should be amended to replace 'that is, he or she could not reason with a moderate degree of sense and composure about whether the conduct, as perceived by reasonable people, was wrong' with 'that is, he or she did not have the capacity to think rationally about whether the conduct, as perceived by reasonable people, was wrong.

It is noted that the Victorian legislature has not so far adopted the suggested amendment.

---

[6] People with cognitive and mental health impairments in the criminal justice system: Criminal responsibility and consequences: Report No 138: May 2013: New South Wales Law Reform Commission.

It is also important to note that, in passing the amendments to the Criminal Code in 2002, the NT Parliament did not intend any change in the form of the M'Naghten Rules. In introducing the Bill the Attorney-General, Dr Toyne, said:

> A defence of mental impairment will replace the defence of insanity, although the substantive law regarding the offence remains unchanged.[7]

Subject to the definitional changes discussed in section 5.1 above, there seems no reason to amend the M'Naghten Rules as appearing in the NT Criminal Code. Although the suggested variation of the M'Naghten Rules may seem to clarify to some degree the present wording, the degree of clarification does not appear to justify amendment of a familiar and long-accepted terminology.

Recommendation 1

'Mental disturbance' should be added as one of the inclusions under the definition of 'mental impairment' in section 43A of the Criminal Code.

Recommendation 2

The definition of 'mental illness' under section 43A of the Criminal Code should be replaced with reference to section 6 of the *Mental Health and Related Services Act*.

Recommendation 3

Section 43C(1)(b) of the NT Criminal Code should not be amended to replace '(that is that he or she could not reason with a moderate of sense and composure about whether the conduct is perceived by reasonable people was wrong)' with '(that is, he or she did not have the capacity to think rationally about whether the conduct as perceived by reasonable people was wrong)'.

[7] Dr Toyne: Criminal Code Amendment (Mental Impairment and Unfitness to be Tried) Bill 2002: Second Reading Speech: Hansard: 15.05.2002

6.0 DEVELOPMENT OF MENTAL IMPAIRMENT AS A DEFENCE

The introduction of the term 'mental impairment' into the NT Criminal Code, as with similar amendments in other Australia jurisdictions, was accompanied with a considerable change in the legislative policy dealing with such cases. This policy reflected the increase in contemporary views that persons mentally impaired could be effectively treated, and that only in extreme cases could a lengthy or even permanent confinement be justified.

In earlier times the defence of 'insanity' was pleaded only in serious cases. This was because a finding of 'insanity' meant that the court ordered the accused to be kept in custody as a 'criminal lunatic'. The result, as earlier editions of Kenny's Outlines of Criminal Law[8] relate, 'the confinement is usually lifelong'.

Thus it was hardly in the interests of an accused charged with, say, theft or burglary, to plead insanity and ensure a probable lifelong detention; whereas, if simply convicted, he could face a term of years, at the expiration of which he would be free to continue his professional career. Only in the more extreme case of, say, a charge of murder, when the penalty on conviction was death, might an accused be prepared to plead 'insanity' as the lesser of two evils.

The position these days is vastly different. Section 43I(2) of the Criminal Code allows the court to release the accused under a supervision order or unconditionally. Further, under section 43I(3), the court may also make an interim order for bail, remand of the person in custody (whether in a custodial correctional facility or another place) and/or the examination of the person by a psychiatrist or other expert.

Contemporary methods of treatment achieve the result that many persons suffering mental impairment do not need to be detained for long periods, and, while being detained, may receive treatment appropriate to their condition.[9]

---

[8] For example, the 15th Edition, 1946, page 67.

[9] Detailed rules about the supervision orders that may be made by the Supreme Court, after a defendant is found not guilty, are contained in Part IIA, Division 5 of the Criminal Code.

7.0 EARLIEST POSSIBLE EXAMINATION

In her submission (refer Appendix B) the Chief Psychiatrist, Dr Peggy Brown, stresses the need for targeted training for Police so that they may exercise discretion about whom and when to charge an offender, if the offender appears mentally ill. Dr Brown also recommends early assessment by clinical staff after apprehension of mentally ill persons by Police, in accordance with the National Principles for Forensic Mental Health (refer Appendix C).

The NTLRC notes Dr Brown's comments and the importance of NT Police and the Department of Health liaising closely to explore initiatives for pre-court assessment and diversion of individuals who have mental health issues.

NT Police are already involved in the interaction between the criminal justice system and persons with mental health issues.

Section 32A of the *Mental Health and Related Services Act* provides that if a police officer believes on reasonable grounds that:

> (a) a person may require treatment or care under the Act having regard to the appearance and behaviour of the person; and
>
> (b) the person is likely to cause serious harm to himself or herself or to someone else unless apprehended immediately; and
>
> (c) it is not practicable in the circumstances to seek the assistance of a psychiatric practitioner, a medical practitioner or a designated mental health practitioner

the police officer may apprehend the person and bring the person to an authorised psychiatric practitioner, a medical practitioner or a designated mental health practitioner for an assessment under section 33. The practitioner is then required to make an assessment under section 33 of the *Mental Health and Related Services Act*, to determine whether the person is in need of treatment under the Act.

Pursuant to section 37 of the *Mental Health and Related Services Act* a practitioner or police officer may apply to the Mental Health Review Tribunal for a warrant to apprehend a person who may be unable to care for himself or herself, and who may fulfil the criteria for involuntary admission on the grounds of mental illness or mental disturbance,[10] in circumstances where all other reasonable avenues to assess the person have been exhausted. A warrant issued by the Tribunal authorises a police officer to apprehend and control the person and to bring the person to a practitioner for an assessment of the person.[11]

Therefore, there are already in place some statutory mechanisms for early intervention in relation to persons suspected of suffering from a mental illness or a mental disturbance. The NTLRC understands that a police officer making an assessment under section 32A of the *Mental Health*

---

[10] In accordance with s14 and 15 of the *Mental Health and Related Services Act*.

[11] A section 37 warrant may also authorise a practitioner to apprehend and control the person and to conduct an assessment of the person.

and Related Services Act will refer the person to the Crisis Assessment Triage Team (CATT) in the first instance. In remote locations, where access to the Crisis Assessment Triage Team is unavailable, other arrangements are in place with local clinics to arrange assessments.

Of course, where there has been such intervention involving a person charged with a criminal offence it is essential that the court be apprised of that interaction with the mental health system as early as possible during criminal proceedings so as to assist in the diversion of that person from the regular criminal justice process.

It is worth noting that as part of his coronial findings in relation to the inquest into the death of Terrence Daniel Briscoe [2012] NTMC 032, the Northern Territory Coroner made some observations about the employment of nurses in NT Watch Houses,[12] and recommended that the Northern Territory Government give urgent attention to providing nursing staff on a daily basis to the Watch Houses in Darwin, Alice Springs, Katherine and Tennant Creek, together with a suitably equipped medical room within the Watch House.[13] It is understood that custody nurses are employed at the Darwin, Katherine and Alice Springs Watch Houses. Tennant Creek does not employ a 'custody nurse' but rather relies upon arrangements taking advantage of the closeness of the police watch house to the hospital.

The employment of nurses at NT Watch Houses presents as a key mechanism for screening and identifying persons who may be suffering from a mental illness or mental disturbance at the earliest possible time during their contact with the criminal justice system; and for the referral of such persons to a medical practitioner, an authorised psychiatric practitioner or a designated mental health practitioner for a mental health assessment and treatment if necessary.

NTLRC understands that NT Police rely on the Director of Public Prosecutions Guidelines when making a decision to proceed with an arrest if the defendant's behaviour is predicated by some form of mental health issues. If a decision is made not to proceed with an arrest, thereby diverting the person from the criminal justice system, NT Police have formalised referral arrangements using 'Supportlink' which allows members to refer the person to relevant support agencies, including the Department of Health. This referral is also utilised if Police attend an incident whereby the person's behaviour is 'unusual' but not criminal in nature.

It is also understood that NT Police have General Orders that address their dealings with mentally ill persons.

Recommendation 4

The assessment and diversion of individuals prior to a matter being brought before the court should remain a matter for the NT Police.

[12] See pp 68-72 of the coronial findings.
[13] See p 79 of the findings.

8.0 SUMMARY JURISDICTION

The Court of Summary Jurisdiction has a number of powers under the *Mental Health and Related Services Act,* in relation to accused persons with mental health issues.

8.1 Involuntary Treatment

Whether or not there has been any prior indication that a person may be suffering from a mental illness, the person's mental state and presentation in court (whether in custody or on bail), in addition to information given to the Court, may trigger the Court's powers under Part 10 Division 1 (sections 73A -76) of the *Mental Health and Related Services Act.*

A person who is subject to assessment and treatment under Part 10 Division 1 of the MHRSA may either be admitted to bail or remanded in custody. Equally, a person who has been subject to, and completed the assessment and treatment process, may be bailed or remanded in custody.

8.2 Section 77

Section 77(4) of the *Mental Health and Related Services Act* requires the Court of Summary Jurisdiction to dismiss a charge if satisfied that, at the time of the offence, the accused was suffering from 'mental illness' or 'mental disturbance' (the operation of section 77 is discussed further below at section 11).

8.3 Voluntary Treatment on plea or finding of guilt

Section 78 of the *Mental Health and Related Services Act* empowers the Court, where a person has pleaded guilty to an offence or has been found guilty of an offence, to request from the Chief Health Officer an assessment of, and if appropriate a voluntary treatment plan for the person if:

(a) the Court is of the opinion the person suffers from a mental illness or mental disturbance that is likely to have contributed to the conduct constituting the offence; and

(b) the Court is satisfied the person

  (i) recognises that he or she suffers from a mental illness or mental disturbance and

  (ii) has made, or is willing to make, a conscientious effort to address problems associated with the mental illness or mental disturbance; and

(c) the Court considers it appropriate for the offence to be dealt with under this Division having regard to the nature and seriousness of the offence; and

(d) the prosecution and the person consent to the offence being dealt with under this Division.

If the assessment indicates that it is appropriate to treat the person under a voluntary treatment plan the court may adjourn the proceedings for a period not exceeding 6 months, and grant the

person bail on the condition that they enter into an agreement to participate in the treatment plan.[14]

If the proceedings have been adjourned the court must review the person's participation in the voluntary treatment plan on the resumption of the proceedings.[15] If the person has completed the treatment plan, the court may (a) dismiss the charge; or (b) deal with the person under the provisions of the *Sentencing Act*.[16]

8.4 Mitigation

Independently of the provisions of s 78 of the *Mental Health and Related Services Act*, a person may at any time plead guilty to an offence and seek to rely upon a mental illness or a mental disturbance as a mitigating circumstance. In such cases a pre-sentence report (incorporating a psychiatric or psychological report) is commonly ordered by the court either at the request of the defendant or on the court's own initiative.

8.5 Mental Health Order

Finally, the court has power under the provisions of Part 4 of the *Sentencing Act* to make mental health orders.[17] A court based clinician would play a key role in the implementation of such orders, particularly during the assessment phase. Whenever the provisions of Part 4 of the *Sentencing Act* are invoked, it would again make sense to divert the offender into the specialist mental health list.

---

[14] See s 78A. If it is not appropriate to treat the person under a voluntary treatment plan, the court must deal with the person under the provisions of the *Sentencing Act*.

[15] See s 78B.

[16] See s 78B(3). If the person has not completed the treatment plan the court may (a) adjourn the proceedings for a further period of up to 6 months and grant the person bail on the condition that they complete the treatment plan; or (b) deal with the person under the provisions of the *Sentencing Act*.

[17] These are set out in Attachment D and are briefly discussed at p 14 below.

9.0 MENTAL HEALTH COURT or MENTAL HEALTH DIVERSION LIST

By way of background, most Australian jurisdictions have developed and implemented specialist mental health court lists or diversionary programs (at the level of the Magistrates Court) which are designed to divert people with mental health issues (who have been charged with the commission of criminal offences) from the mainstream criminal justice system.

The aim of these specialist court lists and diversionary programs is to prevent further offending by adopting a more therapeutic response to the offending behaviour of persons with mental health problems, and diverting them away from the regular criminal justice system by providing access to early assessment and interventions that address their mental health needs and their offending behaviour, as well as providing them with appropriate treatment in order to reduce their likelihood of re-offending.

All of these alternative criminal justice initiatives have a common goal - which is to significantly improve the interaction that people with mental health problems have with the criminal justice system by providing a different and a better experience for persons who have a mental illness and a more effective process for dealing with offenders with such problems.

In order to ensure that mental health issues are adequately explored and addressed the most appropriate course is for matters in the Court of Summary Jurisdiction, involving a question of the defendant's mental health, to be referred to a specialist Mental Health Court or Mental Health Diversion List.

It is envisaged that a specialist Mental Health Court or Mental Health Diversion List would be constituted by an appropriately qualified Magistrate and hold all the powers of a Court of Summary Jurisdiction. In addition, the Court should have the power to make supervision orders, similar to the Supreme Court under Part IIA of the Criminal Code (discussed further below in section 11).

The Mental Health Court or Mental Health Diversion List would also be supported by court-based mental health clinicians who would assist the Court in assessing whether the accused was suffering from mental illness or mental disturbance and determining the most appropriate course (role discussed further below at section 10). The Committee acknowledges that cognitive impairment does not form part of the core practice of those who will be appointed as Mental Health Clinicians and there may be need for external consultation.

It is anticipated that the Court of Summary Jurisdiction will be alerted to any mental health concerns at the earliest available opportunity. Those who may be in a position to raise concerns include the Police, prosecution, defence counsel, family members, carers or correctional services staff. In addition, the person's mental state and presentation in court (whether in custody or on bail) may lead the Magistrate to develop their own concerns. Upon becoming aware of the potential existence of mental health issues, the matter should be referred to the specialist Mental Health Court or Mental Health Diversion List for further investigation. In the first instance, an assessment should be conducted by a mental health clinician.

It is intended that matters be fully disposed of by the Mental Health Court or Mental Health Diversion List and should only be returned to the ordinary criminal justice stream if the court determines there is no mental impairment and the accused wishes to plead not guilty and rely on a defence unrelated to his/her mental health. Given that modern approaches to mental health recognise that a person may suffer from mental health concerns, even if not to the extent that the M'Naghten Rules recognise, there is a clear need to extend mental health enquiries beyond consideration of a person's discharge under section 77 of the MHRSA, to persons found guilty.

Recommendation 5

There should be established a specialist Mental Health Court or Mental Health Diversion List constituted by an appropriately qualified Magistrate to which persons with possible mental health issues (including cognitive impairment), who have been charged with the commission of a criminal offence in the Court of Summary Jurisdiction, would be referred, and thereby diverted from the regular criminal justice system and into a forum better equipped to deal with defendants who may have mental health issues or a cognitive impairment.

Recommendation 6

If it appears that a defendant may have mental health issues, including cognitive impairment, the Court of Summary Jurisdiction should refer such person's matter/s to the Mental Health Court or Mental Health Diversion List.

Recommendation 7

The following persons should be able to report concerns regarding a defendant's mental health to the Court of Summary Jurisdiction:

(a) Members of the police force;
(b) Legal representatives of such person;
(c) Those involved in the prosecution of such persons;
(d) Community Corrections Officer;
(e) The family or family carers, or other persons involved in the care of such persons;
(f) Any member of the public having a connection with and sufficient knowledge of such person to give relevant information about such persons.

The means for making and receiving a 'report' will be managed by the Court.

Recommendation 8

The jurisdiction of the Mental Health Court or Mental Health Diversion List should include, but not be limited to:

(a) Assessment of a defendant's bail application;
(b) Assessment and admission of a defendant, under Part 10, Division1 of the MHRSA;
(c) Consideration of applications for dismissal of a charge on the basis of mental illness or mental disturbance, under section 77 of the MHRSA;
(d) Making voluntary treatment plans, under section 78 of the MHRSA;
(e) Making orders for and consideration of pre-sentence reports requiring psychiatric or psychological examinations; and
(f) Making Mental Health Orders, under Part 4 of the *Sentencing Act*.

Recommendation 9

The Mental Health Court or Mental Health Diversion List should have all powers of the Court of Summary Jurisdiction, including but not limited to:

(a) Hearing such evidence and examining such reports as it considers necessary and, hearing all arguments and submissions as may be addressed to it by legal representatives or mental health professionals, including Mental Health Clinicians and the Chief Health Officer;

(b) Ordering the provision of reports from an expert as necessary;

(c) Ordering the defendant attend for examination, for the purpose of preparation of such a report as necessary.

Recommendation 10

The Mental Health Court or Mental Health Diversion List should consider any referred matter in its entirety, including any examination of the defendant's fitness to stand trial, defence of mental impairment or, finding none of these, the defendant's sentence and plea of Guilty.

Recommendation 11

The Mental Health Court or Mental Health Diversion List should only refer a matter back to the Court of Summary Jurisdiction if it determines:

(a) there is no mental impairment; and

(b) the defendant is fit to stand trial; and

(c) the defendant wishes to plead Not Guilty.

Such a hearing is then to be conducted in the ordinary criminal justice stream of the Court of Summary Jurisdiction.

Recommendation 12

The Chief Magistrate may at any time, and in his complete discretion, give such directions as to the procedures to be adopted in the Mental Health Court or Mental Health Diversion List as he considered will be conducive to the more efficient operation of the Court.

10.0 MENTAL HEALTH CLINICIANS

The lynchpin of all of the specialist court lists or diversionary programs around Australia are court based clinicians or their analogue. It is against this background that the involvement of court based mental health clinicians[18] would greatly improve the interaction between mentally ill offenders and the criminal justice system in the Northern Territory. Court based clinicians could perform a variety of functions with the overarching goal of diverting mentally ill offenders into a specialist Mental Health Court and possibly a mental health diversionary program along the lines of the Tasmanian Mental Health Diversion List and the Victorian Assessment and Referral Court List.[19]

The primary function of court based clinicians would be to screen and identify persons coming before the court who are suspected of having a mental illness or cognitive impairment. This process would commence on the first occasion the person appears before the court, if not sooner.

When the person comes before the court in custody (for example, in relation to a bail application), it is anticipated that the court based clinician would be in a position to report to the court on the result of his or her initial assessment of the defendant. As part of that assessment the clinician would review the police Statement of Alleged Facts, Department of Correctional Services documents and any record of the person's prior contact with Mental Health Services (psychiatric history) and any other available relevant information. The result of this assessment would become highly relevant to the future progress of criminal proceedings and the direction in which the proceedings would move.

Dependent on the initial assessment, it is likely that the matter would be referred to the Mental Health Court or Mental Health Diversion List, with the potential for psychiatric examination and monitoring.

The court based clinician would play a pivotal role in co-ordinating (and in certain cases preparing) all necessary assessments, reports and treatment orders and to make available to the Court all relevant information, including in relation to:

(a) Assessment of a defendant for the purposes of bail;

(b) Assessment and admission of a defendant, under Part 10 Division 1 (sections 73A-76) of the *MHRSA;*

(c) Applications for dismissal of a charge on the basis of mental illness or mental disturbance, under section 77 of the *MHRSA*;

(d) Voluntary treatment plans, under section 78 of the MHRSA;

(e) Pre-sentence reports requiring psychiatric or psychological examinations;

(f) Mental health orders, under Part 4 of the *Sentencing Act*.

---

[18] It is not envisaged that the Court would directly employ Mental Health Clinicians and, instead, the Department of Health would be responsible for recruitment and retention of Clinicians, with formal oversight by the Chief Magistrate.

[19] Such diversionary programs are heavily resource-dependant and their workability depends on the availability of adequate service providers.

It is envisaged that the court based clinician would perform a valuable role in the communication of proposed treatment plans, supervisory orders and bail conditions to the Court. The clinician could also appear as a 'friend of the court' and provide impartial views on mental health matters and make recommendations outlining options for the court in dealing with matters, including the grant of bail, particularly in terms of assessing the offender's willingness and capacity to undergo any assessment/examination. The clinician would also be expected to provide regular updates to the Court during the course of a person's matter.

However, the role of a court based clinician could be substantially extended beyond the above relatively conventional spheres of involvement - albeit within the structure of a specialist Mental Health Court or Mental Health Diversion List - and optimised in the context of a therapeutic regime similar to the mental health diversionary mental health programs that operate in Tasmania and Victoria.

Consistent with both of those diversionary programs a court based clinician in the Territory could perform a vital role in the various phases of the mental health diversionary process. It is envisaged that the clinician would be involved in:

(a) the screening and identification of persons suspected of having a mental illness or a mental disturbance and their suitability to participate in the diversionary program;

(b) the facilitation of psychiatric assessment and triage by a mental health professional of persons identified in the screening process;

(c) the gathering of background health information and documentation to support clinical findings and the integration of all relevant information into a court report in consultation with supervising psychiatric staff;

(d) reporting to the court – as a 'friend of the court' – and providing impartial views on mental health matters and making recommendations outlining options for the court in dealing with such matters;

(e) the facilitation of diversion by communicating with appropriate service providers and providing relevant information to assist with the integration of persons into treatment;

(f) the formulation of a treatment plan in consultation with the participant, supervising psychiatric staff and service providers;

(g) the monitoring of the person's progress while on the treatment plan and reporting to the court on the person's progress at periodic court reviews;

(h) the provision of a final report to the court prior to finalisation of the matter and sentencing.

Finally, but not least, the efficient transfer of information (to the court) concerning any person being considered for diversion, or while on diversion, would be critically important to the success of any specialist Mental Health Court or Mental Health Diversion List. There would need to be put in place a protocol permitting the ready exchange of information between NTG Mental Health Services (including Forensic Mental Health and the Mental Health Review Tribunal) and the court. Relevant information would include a person's interaction with the Mental Health Review Tribunal and Forensic Mental Health Services. The court based court clinician would play an indispensable

role in this process of information-sharing. The facilitation of information sharing across all agencies is addressed below at section 13.

Recommendation 13

Mental Health Clinicians should be appointed to assist the Court of Summary Jurisdiction and specialist Mental Health Court or Mental Health Diversion List in all matters which may arise in relation to the mental health of a defendant, including but not limited to:

(a) making an initial assessment of persons appearing before the Court of Summary Jurisdiction and accused of a criminal offence and report to the court if it appears that such persons may be suffering from mental illness;
(b) reporting and seeking immediate assistance from appropriate authorities under the *Mental Health and Related Services Act* if it appears that such persons may be in immediate danger of self-harm or harming others;
(c) assisting the Mental Health Court or Mental Health Diversion List to consider whether a person appearing before that Court, may be suffering from a mental illness;
(d) linking such persons with such services as may be of help in their condition and, if necessary, to seek immediate assistance from such services.
(e) carrying out such functions or make such reports as the Chief Magistrate may direct;
(f) being aware of and applying, where appropriate, the objects of the *Mental Health and Related Services Act* as set out in section 3;
(g) coordinating and assisting with preparation of assessments, treatment plans and communication of the same to the Court, under Part 10 of the *Mental Health and Related Services Act*; and
(h) the monitoring of the person's progress while on the treatment plan and reporting to the court on the person's progress at periodic court reviews.

Recommendation 14

The appointment of Mental Health Clinicians should be up to the Chief Magistrate, however, considerations regarding the minimum qualifications of such Clinicians should be given, including but not restricted to:

(a) Holding a current unrestricted registration with the Australian Health Practitioner Regulation Agency, under the *Health Practitioner National Law Act 2009,* in nursing, psychology, occupational therapy or medicine;
(b) Holding a mental health nursing qualification accredited by the Nursing and Midwifery Board of Australia;
(c) Holding a Bachelor of social work and current accreditation by the Australian Association of Social Workers;
(d) Having a post graduate qualification in mental health nursing; or
(e) Having substantial experience in forensic mental health in courts, prison or the community.

11.0 SECTION 77 OF THE MENTAL HEALTH AND RELATED SERVICES ACT

The Court of Summary Jurisdiction has jurisdiction to hear non-indictable offences and Minor Indictable Offences (if the Magistrate deems the charge is fit to be heard and determined summarily under Part V, Division 2 of the *Justices Act*).

Section 77(4) of the *Mental Health and Related Services Act* requires the Court of Summary Jurisdiction to dismiss a charge if satisfied that, at the time of the offence, the accused was suffering from 'mental illness' or 'mental disturbance'.

The M'Naghten Rules remain the test. That is, it must be proved that, at the time of the offence, the accused did not know what they were doing, or, if they did know, that they did not know that what they were doing was wrong.

Jonathon Hunyor and Michelle Swift in their article 'A Judge Short of a Bench: Mental Impairment and Fitness to Plead in the NT Legal System',[20] refer to two often expressed concerns about the dismissal of a charge under s 77:

> The first is a concern that a person with a mental illness which may have led them to engage in criminal conduct will be released without any supervision or control over their behaviour. The second is that making a section 77 order is tantamount to letting someone off.[21]

As to the first concern, the authors go on to say:

> There may, of course, be legitimate concerns about the conduct of a person who has a mental illness and the safety of the community. But we query whether these questions should be allowed to intrude into an inquiry into criminal responsibility.
>
> In our view, it is more appropriate in cases involving people who have mental illnesses for community safety to be protected through the mental health system, rather than the criminal justice system. The provisions of the MHRSA allow for the involuntary treatment of people with mental illnesses or their supervision on community based orders where this is required to prevent a person with a mental illness from harming themselves and/or others.[22]

As for the second concern, the authors point to a general perception (apparent from the contents of some psychiatric reports) that 'a s77 order may amount to letting a person evade responsibility for their actions'.[23] In response the authors say:

---

[20] A paper presented at the Criminal Lawyers Association Northern Territory Conference at Sanur, Bali on 30 June 2011: http://clant.org.au/images/images/the-bali-conference/2011/Hunyor,%20J%20&%20Swift,%20M%20-%20A%20judge%20short%20of%20a%20full%20bench-%20mental%20impairment%20&%20%20fitness%20to%20plead%20in%20the%20NT%20Criminal%20Legal%20System%20_2011_.pdf.

[21] Hunyor and Swift n 12, p9.

[22] Hunyor and Swift n 12, p9.

[23] Hunyor and Swift n12, p9.

> Of course, if a person is criminally responsible for their actions, 'letting them off' may be a legitimate basis for concern. But it is not, in our view, a legitimate concern in determining the very question of criminal responsibility.[24]

Although section 77 appears in the *Mental Health and Related Services Act* , in essence it creates a criminal defence. As stated by Fairall and Yeo in *Criminal Defences in Australia*[25] the term 'criminal defence' may be 'legitimately used to refer to any answer to a criminal charge or any claim that, if accepted, would necessitate an acquittal'.

11.1 Principles of a mental impairment defence

Section 77 creates a mental impairment defence which is grounded in two important principles:[26]

(a) a mental impairment may act as an excuse from criminal responsibility

(b) the community must be protected from people who, as a result of a mental impairment, are a risk to themselves or others.[27]

Although section 77 encapsulates the first important principle, it does not reflect the second important principle.

Section 77 only excuses a person from criminal responsibility if the person fulfils the requirements of section 77(4). If the court is satisfied as to the matters contained in section 77(4) the person is entitled to an acquittal by way of a dismissal of the charge or charges before the court. It is misleading to say that a section 77 order is tantamount to 'letting someone off'. If a person meets the statutory criteria they are excused from criminal responsibility, as is the case with any other criminal defence: they are entitled to be acquitted.

11.2 Supervision after acquittal

It is interesting that section 77 does not encapsulate the second important principle of a mental impairment defence by providing some therapeutic supervisory mechanism designed to protect the community from offenders who, as a result of mental impairment, are a risk to themselves or others.

One suspects that the rationale for not including a therapeutic and supervisory regime was that the Magistrates Court is a court of summary jurisdiction dealing with criminal cases of less seriousness than matters dealt with in the Supreme Court, where the mental impairment

---

[24] Hunyor and Swift n 12, p 10.

[25] Fairall. PA & Yeo. S: 2005, Criminal defences in Australia, 4th ed., LexisNexis Butterworths, Sydney, NSW, p 1

[26] See the VLRC Report.

[27] See the New South Wales Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Criminal Responsibility and Consequences,* Consultation Paper No 6 (2010) 50. The public safety concern is that an unconditional discharge may compromise community safety: without treatment or supervision the offending behaviour of some persons could escalate and lead to more serious consequences for the person and the community: see the Victorian Law Reform Commission 2014 Report on its Review of the *Crimes (Mental Impairment and Unfitness to be Tried Act 1997* at [5.49]

provisions of Part 11A Division 1 of the *Criminal Code* apply. However, the reality is that the Magistrates Court can exercise summary jurisdiction over minor indictable matters, which can carry up to 14 years imprisonment as a maximum penalty, and which in the absence of the consent of both the prosecution and defence must be dealt with in the Supreme Court and subject to the provisions of Part 11A Division 1 of the Criminal Code, if a mental impairment defence is to be relied upon.

It is conceptually difficult to reconcile the provisions of section 77 of the *Mental Health and Related Services Act* with the provisions of Part 11A, Division 1, of the Criminal Code. Given that both statutory provisions deal with a mental impairment defence and the gravity of some offences dealt with summarily in the Magistrates Court there appears little, if no, justification for creating two different regimes. While many summary offences dealt with in the Magistrates Court under section 77 could be dealt with solely by a dismissal of the charge, other more serious indictable offences (if they were to be dealt with under section 77) may warrant some form of therapeutic intervention and supervision consistent with the second important principle of the mental impairment defence. The inescapable logic is that section 77 should contain a therapeutic interventionist and supervisory component.

Any concern that a person may present as a danger to either themselves or the community is not relevant to the determination as to whether the person should be excused from criminal responsibility due to a mental impairment. Such a concern is only relevant to whether or not the person requires therapeutic intervention and supervision to control the mental illness or mental disturbance that caused or contributed to the offending behaviour so as to alleviate the risk to the safety of the community or themselves posed by their mental illness of mental disturbance. Furthermore, the suggestion that concerns for community safety are best addressed through the mental health system, rather than through the vehicle of section 77 of the *Mental Health and Related Services Act* (as part of the criminal justice process) overlooks the second important principle underpinning the mental impairment defence.

The suggestion that concerns for public safety are best addressed by the mental health system (independently of the criminal justice system) leaves open the real possibility that a person who has been excused from criminal responsibility due to mental impairment – and who poses a significant risk to the safety of the community and themselves due to their mental illness or mental disturbance - may be overlooked or neglected and fail to be brought within the operation of the *Mental Health and Related Services Act* for one reason or another. The ability to address such concerns during the criminal law process overcomes the problem of people 'falling between the cracks'.

11.3 Summary Jurisdiction

In its present formulation section 77 has given rise to another problem that relates to the exercise of summary jurisdiction in matters that involve an application for dismissal of a charge under that section. There are two preconditions for the operation of section 77: first, the person must be charged with an offence in proceedings before a court (other than proceedings for a committal or preliminary hearing) and the court must be exercising summary jurisdiction.

Section 77(1) raises the question as to when the court is exercising summary jurisdiction.

The Court's exercise of summary jurisdiction is governed by a number of provisions in the *Justices Act*.

Section 120(1) of the *Justices Act* confers on the Court jurisdiction to hear and determine in a summary manner (whether or not the defendant consents) minor offences contrary to sections 210, 219, 221, 224, 227 or 229 of the Criminal Code, or an attempt to commit such an offence, where the value of the property involved does not exceed $5000.

Section 121A of the *Justices* Act provides that subject to section 122A, where the person is charged before the Court with an indictable offence, and the offence is either punishable by not more than 10 years imprisonment or against sections 120, 123, 228, 229 and 241 of the Criminal Code and punishable by not more than 14 years imprisonment, the Court has jurisdiction to hear and determine the matter in a summary manner and pass sentence on the person so charged provided:

(a) in the opinion of the Court, the charge is not one that the Court has jurisdiction apart from this section, to hear and determine in a summary manner; and

(b) the defendant consents to it being so disposed of; and

(c) the prosecutor consents to it being so disposed of; and

(d) the Court is of the opinion that the case can properly be disposed of summarily.

Section 121A(1AA) provides that the Court may seek from the prosecutor an outline of the evidence that will be presented for the prosecution for the purposes of enabling the Court to determine whether to hear and determine the charge in a summary manner.

Section 131A(1) of the *Justices Act* confers jurisdiction on the Court to hear and determine in a summary manner a charge in respect of an offence against section 186, 188(2), 188A or 188A(1) or 2(a) of the Criminal Code.[28] However, the Court must decline jurisdiction if it is of the opinion that the charge should be prosecuted on indictment: see s 131A(2).[29]

The problematic relationship between the statutory preconditions for the exercise of summary jurisdiction and the hearing and determination of section 77 applications has arisen in at least two cases.

In *Mununggurr v Gordon & Mununggur v Balchin* [2010] NTSC 82 the presiding magistrate expressed concern about exercising summary jurisdiction in relation to a matter involving a serious offence where an application was made under section 77 because of the unconditional

[28] These sections relate to violent offences.

[29] There is conflicting authority as to whether s 131A is also subject to the provisions of s 121A: see *R v Cavit Ex Parte Griffiths* [1986] 39 NTR 1; *Gadatiya v Lethbridge* (1992) 106 FLR 265; *The Queen v Moreen* [2001] NTSC 29; *Birkeland-Corro v Tudor Stack* (2005) 15 NTLR 208.

nature of a dismissal under that section and the absence of any power to impose a therapeutic supervisory order in an appropriate case.

In *Taylor v Bamber* [2011] NTSC 36 it was apparent that the prosecutor was not prepared to consent to summary jurisdiction because of the section 77 application and the unconditional nature of a dismissal under that provision.

One of the preconditions for the exercise of summary jurisdiction under section 121A is the requirement that the court form the opinion that the matter can properly be disposed of summarily. Similarly, the prescribed violent offences can only be disposed of summarily if the court is not of the opinion that they should be prosecuted on indictment. In each case, the provisions themselves are silent as to the matters that the court may take into account in forming the relevant opinion. The only restriction on the matters that may be taken into account is relevance: the matter must be relevant to the opinion formed by the court.

The fact that the dismissal of a charge under section 77 of the *Mental Health and Related Services Act* results in an unconditional discharge which, without any concomitant order for treatment or supervision, may compromise community safety as well as the safety of the person would be a relevant matter.

In a similar vein, the VLRC Report made the observation that 'one of the factors relevant to a magistrate's determination of whether to grant summary jurisdiction is the adequacy of the sentencing orders available to the court': a 'magistrate may be less inclined to grant summary jurisdiction if they regard a discharge and the absence of any power to impose an order to be inadequate after a finding of not guilty due to mental impairment'[30] – even if the type of offence would allow it be heard and determined summarily.

In *Taylor v Bamber* [(2011)] 28 NTLR 173 at [9] – [10] Barr J highlighted a feature of the section 77 process that may also bear upon the exercise of summary jurisdiction in cases involving an application under s77:

> Mr Robson for the second defendant suggested in the course of his argument to the court that the procedures in s 77 were 'crude and rudimentary'. For the purposes of this decision, I do not need to make findings in relation to that characterisation. However, I do note that 'designated mental health practitioner' (whose advice informs the Chief Health Officer) may be a psychologist, registered nurse, occupational therapist, Aboriginal health worker, social worker or an ambulance officer. True it is that the person needs to have not less than two years approved clinical experience and have completed an approved 'training and orientation course' before the person can be appointed as a 'designated mental health practitioner'. However, to certify that a person was suffering from a mental illness or mental disturbance at the time of offending requires a retrospective medical diagnosis, and to certify that such mental illness is likely to have materially contributed to the offending conduct requires an

[30] See [5.44] – [5.45] of the VLRC Report.

expert opinion as to causation. It is therefore unusual that the advice of persons in some of the occupations referred to is treated as equivalent to the advice of a specialist psychiatrist and is sufficient under the statute to relevantly inform the Chief Health officer to enable him or her to give the s 77(2) certificate.

A reassuring factor may be that the Chief Health Officer under the *Public Health Act 1952* (NT) must be registered or entitled to be registered as a medical practitioner: see s 5(1)(b) of the *Public Health Act*. The Chief Health Officer may, however, delegate to any person all or any of his powers or functions under the *Public Health Act* (or any other law in the Territory) and so it is possible that the Chief Health Officer's powers under the *Mental Health and Related Services Act* could be delegated to someone who is not a medical practitioner.

The fact that a process that can lead to an absolute discharge may be less than exact may also relevantly affect the decision of the court to exercise summary jurisdiction where a section 77 application is contemplated.

Finally, the provisions of section 122A – which prescribe the circumstances under which serious or difficult matters are not to be dealt with summarily – may also relevantly influence the decision to exercise summary jurisdiction in cases involving an application under section 77.

The reluctance of the prosecution to consent to summary jurisdiction and that of the Court to assume summary jurisdiction in relation to some matters involving a section 77 application has serious implications. Those persons who wish to avail themselves of the mental impairment provisions of s77 have to make a decision – usually informed by legal advice – to either forgo the defence of mental impairment that is available in the Magistrates Court; or have their matter transferred to the Supreme Court (through the committal process) to take advantage of the mental impairment provisions of Part11A Division 1 of the Criminal Code.

A number of factors may militate against the latter course of action being adopted, including the delay occasioned by opting to proceed by way of the committal process, and the subsequent delay in having the matter determined in accordance with the mental impairment provisions of the Court; not to mention the consequences of being dealt with under that onerous regime. The undesirable - and clearly unintended - result may be that some offenders reluctantly decide to have their matter dealt with summarily in the Magistrates Court when they have, in fact, a viable mental impairment defence which has the potential to excuse them from criminal responsibility. Similar issues in Victoria were recently considered by the VLRC Report.[31]

11.4 Therapeutic Supervisory Orders

The current reluctance of prosecutors to consent to summary jurisdiction and that of the Court to assume summary jurisdiction - as well as the consequential negative or undesirable effects - might be cured by amending s 77 to include a discretionary power to make therapeutic supervisory orders.

---

[31] See [5.46] of the Report.

If the logic and the desirability of including a therapeutic supervisory regime in section 77 is accepted,[32] what form should such a regime take?. Should it assume the form of supervision orders that may be made under Division 5 of Part IIA of the Criminal Code, or a different regime providing the court with powers under Part 4 of the *Sentencing Act* (Mental Hospital Orders[33]); or again an altogether different regime.

Supervision orders made under Part 11A Division 5 of the Code may be custodial or non-custodial and subject to such conditions as the Supreme Court deems appropriate.

Section 43ZM of the Code prescribes the overarching principle governing the making of a supervision order under Division 5 of Part 11A:

> *In determining whether to make an order under this Part, the court must apply the principle that restrictions on a supervised person's freedom and personal autonomy are to be kept to the minimum that is consistent with maintaining and protecting the safety of the community.*

Section 43ZN(1) sets out the considerations that must be taken into account by the court when deciding whether to make a supervision order:

> *In determining whether to make an order under this Part, the court must have regard to the following matters:*
>
> *(a) the need to protect people from danger;*
> *(b) the nature of the mental impairment, condition or disability;*
> *(c) the relationship between the mental impairment, condition or disability and the offending conduct;*
> *(d) whether there are adequate resources available for the treatment and support of the supervised person in the community;*
> *(e) whether the accused person or supervised person is complying or likely to comply with the conditions of the supervision order;*
> *(f) any other matters the court considers relevant.*

There are provisions in Division 5 that govern the commitment to custody in a prison or another appropriate place of persons subject to a custodial supervision order.[34]

Although supervision orders are made for an indefinite period, they are subject to review and capable of being varied or revoked.[35]

The regime established under Part 4 of the *Sentencing Act* is of a different ilk.[36]

---

[32] It should be noted that the VLRC Report supported the conferral on the Magistrates Court of a power to make therapeutic supervisory orders : see [5.54] –[5.61].
[33] The Part 4 orders are referred to as "Community Treatment Orders" in the Terms of Reference.
[34] See ss 43ZA(1)(a), 43ZA(2) and 43ZA(3).
[35] See ss 43ZC, 43ZK and 43ZD.
[36] See Attachment D.

Unlike the provisions of Part 11A, Division 5 of the Code, mental health orders made under Part 4 of the *Sentencing Act* are predicated on the person being found guilty of an offence – not on the basis of being found not guilty due to mental impairment. Could these provisions be adapted to the situation of a dismissal of a charge under s 77 of the *Mental Health and Related Services Act*?

As an alternative to the above two regimes, a more community based model that harnesses the provisions of Part 7 of the *Mental Health and Related Services Act*, may be preferable.

There is also scope for an eclectic model that incorporates the most appropriate elements of all three regimes.

Ultimately, there is a need "to design a scheme that suits the level of risk associated with the lower level of offending that can be dealt with in the Magistrates' Court and is not as onerous as the scheme that applies in the higher courts"[37], and to implement a model that is "suited to the Magistrates Court's operation where the conduct of proceedings is very practical, flexible and expeditious, given its large workload".[38]

11.5 Procedural Aspects of the section 77 process

Although not covered by the Terms of Reference, there are issues relating to the operation of section 77 of the *Mental Health and Relate Services Act* which are sufficiently associated with the matters to be investigated and examined within the present Terms of Reference to warrant expansion of the Terms of Reference to encompass a review of the procedural aspects of applications under s 77 of the *Mental Health and Related Services Act*.

The procedures to be followed in hearing and determining an application for a dismissal of a charge under section 77 of the *Mental Health and Related Services Act*, which were explicated in *O'Neill v Lockyer* [2012] NTSC 10, appear to be unduly convoluted and ill-suited to the Court of Summary Jurisdiction where proceedings must be conducted in a practical and expeditious manner, given the court's large workload.

The process is unnecessarily protracted, complicated and inefficient - and overall is an unsatisfactory process in a robust court of summary jurisdiction.

The process under section 77 is initiated by a request from the court to the Chief Health Officer for a certificate in the approved form stating:

(a) whether at the time of carrying out the conduct constituting the alleged offence, the person was suffering from a mental illness or mental disturbance; and

(b) if the person was suffering from a mental illness or mental disturbance – whether the mental illness or disturbance is likely to have materially contributed to the conduct.

---

[37] See [5.58] of the VLRC Report.
[38] See [5.62] of the VLRC Report.

The Chief Health Officer must not give the court the certificate unless he or she has received and considered advice concerning the person from an authorised psychiatric practitioner or designated mental health practitioner.

However, the certificate that is provided to the court is not determinative of the issues addressed in the certificate. The court cannot rely on the certificate alone – without further evidence for the reasons given by Barr J:

> I assume ...that a certificate will contain a statement of the Chief Health Officer as to whether (or not) at the time of the alleged offence a defendant was suffering from a mental illness or mental disturbance; and that it may also contain a statement as to whether the mental illness or disturbance was likely to have materially contributed to the offending conduct. Such statements are necessarily based on opinion: the opinion of the Chief Health Officer, informed by the advice (factual details and opinion of an "authorised psychiatric practitioner or designated mental practitioner" under s77(3). The opinion of the Chief Health Officer may be an expert opinion actually reached by the Chief Health Officer himself or herself, or may be a simple transmission of the opinion of another person, that is, of the psychiatric practitioner or mental health practitioner who provided advice under s77(3). The opinion of the Chief Health Officer may be a combination of both.[39]

The certificate is not to be relied on exclusively for the purpose of the court satisfying itself under section 77(4)(a) that "at the time of carrying out the conduct constituting the alleged offence the person was suffering from a mental illness or mental disturbance."[40] In many cases the certificate may be inadmissible (as evidence), and even if it is admissible the weight it may be accorded may be nil or slight.[41]

The certificate is not binding on the court and the court is required to consider all the evidence.[42]

It must be remembered that the Chief Health Officer is only required to provide a certificate as to the matters referred to in s 77(2): it is for the court and not the Chief Health Officer to consider the matters in s 77(4)(b).[43]

A distinction is to be drawn between the considerations of the Chief Health Officer and those of the court within the context of s 77:

---

[39] *O'Neill v Lockyer* [2012]NTSC 10 at [6].
[40] *O'Neill v Lockyer* [2012] NTSC 10 at [6].
[41] *O'Neill v Lockyer* [2012] NTSC 10 at [6].
[42] *O'Neill v Lockyer* [2012] NTSC 10 at [6]. This is consistent with the statement made by Kelly J in *Munungguur* in relation to s 77(4)(a):
"...the Court must undertake its own assessment of those matters, which it can only do by considering relevant evidence...the subsection plainly requires the Court to undertake its own assessment of those matters; it does not require, or authorise, the Court to accept the certificate of the Chief Health Officer as determinative of those questions".
[43] *O'Neill v Lockyer* [2012] NTSC 10 at [6].

> ...the certificate is directed to a different question from that to be decided by the Court under s77(4). Both the Chief Medical Officer and the Court must determine whether at the time of carrying out the conduct constituting the alleged offence the person was suffering from a mental illness of mental disturbance. Thereafter the enquiries differ. The Chief Medical Officer must state whether the mental illness or disturbance is likely to have materially contributed to the conduct. That is a different matter from that which the Court must determine under s 77(4), namely, whether, as a consequence of the mental illness or disturbance, the person: (i) did not know the nature and quality of the conduct; (ii) did not know the conduct was wrong; or (iii) was not able to control his or her actions.[44]

Accordingly, the Chief Health Officer must leave the section 77(4)(b) matters for the consideration and determination of the court.[45]

The Court should always go "behind the certificate".[46] Whether the court should receive as evidence the report on which the Chief Health Officer has relied is a separate question, to be answered by the court by reference to relevance and admissibility, as well as the principles relating to receipt of expert evidence.[47]

The court's power to dismiss a charge pursuant to s77(4) is not entirely dependent on an initial establishment of the causal link between the defendant's mental state and the conduct in question through the s 77 certificate:

> The court's power to dismiss charges pursuant to s 77(4) can only be exercised after the court has received a certificate from the Chief Health Officer requested by the court under s 77(2)....
>
> However, notwithstanding the requirement that the Court first receive a certificate from the Chief Health Officer before proceeding under s 77(4), the court's powers to dismiss charges pursuant to s 77(4) is not dependent on the establishment of the causal link, via the s 77 certificate, between the defendant's mental state and the conduct in question.
>
> The court has an independent role to consider and assess the evidence in any criminal hearing where it is exercising summary jurisdiction. The court hears the evidence in chief and cross–examination of all prosecution and defence witnesses (including possibly the defendant). It therefore follows that the court's findings and conclusions may be very different from the matters stated by the Chief Health Officer in the s 77(2) certificate. So, for example, even if the certificate certifies in the negative to the issue in s77(2)(a), or in the affirmative to the issue in s 77(2)(a) but in the negative to that in s77(2)(b), the court might well arrive at an opposite conclusion after considering the

---

[44] *O'Neill v Lockyer* [2012] NTSC 10 at [6] citing the statements made by Kelly J in *Mununggurr* at [6].
[45] *O'Neill v Lockyer* [2012] NTSC 10 at [6].
[46] *O'Neill v Lockyer* [2012] NTSC 10 at [6].
[47] *O'Neill v Lockyer* [2012] NTSC 10 at [6].

> identical issue to s7(2)(a) as part of its s 77(4)(a) deliberations, and may make findings under s77(4)(b) inconsistent with the certificate of the Chief Health Officer under s77(2)(b).[48]

The purpose of the section 77(2) certificate is to give a preliminary indication to the court and to the parties as to whether the defence of mental illness/mental disturbance might be available:

> In practice, given that the court has to request the certificate, the court would probably have already detected in the facts or evidence some indication of mental illness/mental disturbance on the part of the defendant. The certificate takes the consideration to the next stage by providing an opinion or statement as to whether (or not) at the time of the alleged offence the defendant was suffering from a mental illness or mental disturbance; and to whether the mental illness or disturbance is likely to have materially contributed to the offending conduct.
>
> ...the s77(2) certificate cannot be other than a preliminary indication, a "red flag" as it was described in submissions before me.[49]

The defendant has the onus of establishing the defence of mental illness or mental disturbance under section 77(4), consistent with the common law in relation to the defence of insanity in a criminal trial.[50] The standard of proof is on the balance of probabilities.[51]

The section 77 process is protracted because it often takes considerable time to receive the certificate, and once the certificate is provided further time elapses before the report on which the certificate is based is provided to the court and the parties. Once the report has been made available the matter is case managed by the court – including the fixing of a hearing date. It can be some time before the application is heard and determined by the court. This drawn out and unduly complicated process is inconsistent with the requirements of the court of summary jurisdiction which are to dispose of matters in a practical and expeditious manner.

As will be seen from the decision in *O'Neill v Lockyer* [2012] NTSC 10 the certificate is not determinative of the issues addressed in sections 77(2) (a) and (b) – and in fact may be inadmissible in some cases, and even where admissible may be accorded nil or slight weight. Therefore, as the certificate may have little – if no - evidentiary value, one must question its practical value within the legislative scheme created by section 77 of the *Mental Health and Related Services Act*.

Although it is said that the purpose of the section 77(2) certificate is to provide a preliminary indication as to whether the defence of mental impairment or mental disturbance might be available, is it really necessary to have such a 'red flag', which often takes a considerable time before it is raised?

---

[48] *O'Neill v Lockyer* [2012] NTSC 10 at [6].
[49] *O'Neill v Lockyer* [2012]NTSC 10 at [6].
[50] *O'Neill v Lockyer* [2012] NTSC 10 at [6].
[51] *O'Neill v Lockyer* [2012]NTSC 10 at [6].

The advice (report) on which the certificate is based also raises some issues.

The first issue is the one adverted to by Barr J in *Taylor v Bamber* [(2011)] 28 NTLR 173 at [9] – [10] in relation to the providers of the advice.[52] The advice upon which the Chief Health Officer relies must be professionally sound to ensure that the statutory regime for the dismissal of charges pursuant to s 77 of the *Mental Health and Related Services Act* is sufficiently rigorous.

The second issue is that raised by Hunyor and Swift:

> Another unclear aspect of s 77 is that the matters addressed by the Chief Health Officer's certificate differ from those matters about which the Court must be satisfied and there is no established procedure for the Court to receive evidence as to the matters it must consider.
>
> Certificates from the Chief Health Officer are required to address two questions only: whether at the relevant time the person was suffering from a mental illness or mental disturbance and whether "the mental illness or disturbance is likely to have materially contributed to the conduct".
>
> It is then for the court, after receiving the certificate, to satisfy itself of a different set of criteria: whether the person was suffering from a mental illness/disturbance; and as a consequence whether the person did not know the nature and quality of the conduct; or did not know the conduct was wrong; or was not able to control his or her actions. If the court is so satisfied, it must dismiss the charge.
>
> In practice, mental health practitioners frequently give their opinions in their reports to the Chief Health Officer about matters that the Court is required to address despite this being beyond the scope of the matters about which the Chief Health Officer is required to report.[53]

The lack of clarity in relation to this matter of procedure requires consideration.

Finally, but not least, s 77 could be more explicit as to the burden and standard of proof as is the case with the mental impairment provisions of Part 11A Division 2 of the Criminal Code.

Consideration needs to be given to devising a simpler and more practical and expeditious, but sufficiently rigorous, process for hearing and determining applications under section 77.

A possible option would be for the Court to request, at the outset of a section 77 application, a psychiatric report, the author of which is sufficiently qualified to express an opinion as to the requisite matters – thereby circumventing the current protracted and cumbersome process.

---

[52] See p 12 above.
[53] Hunyor and Swift n 12, p 8.

11.6 Adoption of Procedure under Part IIA

The Committee concludes that Part IIA, Division 5 of the Criminal Code should be adopted in the Court of Summary Jurisdiction but with variation to ensure that processes are simplified as far as practical to align with the practice and conduct of the Court of Summary Jurisdiction.

One variation is relatively obvious, the removal of any requirement for a jury. The removal of the jury as finder of fact may, however, pose an issue with respect to section 43ZO of the Criminal Code, as counsel may need to agree to certain facts, without instructions. One must query whether allowing counsel to agree to facts upon which the Magistrate will act, if satisfied that the facts are proved, removes the presumption of innocence.

Another variation is that supervision orders be made for a specific time, but not connected to the custodial sentence the person might have served. The basis for this is that the order is not to punish but to protect, and linking the length of the order to the penalty for the 'crime' (of which the person is not guilty) suggests that the underlying rationale remains punishment rather than prevention of problems for the future. A further objection would be that if a time limit is based on the custodial sentence the person might have served, this would require the Magistrate to go through a process to determine what that sentence might have been and raise a potential ground for challenge that the 'sentence', and therefore the period of the order is too long.

Given the extensive jurisdiction of the Court of Summary Jurisdiction, the NTLRC considers that a maximum period of 12 months provides a suitable framework within which the Court can operate. As supervision orders will be made for a fixed period of time, mandatory periodic review will also be unnecessary. It will be a matter for the Court to set any timeframes for monitoring and review within the period of the order, given the circumstances of the individual case.

Special mention should be made regarding the Court's powers upon a breach of supervision order. A number of stakeholders submitted that breaches should not result in a criminal conviction, nor imprisonment. It is the view of the NTLRC that a breach of supervision order be dealt with by the Court of Summary Jurisdiction in the same way that a breach is dealt with by the Supreme Court under Part IIA of the Criminal Code. This will allow the Magistrate to review the matter and make appropriate orders. There should be no formal offence for breaching an order, but, in appropriate circumstances a review of the orders in place, including the potential for imposition of a custodial order may be necessary. However, as noted in section 4.0, the NTLRC notes the general principle that persons with a mental illness should not be detained in a correctional facility.

Recommendation 15

The Mental Health Court or Mental Health Diversion List should have jurisdiction to hear all matters currently falling within section 77 of the *Mental Health and Related Services Act*.

Recommendation 16

The requirement for a Certificate to be furnished by the Chief Health Officer under section 77 of the *Mental Health and Related Services Act* should be removed and replaced with the requirement for a comprehensive report to be completed by the Chief Health Officer or an 'authorised psychiatric practitioner' or 'designated mental health practitioner' as defined in *Mental Health and Related Services Act*.

Recommendation 17

The Report referred to in recommendation 16 should address the defendant's mental impairment and provide recommendations regarding the defendant's ongoing supervision and treatment.

Matters to be considered in the report need to reflect the matters set out in section 77(4) of the *Mental Health and Related Services Act*.

Recommendation 18

The Mental Health Court or Mental Health Diversion List should be provided with the power to make therapeutic supervisory orders in the form of Part IIA, Division 5 of the Criminal Code, but with variation to ensure that processes are simplified as far as practical to align with the practice and conduct of the Court of Summary Jurisdiction including – the limitation that supervision orders be made for a specific period of time, no longer than 12 months, having regard to the therapeutic needs of the person.

12.0 FITNESS FOR TRIAL

Section 43J of the Criminal Code provides that a person is unfit to stand trial if the person is:

(a) Unable to understand the nature of the charge against him or her;

(b) Unable to plead to the charge and to exercise the right of challenge;

(c) Unable to understand the nature of the trial (that is that a trial is an inquiry as to whether the person committed the offence);

(d) Unable to follow the course of the proceedings;

(e) Unable to understand the substantial effect of any evidence that may be given in support of the prosecution; or

(f) Unable to give instructions to his or her legal counsel.

In accordance with sections 43K and 43L of the Criminal Code, the onus of proof is on the party questioning the accused's fitness to stand trial (which may be either the prosecution or the defence, although in practice this is more likely to be the defence), on the balance of probabilities. However, if the Court raises the question, no party bears the onus.

The Court of Summary Jurisdiction does not have the power to determine unfitness to stand trial.

When a person is charged with an indictable offence (including an indictable offence triable summarily) and there is an issue raised concerning their unfitness to stand trial, in order for the issue to be determined the matter must proceed by way of a preliminary examination and the person must be committed to the Supreme Court. If the issue of unfitness is raised in relation to a summary offence, the Court of Summary Jurisdiction has no option but to "go no further and desist from hearing the charge" because the court has no power to determine unfitness for trial and is unable (due to the offence being of a summary nature) to commit the defendant to the Supreme Court to have the issue determined.[54]

As pointed out in the VLRC Report on its Review of the *Crimes (Mental Impairment and Unfitness to Be Tried) Act 1997*, the lack of power to determine unfitness to stand trial in the Victorian Magistrates Court may have negative or undesirable outcomes:

1. If the court does not grant summary jurisdiction (in relation to an indictable offence) due to a lack of power to determine the issue of unfitness the prosecution may decide to withdraw the charges, rather than proceed by way of the committal process;[55]

2. The defendant may be pressured to plead guilty rather than expose himself or herself to the onerous process and supervision regime in the higher courts;[56] or

---

[54] See *Pioch v Lauder* (1976) 27 FLR 79. This case was applied in *Ebatarrinja v Deland* (1998) 194 CLR 444.
[55] See [5.19] of the Report.

3. The absence of a power to determine the issue of unfitness in the Magistrates' Court operates unfairly (and unjustly) against a defendant with a mental illness because they do not have the same right as other defendants to have their matter heard in a lower court.[57]

One might reasonably suspect similarly negative or undesirable outcomes in the Northern Territory due to the lack of power in the Court of Summary Jurisdiction to determine the issue of unfitness to stand trial.

As there is a "considerable practical overlap between the question of fitness to plead for trial and the defence of mental impairment",[58] there is a sufficient basis for the present Terms of Reference to be expanded to include an investigation and examination and report (including any recommendations) in relation to the lack of power in the Court of Summary Jurisdiction to determine the issue of unfitness to stand to trial.

Recommendation 19

In relation to all matters that the Court of Summary Jurisdiction would have jurisdiction to hear summarily (including minor indictable offences), all questions relating to a defendant's fitness to stand trial should be dealt with by the Mental Health Court or Mental Health Diversion List.

Recommendation 20

The process and matters to be considered by the Mental Health Court or Mental Health Diversion List in determining the defendant's fitness should be adapted from those under Part IIA of the Criminal Code, simplified as far as practical to align with the practice and conduct of the Court of Summary Jurisdiction.

[56] See [5.20] – [5.25] of the Report.
[57] See [5.34] of the Report.
[58] See Stephen Gray and Justice Jenny Blokland *Criminal Laws Northern Territory* (2012 The Federation Press) p 80.

13.0 INFORMATION SHARING

The Northern Territory Law Reform Committee has consulted with the Information Commissioner regarding the exchange of information between the Department of Health, Mental Health Review Tribunal and the Court (including Mental Health Clinicians).

To facilitate information sharing across agencies, likely legislative amendment will be required, in addition to a Practice Direction and/or the development of a Code of Practice.

13.1 Privacy and Consent

Privacy issues in a health context are of major concern to health professionals. There are statutory restrictions on the sharing of personal and health information, such as the *Information Act*, and professional conduct restrictions contained in various professional codes of conduct or practice.

In this case, although information is sought for the ultimate benefit of the individual, some health practitioners are likely to draw a distinction between information provided to meet the therapeutic needs of the patient and the 'assessment' and disposition requirements of the Court. In that context, it is very important that there be clear understanding and authority for the exchange of information.

There would appear to be several situations in which the Court or a clinician would seek mental health information about a person:

(a) **pre-court**, when a person may have been charged but is yet to appear before a Magistrate, a clinician may seek information from Health or the MHRT, about the mental health of the person or in order to establish whether the person is already undergoing treatment or is subject to an MHRT order;

(b) by way of a **Court order** for a formal report on the person (this would be authorised by law); or

(c) **post-court**, in order to monitor/supervise ongoing compliance with an order of the Court.

13.2 *Information Act*

Mental health information is 'sensitive information' under the *Information Act*. Collection, use and disclosure of sensitive information is permitted if it is authorised or required by law (IPPs 2.1 and 10.1).

Other bases for permission to disclose in these circumstances are problematic at best. For example:

- consent of the individual will be problematic if the person does not have the requisite capacity;

- the 'serious and imminent threat to the life or health of a person' exception may arise in some cases but will not in most;

- the 'law enforcement' exception only extends to use by or on behalf of a law enforcement agency (which by the terms of the definition would probably not include a court).

Under section 5(1)(i) and (j) of the *Information Act*, a Territory court or a Territory tribunal is a public sector organisation that must comply with its provisions. Section 5(5) of the Act, however, excludes from compliance 'a court in relation to its judicial functions', 'a tribunal in relation to its decision-making functions' and 'a magistrate or justice in relation to a preliminary examination under Part V of the *Justices Act*.'

Section 5(8) of the Act states:

> *A reference to a court or tribunal includes a reference to the following:*
>
> *(a) the members of the court or tribunal;*
>
> *(b) the registrar (however described) and the other officers of the court or tribunal;*
>
> *(c) the staff in the registry and other offices of the court or tribunal;*
>
> *(d) the personal staff of the members of the court or tribunal;*
>
> *(e) any other staff of the court or tribunal.'*

It may be arguable that the act of court clinicians obtaining information from Health or the MHRT falls within the exclusion. A criminal charge will already be before the court at the time information is shared, and it may fall within the definition of 'judicial functions'.

Although not completely on point, Kelly J in Kowcun[59] upheld the Information Commissioner's earlier decision that the Anti-Discrimination Commission mediation process was part of the Tribunal's 'decision making functions'. In short, Her Honour took a broad approach to defining 'decision-making'. It is likely that the same broad interpretation would be given in this current situation to the definition of 'judicial functions'.

If the role of court clinician is legislated, the proposed legislative scheme, combined with the above argument, is likely to justify collection of information by court clinicians. However, there is a further step in considering whether it authorises or requires disclosure of such information by Health or the MHRT.

One could argue that an exclusion for 'judicial functions' would by necessary implication extend to the disclosure of information by another body for those purposes. However, this leaves ample room for dispute and refusal by a health practitioner to supply information on the basis that they may be breaching an IPP.

---

[59] Kowcun v Brenda Monaghan, Information Commissioner & Anor [2013] NTSC 57

It would be prudent for there to be an express legal basis for the Court to undertake the processes being adopted and following on from that, a clear legal authorisation or requirement for the information to be collected, used and disclosed for those purposes.

13.3 Alternatives

While detailed provisions could be included in legislation, there are two other potential alternatives.

One would be to describe the functions of court clinicians and the process for obtaining information in rules or a Practice Direction issued by the Chief Magistrate. This would form the basis for a legal authorisation or requirement to disclose information.

The other would be the development of a draft Code of Practice under Part 5, Division 3 of the *Information Act*. Although, it should be noted that this option has not been given any considerable attention and would require further detailed consideration before it was deemed suitable.

If suitable, a Code of Practice could be developed jointly by relevant health, MHRT and court officers, including court clinicians. This would allow for dialogue between all parties involved in information exchange to ensure that practical working arrangements are developed and reflected in the Code. Any draft Code would be subject to approval by the Information Commissioner.

Recommendation 21

The exchange of information between the Department of Health, Mental Health Review Tribunal, court clinicians and the Court should be formalised so as to ensure workable information sharing arrangements and compliance with the *Information Act*.

14.0 COST IMPLICATIONS

As the Mental Health Court will be constituted using an existing magistrate and will displace some of the current workload from the Court of Summary Jurisdiction, there will be no additional resourcing required for the court. Additional resources may, however, be required by the relevant legal service providers (notably the Office of the Director of Public Prosecutions and legal aid agencies).

The NTLRC acknowledges that there will also be significant cost implications for the Department of Health, which are addressed further in section 18.

In consultation with the Attorney-General of the Northern Territory, the Chief Magistrate has facilitated the introduction of Mental Health Clinicians in Courts of Summary Jurisdiction at Darwin and Alice Springs, which are currently funded by 'NT Funding'. Ideally, Mental Health Clinician's would be extended to certain remote locations, which would undoubtedly involve considerable cost.

Overall, the Committee accepts that many of the recommendations may not be immediately practicable, nevertheless, the recommendations will achieve a long-term cost reduction as illnesses will be recognised and treated at an early stage and offenders will be less likely to reoffend and/or be imprisoned.

15.0 VICTIM IMPACT

There is tension between society's need to adequately 'punish' the individual who has engaged in certain conduct and ensuring that the person receives necessary treatment for their mental impairment/illness. Many of the court processes addressed above may be seen as lenient as the offender is not 'punished' for their actions.

Part of the reparation to the victim in criminal cases is the knowledge that the offender is being punished. The NTLRC has considered the impact of the above court processes on the victim and queried what more can be done to offer consolation and redress to the victim, while also addressing the public perception.

Communication is key. Providing the victim with an opportunity to express themselves is a vital step towards reparation. In addition, ensuring that the decision and reasons for the decision are adequately communicated is vital. In this regard it is envisaged that the Mental Health Clinician would be in a position to provide invaluable assistance by way of explanation of the clinical decision. Although, the NTLRC notes that it may not be appropriate for the Mental Health Clinician to engage directly with the victim, this assistance may be provided through a conduit, for example the Witness Assistance Service.[60]

The proposed amendment to section 77 of the MHRSA to provide the Court of Summary Jurisdiction with the ability to implement and supervise therapeutic orders should also reassure the victim and community that the individual is not being allowed into the community unsupervised.

Given the limit on the use of Victim Impact Statements under the *Sentencing Act*, there is no formal means for the Court of Summary Jurisdiction to take the victim's views into account unless they are sentencing an offender. However, if the provisions of Part IIA of the Criminal Code are extended to the Court of Summary Jurisdiction, the Court will be able to take into account the victim's views.[61] Further, the Court will be able to ensure the victim receives necessary counselling.[62]

Recommendation 22

Ensuring that the victim of an offence remains informed throughout the process and is provided the opportunity to express their views, should be a priority. Counselling services should also be made available to the victim.

[60] In this regard, it should also be clarified that the NTLRC does not envisage the Department of Health providing victim counselling.
[61] Refer section 43ZL Criminal Code (NT).
[62] Refer section 43ZP Criminal Code (NT)>

16.0 INVOLVEMENT OF THE MENTAL HEALTH REVIEW TRIBUNAL

In order for the MHRT to place an individual on an involuntary treatment order, certain criteria must be met, including:

(a) the person is incapable of giving informed consent to the treatment;

(b) [in some cases] the individual has recently exhibited irrational behaviour; [63]

(c) is likely to cause serious harm (to themselves or another);

(d) represents a substantial danger to the community;

(e) is likely to suffer serious mental or physical deterioration; and

(f) there is no less restrictive means of ensuring the person receives treatment.[64]

Under the proposed scheme (refer to section 11 above), the Court of Summary Jurisdiction will have broad powers to supervise individuals and order treatment as necessary. As a result, the Court of Summary Jurisdiction is better placed and may order treatment and supervision even if an individual is no longer exhibiting symptoms. Supervision in this regard will go a long way to protecting the community (and the individual), particularly if the individual's conduct is episodic (for example, contingent on their alcohol consumption).

The Court of Summary Jurisdiction will not act alone, without guidance from expert medical practitioners, and will have access to expert psychiatric evidence both in relation to the offending conduct and any future treatment and/or supervision. Further, contingent on the success of information sharing (refer to section 13.0 above), the Court will be aware of any current treatment orders made by the MHRT and will not interfere with or duplicate these orders.

The jurisdiction of decision making and review for those found unfit to plead or not guilty by way of mental impairment was considered in the VLRC Report, with the ultimate recommendation that the court-based model be retained. This recommendation was made by the VLRC in consideration of the following:

(a) there was insufficient support for the change;

(b) the courts had developed significant procedural framework, safeguards and jurisprudence;

(c) judicial scrutiny is warranted given the process concerns legal and human rights issues, questions on the continued detention of a person and community safety; and

(d) Courts confer greater legitimacy and authority to decision making, which is more effective at ensuring public confidence and protecting victims' interests.

---

[63] Under section 15 of the *Mental Health and Related Services Act*, irrational behaviour must have been exhibited in the preceding 48 hours.

[64] See sections 14-16 of the *Mental Health and Related Services Act*, noting that not all criteria apply in each situation.

The NTLRC adopts the position in the VLRC Report and reiterates that the Court is the most appropriate body to fully dispose of matters involving criminal charges and, ultimately, criminal responsibility. However, there may be scope for the Court to refer a matter to the Mental Health Review Tribunal if appropriate. For example, at the end of the relevant 12 month period if the person is still in need of treatment or supervision.

17.0 APPLICATION TO YOUTH

The NTLRC has turned its mind to the application of the above provisions to youth. The general consensus is that a youth should be able to avail themselves of the same provisions and protections available to adults.

18.0 DEPARTMENT OF HEALTH

Further to the submissions made by the Chief Psychiatrist, Dr Peggy Brown, and the Chief Health Officer, Professor Dinesh Arya, the Department of Health provided the NTLRC with comments on a draft of this Report.

The NTLRC notes that the Department of Health essentially supports the principles and intentions of this Report, and 'looks forward to working collaboratively with the Department of the Attorney General and Justice towards improving the interface between mentally ill or cognitively impaired people and the justice system in a sustainable way that benefits the Territory community'.

The Department of Health has also drawn attention to certain specific recommendations of this Report as requiring further consideration.

The NTLRC has considered these matters, and is of the opinion that, in most cases, the present recommendations are sufficiently broad to cover the concerns raised by the Department. In other cases the issues raised can be sufficiently resolved by the cooperation and discussion on practical matters presently existing between the Department of Health and the Chief Magistrate, which assuredly will continue to the benefit of both.

It is fair to say, however, that the principle and understandable concern of the Department of Health is that the recommendations entail 'substantial resource implications for the Department'.

In formulating the recommendations the NTRLC has kept in mind the direction in the reference by the Attorney-General that 'the Committee should have general regard to the cost implications of the recommendations'. It has stayed firmly away from the usual colourful and over-idealistic schemes guaranteed to solve all matters by some sort of wand waving at vast expense. The Committee has concentrated on practical measures that can be achieved in practical ways.

The Committee believes that the recommendations it has suggested are absolutely necessary to achieve fair and equitable treatment for the substantial number of unfortunate people who fall below the confines of ordinary behaviour, but not necessarily within the confines of the M'Naghten Test.

Such people obviously require proper recognition and treatment: and it is to this end that the recommendations are formed. Furthermore, this Committee believes that early recognition and treatment will, in fact, relieve the Territory of the inevitable greater and more costly expense, presently incurred by caring for such people after their condition has been exacerbated by delayed recognition.

APPENDIX A

Roundtable Participants

NTLRC Mental Health Issues Sub-committee

Professor Dinesh Arya, Chief Health Officer/Chief Medical Officer, Department of Health (NT)

Greg MacDonald, Lawyer, Solicitor for the Northern Territory

Dr Peggy Brown, Chief Psychiatrist, Department of Health (NT)

Acting Professor Robert Parker, Director Psychiatry, Department of Health (NT)

Dr Ranjit Kini, Consultant Psychiatrist, Forensic Mental Health Service, Department of Health (NT)

Dr Marcus Tabart, Clinical Director, Central Australian Mental Health Service, Department of Health (NT)

Ms Margaret Farrell, Director, Office of the Chief Psychiatrist, Department of Health (NT)

Ms Merrilee Cox, Director, Office of the Chief Psychiatrist, Department of Health

Mr Paul Usher, Crown Prosecutor, Director of Public Prosecutions (on behalf of the Director of Public Prosecutions)

Mr Russell Goldflam, Lawyer and Barrister, Northern Territory Legal Aid Commission (on behalf of the Northern Territory Legal Aid Commission)

Mr Jonathon Hunyor, Lawyer and Barrister, North Australian Aboriginal Justice Agency (on behalf of the North Australian Aboriginal Justice Agency)

Ms Lauren Macaulay, Social Justice Legal Officer, Central Australian Aboriginal Legal Aid Service (on behalf of the Central Australian Aboriginal Legal Aid Service

Ms Cassandra Ellis, Medico-legal Investigations and Review Consultant, Department of Health (NT)

Submission to Northern Territory Law Reform Commission

'Interactions between people with mental health issues and the criminal justice system'

Dr Peggy Brown Chief Psychiatrist, Northern Territory Mental Health Directorate

A. What measures might be taken to improve the interaction that people experiencing mental health issues have with the justice system?

- More resources for the mental health system for assessment and treatment, especially for people with prior contact with the criminal justice system
- Mental health worker embedded within Police command centre
- Mandated mental health training program for all NT police
- Information sharing protocol between mental health and police.
- Regular meetings between MH and Police – at strategic as well as operational level
- Police exercise discretion about whom/when to charge if the offender appears mentally ill, and so require targeted training about when and how to exercise discretion in relation to persons with mental illness/disorders
- Early assessment by clinical staff after apprehension of mentally ill person by police
- Mental health training program for magistrates
- Regular meeting between Mental Health and Chief Magistrate re: procedural matters
- Mental health staff attending to assist police where there is an incident involving a current/known mental health client, or a person exhibiting symptoms of mental illness
- Support person to attend when police question a current/known mental health client

B. In particular, what steps might be taken to ensure that the first point of contact for a person experiencing mental health issues after arrest is with the mental health system and not the justice system?

- Early assessment by clinical staff after apprehension of mentally ill person by police, in accordance with the *National Principles for Forensic Mental Health* ('Principles').[1]
- Need to consider how this is best done in remote areas for efficiency and cost effectiveness – videoconferencing is an option
- Mental health clinicians visiting watch house in Darwin and Alice Springs
- Capacity for CATT to visit watch house after hours if required
- Possible role for mental health peer workers to work with mental health staff in watch house/court to engage and support mentally ill offenders

[1] Refer to Principle 3, National Statement of Principles for Forensic Mental Health, Health Ministers' Advisory Council, 2006 – dealt with at the conclusion of this paper.

C. **Would a court based mental health clinicians assist? How would this function in practice?**

- Court based clinicians can assist in providing mental health assessments where required for anyone currently on the court list or where the Magistrate specifically requests advice on the need for clinical treatment
- Clinicians can also scan daily court lists for any individuals known to mental health and ensure that their mental state is assessed and advice provided to the Magistrate/Justice in a timely manner to assist early diversion where possible.
- Court based clinicians cannot provide a full medico legal report to the Court as this is a resource and time intensive process and outside their area of expertise. They can however give an indication to the court as to whether the person has current signs of mental illness which might require referral to the treatment system and/or trigger diversion to the mental health court.
- Currently, privacy considerations may preclude the provision of information to the Court about an individual's previous contact/treatment in the mental health system (including their concordance with previous treatment) unless the individual consents to the release of such information, or unless an alternate authorising power is granted via an alternate means (via legislation or substitute decision maker).

D. **Should a medical examination occur if the police suspect an arrested person has mental health issues?**

- If the arresting police suspect an offender has a mental illness (MI), then that individual should be assessed as soon as possible and appropriate actions taken, depending on the outcome of the assessment and the willingness or otherwise of the offender to agree to treatment.

- It may be that MI was a contributing factor to the offending behaviour or it may be that while MI was not a contributing factor to the offending, that it renders the individual more vulnerable during any period of incarceration. All of this information is important, especially for the magistrate/judge dealing with their matter, when it comes before the court.

- If the matter is urgent, police should take the individual to the nearest health/mental health facility for the purpose of a mental health assessment. If the matter is less urgent, then the person can be seen by clinicians who attend the watch house or the court clinicians. Challenges arise if the person is bailed and therefore not detained in custody.

Alternatives

1. The primary alternative to the mental health court model that has been proposed for NT is really an expanded version such as the Queensland Mental Health Court. This is constituted by a Supreme Court judge, assisted by 2 psychiatrists, who deal with summary and indictable offences. Referrals to the Court can be made by any party, but there are certain requirements which require specific matters to be referred to it (e.g. when an individual who is on a mental health order is charged with an indictable offence). The Court sets aside the rules of evidence and has powers of inquiry which means it can take all steps necessary to inform itself in relation to the mental state of an offender at the time of an offence. It rules on matters relating to unsoundness of mind

(USM) and fitness for trial or otherwise (NFFT), and it can make orders relating to the disposition of the offender where a finding of USM or NFFT is made. Individuals under these forensic orders are then referred to the Mental Health Review Tribunal for further monitoring and decisions regarding their orders.

2. Diverting mentally ill offenders to a specialist mental health court is preferable to the matters proceeding through standard court proceedings where little attention, if any, may be paid to the issue of the offender's mental illness, their risk to self or others, and their risk of reoffending as a result of mental illness.

3. 'The 'first point of contact' will need to be a flexible model to cater to the Territory's large geographical area and distributed population. Contact through the local mental health clinicians should be the first point of contact if a dedicated court/watch house service does not exist. This could be done face to face or via videoconference. The major challenge is where the level of offending does not require the person to be detained at the watch house and hence they are bailed but they do not subsequently attend for an assessment. Individuals should not be remanded in custody solely for the purpose of a mental health assessment, especially if that assessment may take some time to occur. The option for this is for there to be a provision in either the *Mental Health and Related Services Act* or the *Criminal Code* that allows for the offender to be taken to the nearest mental health service for an assessment and then returned only to the custody of the police/court.

Court based clinician

4. Agree but need to consider issues relating to consent and privacy. Also need to be clear about the role of the court clinicians. It is not practicable for the role to include providing the Court with full medico legal assessments (as outlined above) nor can they be case managers of people who have been before the Court. Feedback from the forensic team was that clinicians are uncomfortable providing reports outside of their area of expertise, which is clinical rather than legal – as touched on above.

5. See above for comments in relation to how a court based clinician could operate and best practice.

6 – 10. No specific comment.

Police involvement

11. Agreed.

12. No comment

13. I am not aware of any arguments for varying these powers.

14. I don't believe that Police should be administering any 'tests'. However, all Police should be appropriately trained in recognising and responding to people with signs of mental illness or cognitive disturbance.

15. Drug and alcohol workers may provide a valuable service to clients in the watch house. Likewise, disability support workers may also provide a valuable input to those who are clients of their service.

16. Covered above.

17. *At the time of arrest the suspect may show no signs of mental imbalance but may in fact have a history of such. How is this to be determined, consistent with the suspect's right to silence?*

This is difficult as the individual must retain primacy in relation to control over their personal health matters, including in relation to past contact and/or treatment with the mental health system. If an individual was unwilling to consent to the release of such information, then only an order of the Court (e.g. a subpoena) or legislative change could require the information to be provided against the wishes of the person (who presumably has capacity if they are not currently showing signs of mental imbalance).

E. Whether a better outcome might be achieved by amending s77(4) to provide a court exercising summary jurisdiction with options other than mandatory dismissal of the charge if the matters set out in s77(4) are satisfied and a defence of mental illness or mental disturbance is established.

Strongly agree that it is not appropriate for mandatory dismissal to be the only option if the court is satisfied that a defence of mental illness or mental disturbance is established. There are two main reasons for this. The first is that if the person has a mental illness, then they should be diverted to the mental health treatment system so that their treatment needs can be assessed and addressed. This would be in the best interests of the person. The second reason is that the potential for reoffending is high if the underlying cause of the offending is mental illness and it has not been addressed. Again, this is not in the best interests of the person or the community. A third factor to consider is that mandatory dismissal means that s77 is likely to be a very attractive option for any offender seeking to escape a consequence for their actions, and as such, is likely to be over-utilised (or frequent attempts made to use the provision, in circumstances where it may not be appropriate).

F. Whether it might be appropriate to provide a court exercising summary jurisdiction with powers under Part 4 of the Sentencing Act (Community Treatment Orders).

This would be an appropriate option where the offender is deemed to have a mental illness that would benefit from treatment (inpatient or community) and which may have contributed to the offending but where there is insufficient evidence to find that the person is not guilty by reason of mental impairment. The issue here would be exactly what the nature of the order is the court could make and who monitors it. Does the person need to consent to participate in the treatment? If they have capacity and don't consent, then presumably they should be sentenced in the ordinary manner. No one who has capacity to

consent voluntarily to treatment should be placed under an order requiring them to have involuntary mental health treatment, unless there are extenuating circumstances at play e.g. risk to self or others. Where an individual does not have capacity, then it may be appropriate for a community treatment order to be made, but this should come with the same safeguards as an involuntary treatment order under the *Mental Health and Related Services Act* i.e. options for support, scrutiny and review. Effectively, this requires there to be two separate decisions: 1) the decision of the court to defer sentencing to provide an option for treatment but retaining the right to bring the offender back to the court for finalisation of the sentencing at a later point in time and 2) a decision about whether the person meets criteria for involuntary mental health treatment which should be within the province of the mental health system and the MHRT.

G. Provide the court with powers similar to those given under Part IIA of the Criminal Code to the Supreme Court when a finding of not guilty by reason of mental impairment is made (custodial and non-custodial orders, in addition to unconditional release).

The current scheme leaves a 'gap', particularly in relation to people who have episodic or recurring psychiatric illnesses, which are common. This is particularly true for clients who have a 'dual diagnosis' of a substance use disorder and a mental illness, where substance use predisposes the person to becoming unwell. If a person if not mentally unwell at the time a charge is dismissed, there is no avenue for the Court or the mental health system to compel that person to be assessed or treated. For those whose episodic mental illness is associated with criminal behaviour, this gap is especially problematic.

It is entirely reasonable for the court to make an order in relation to the appropriate disposal of an individual who has effectively been found not guilty by reason of mental impairment (NGRMI), and this could be any of the options outlined above. The issue however is that the person should not be subject to detention in a correctional facility if indeed they are found NGRMI as I believe this is a breach of their human rights and international covenants. Such detention should be within an appropriate therapeutic environment (health/disability), with appropriate levels of scrutiny and review built in to the system. Likewise, it is most appropriate for the ongoing monitoring of any such orders to be within the province of the MHRT rather than the Court, for the same reasons. In only the most serious of charges (e.g. murder/manslaughter), it may be appropriate for the final decision about discharge of an order to go back to the presiding court for their agreement, but this is unlikely to be warranted for matters being considered in the Magistrates Court.

Comment on Part IIA of the Criminal Code

Given the current NTLRC reference is in relation to improving the interaction that people with mental health issues have with the justice system, and the potential for a scheme similar to Part IIA of the Criminal Code (Part IIA) to be utilised in the NT Magistrates Court, I make the following comments in relation to Part IIA:

a) As set out above, it is my view that when a person is found NGRMI, any further period of detention should be in a therapeutic environment rather than a correctional facility. Further management of these people should be undertaken by a mental health tribunal (potentially a specially constituted forensic division, which could include a judicial officer, similar to the NSW scheme) rather than the court

wherever possible. Part IIA empowers the NT Supreme Court to make supervision orders in relation to those NGRMI, committing the person to custody in 'a correctional facility or an appropriate place'.[2]

b) Supervision Orders made under Part IIA are for an 'indefinite' timeframe, subject to variation and review provisions. The Court must set a term for a Supervision Order at the time of making the order, commensurate with the term of imprisonment it would have set for a finding of guilt. Section 43ZG(5) provides that the Court must conduct a 'major review' of the Supervision Order within the 3-6 month window prior to the expiry of the term of the supervision order. At a major review, the court must unconditionally release the supervised person unless it considers that would cause a serious risk to the safety of the supervised person or the. However, 'if the Court considers it appropriate', it may adjourn the major review to a time after the expiry of the supervision order term and make interim orders – including that the person continue to be remanded in custody in a correctional facility.[3] If the Court considers that there is a serious risk to the person or public, the Court must make further orders, including the option to continue a custodial supervision order. These provisions mean a person who is NGRMI may be dealt with by the Court (including remanded within a correctional facility) for a term longer than they would have been imprisoned, had they been found guilty of the offence.

c) People who are unfit to be tried can be remanded in custody pending a determination to be made at a Special Hearing as to their criminal culpability and consequent orders. Where a judge determines a person who is not fit to be tried is not likely to be fit within 12 months, the Special Hearing is to be held within 3 months of that determination (s43R). However, section 43U provides that the special hearing for this category of person can be adjourned (on application or at the Court's initiative) for periods up to 3 months, with no limit to the number of adjournments under this section. 43R (5)-(12) deals with those who are NFFT and determined likely to be so within 12 months. The maximum period these individuals can be detained prior to a determination as to culpability is 15 months. Application of these provisions could leave a mentally ill person detained in a correctional facility for an indefinite period, pending any determination as to criminal responsibility.[4] The Part IIA provisions and processes (for dealing with mentally ill accused / offenders) are additional to and not in the alternative to the standard criminal procedures. Given the current provisions, it seems there is potential for breaches of the fundamental human rights of these individuals if they are remanded in custody without appropriate safeguards around timeframes and place of detention.

Extension of powers of the Court of Summary Jurisdiction

18 – 22: No further comment to that set out above at 'E' and 'F', above.

---

[2] If satisfied there is no practicable alternative given the circumstances of the person: section 43ZA(2).
[3] Sections 43ZG(5)(, (5)(A) –(5)(C).
[4] Sections 43R(3), 43U.

Procedural aspects of s77

23 – 24: It seems to me that it is entirely appropriate that the court is not bound by a certificate from the CHO and that it should be able to consider all of the evidence.

25*: Consideration needs to be given to devising a simpler and more practical and expeditious but sufficiently rigorous process for hearing and determining applications under s77.*

There needs to be some way to assist the Court in understanding the validity of an argument of NGRMI. Either this is through the filter of the CHO certificate as currently provided for in the legislation (although I note that there is no requirement for the CHO to have specific mental health expertise) or the Court could be assisted by an appointed advisor who could give the same input. I don't know whether there would need to be statutory changes to allow for this or whether it is a matter or practice rules being established to guide how this could work.

26. As above.

Unfitness to stand trial

27. It would seem to be most cost efficient and effective to provide the Court of Summary Jurisdiction with the power to determine unfitness to stand trial. Referral to the higher court is not only expensive, but is likely to result in considerable delay, including for the offender and any victims.

28. The implications of granting this power is that there needs to be similar processes in place as currently apply in the higher court, including options for review and ultimate disposal of the individual if a decision of NFFT is made (including orders).

29. No specific comment.

'Other'

30. Issues in relation to consideration of the interests of victims of crime must always come into consideration as well as the interests of individuals with mental illness. It can be very challenging to balance these competing interests as well as to reassure the community that their safety and welfare has also been considered.

31. Acts of extreme violence by an individual with no prior criminal history or only a history of eccentricity or minor transgressions remain a risk that can never be fully mitigated. Even the prospect of compulsory psychiatric examinations is unlikely to remove the risk, as psychiatry is an inexact science and cannot predict with absolute certainty the behaviour of an individual at any point in time, let alone at a future point in time.

    No modern society that seeks to respect the human rights of individuals would ever support compulsory psychiatric examinations, nor do the resources exist to allow this to occur.

Overall risks to our society can however be reduced by the appropriate identification and treatment of factors that may lead to offending behaviour. These factors include mental illness but are not confined to mental illness. There are many criminogenic factors that could benefit from early identification and intervention, including many social and psychological issues. Any such approach would require a concerted effort across government and society and a wealth of resources to implement.

National Statement of Principles for Forensic Mental Health

d) In relation the management of mentally ill offenders generally, the NTLRC may wish to have regard to the *National Statement of Principles for Forensic Mental Health* (Principles).[5] The Principles are based on the relevant international and national human rights framework. Rationale for the Principles includes promotion of optimal outcomes for this challenging client group (and the community), as well as a move towards national consistency.

e) While all of the Principles are relevant, of particular significance to the NTLRC current reference are:

    a. Principle 1: Equivalence to the non-offender;
    b. Principle 3: Responsibilities of health, justice and correctional systems;
    c. Principle 4: Access and Early intervention;
    d. Principle 7: Ethical Standards; and
    e. Principle 13: Legal reform.

f) Principle 1 provides that people who are under the control of the justice system should have the same access to the same standard of mental health care as those in the community. Incarceration (on the basis of mental illness) should not be longer than periods that would apply to non-offenders.

g) Principle 3 sets out principles for boundaries between therapeutic and correctional intervention, as well as around transparency and clarity of process. Specific reference is made to the separation of forensic mental health facilities from mainstream prisons –geographically and in terms of ownership and funding. The principle around separation extends to mental health and correctional staff being employed by mental health and correctional agencies respectively, where possible. Principle 3 provides that if a single agency employs mental health and correctional staff, clear separation of responsibilities and appropriative administrative management must be maintained.

[5] National Statement of Principles for Forensic Mental Health, Health Ministers' Advisory Council, 2006.

h) Principle 4 makes specific reference to people in police custody (or otherwise remanded) having timely referral and access to appropriate specialist mental health services. Principle 4 further provides:

> *All custodial facilities should have capacity to assess and treat mental illness within the primary care setting, and to refer to specialist mental health services, both outpatient within the custodial setting and inpatient in a secure mental health hospital, as clinically indicated*

i) Principle 7 applies in relation to sharing of confidential client information – which should be either with the client's consent, or 'to the extent necessary for treatment and care...". The necessity of maintaining separate health and correctional files is noted. The requirements of Principle 7 should be incorporated in any MOU between agencies in relation to management of forensic client information.

j) In making its ultimate recommendations, the NTLRC may wish to reference Principle 13 and the relevant international covenants set out therein.

Northern Territory Law Reform Committee

Interactions between people with mental health issues and justice system

Professor Dinesh Arya, Chief Health Officer, NT

Thank you for the opportunity to be interviewed by the Northern Territory Law Reform Committee ("Committee").

The Committee was particularly interested in consulting with me with respect to the provision of certificates under section 77 of the *Mental Health and Related Services Act* ("the Act").

In particular, the Committee is interested in exploring:

1. What measures might be taken to improve the interaction between people experiencing mental health issues and the justice system;
2. Whether a better outcome might be achieved if the court had options other than mandatory dismissal of a charge if the matters set out in section 77 (4) are satisfied and a defence of mental illness or mental disturbance (collectively, "mental disorder") is established;
3. Other procedural aspects of section 77; and
4. Considerations in relation to fitness to stand trial.

Let me start by indicating my view that the expert clinical opinion in relation to people with a possible mental disorder coming in contact with the justice system should be to:

1. Assist the Court in making its determination in relation to criminal culpability for an offence[1] and
2. Ensure that a person with a mental disorder receives care and treatment so that risk of recurrence of offending behaviour can be minimised.

However, in addition to the above, we must not lose a public health opportunity to ensure that a person with a possible mental disorder coming in contact with the justice system gets appropriate care and treatment without delay.

Therefore, it is important that an assessment as to whether a person is suffering from a mental disorder and whether the person has care and treatment needs, should take place as soon as possible after the person has come in contact with the justice system ("Initial Assessment").

- The category of people who can make requests for Initial Assessments should be broad, and include police officers, legal representative, clinicians in the

[1] By reference to the impact of any mental disorder.

watch house, the person charged with the offence and/or their family/carers ("potential referrers").
- Court Mental Health Clinicians ("CMHCs") should perform the Initial Assessments, triage and link people with appropriate services.

Clearly, the above arrangement has the potential to increase the number of assessments of people within the justice system that may need to be undertaken by CMHCs. However, I would not consider it to be 'wasted' effort considering that if there is a mental health need in the community, it would be appropriate to try and meet that need.

The Initial Assessments would be aimed at meeting people's immediate mental health needs, however, a secondary purpose, at least for selected cases, can also be a preliminary mental health assessment in relation to criminal culpability. This is something that can be considered on a case by case basis by referrers seeking an assessment.

If the Court later requires a section 77 assessment and a certificate is required, that could be undertaken in due course.

In my view, an Initial Assessment would provide the following benefits:

1. Primarily, meeting the mental health needs of people coming in contact with the justice system;

2. Early identification and appropriate diversion and treatment of mentally disordered defendants, would reduce the overall burden on the Court system; and

3. Reducing requests for section 77 certificates.

It is important for me to highlight that the above will have resource implications as the overall number of clinical mental health assessment requests to CMHCs is likely to increase.

In an ideal world, all potential referrers would be trained in relation to when and how to refer for Initial Assessment so this could occur at the earliest point after apprehension. This has further resource implications.

Section 77 requests

If the Court requests a section 77 certificate ("Certificate") to assist in determining criminal culpability, under section 77,in my view the Certificate and / or the report which informs the Certificate ("Report") should address the following matters.

The Certificate / Report should provide a clinical opinion as to:

1. Whether the person was mentally disordered (including disorder of cognition) at the relevant time;
2. If so, whether the person as a result of mental disorder:
    - Did not have capacity to understand the nature and quality of the relevant conduct;
    - Did not know the nature of the conduct was wrong;
    - Was not able to control his or her actions at the relevant time;

If the Chief Health Officer's opinion is that a mental disorder incapacitated the person to such an extent that `he/she did not understand the nature and quality of the conduct; did not know or understand the conduct was wrong; and was not able to control his or her actions' then there should be a requirement for a Management Plan to be implemented, under some form of Court order ("Order").

The Certificate / Report should then also set out:

3. A proposed Management Plan, including any recommendations for treatment or interventions for the mental disorder to ensure that the risk of occurrence of offending behaviour can be minimised;
4. Whether any proposed treatment should be voluntary or involuntary;
5. Whether proposed treatment should be carried out in an inpatient facility or in the community;
6. Proposed date of next review of progress against the Management Plan, by the Magistrate.

A Management Plan and any associated Orders would obviously not be required if the person was not suffering a mental disorder at the time the Report was completed.

Management and monitoring of Orders

In my view, the Mental Health Court or the Mental Health Review Tribunal could undertake the role of making and monitoring Orders.

I would be in favour of the Mental Health Court, rather than the Mental Health Review Tribunal undertaking this monitoring function. I hold this view because I believe that a Mental Health Review Tribunal undertaking routine reviews is a legacy of the past, and not value adding. A resource intensive, expert, Mental Health Review Tribunal should only deal with contentious issues.

Therefore, an ideal process to achieve the above would be an appropriately resourced Mental Health Court supported by Court Mental Health Clinicians.

Once the Magistrate has made a determination in relation to the Report and recommendations presented, the Court Mental Health Clinicians could potentially take a care coordination role in consultation with mental health service providers, to ensure that arrangements are in place for the Management Plan to be implemented and monitored.

Again, such a process may require additional resources for the Mental Health Court (including implementation and review of Management Plans and associated Orders).

Conclusion

By reference to questions set out in the Terms of Reference (26 May 2015), my thoughts can be summarised as follows:

1. A broad category of trained `potential referrers' would ensure assessment is requested at the earliest possible stage of the person with mental disorder coming in contact with the justice system;
2. Early Initial Assessment would facilitate appropriate and efficient care and treatment of persons suffering a mental disorder;[2]
3. Point 2, above, would promote improved mental health outcomes and also efficiency in the court system by decreasing the number of Section 77 requests (hence, more appropriate resource allocation);
4. An amendment to section 77(4) empowering a Court exercising summary jurisdiction to make Orders around recommended Management Plans would assist preventing mentally disordered persons 'falling through the cracks' of the mental health care system and also contribute to efficiency in the courts;
5. Court based Mental Health Clinicians would fulfil a crucial role in facilitating all steps of the assessment, diversion and treatment process of mentally disordered offenders, as well as co-ordinating and liaising between relevant agencies in relation to Assessment, implementation and monitoring of Orders.

[2] Which could be an inpatient or community setting.

APPENDIX C

Australian Health Ministers' Advisory Council

▼

Mental Health Standing Committee

NATIONAL STATEMENT OF PRINCIPLES FOR FORENSIC MENTAL HEALTH 2006

Endorsed by AHMC (2002) and CSMC (2007)

CONTENTS

Preamble

Forensic mental health is a specialised field within mental health. In terms of service planning and development, forensic mental health has been neglected and reform has lagged behind mainstream mental health services.

There is a high occurrence of mental illness amongst inmates in correctional settings. Often mental illness is present in association with other disabilities such as substance abuse and intellectual disability.

Offenders with a mental disorder are a highly stigmatised and marginalised group in our community. There are a number of particularly vulnerable populations within this group, including juveniles, Aboriginal and Torres Strait Islander peoples and people from culturally and linguistically diverse backgrounds. The marginalisation is increased by sensationalised media representations that often give misleading accounts of forensic mental health issues.

These Principles have been developed in the context of, and are underpinned by, international and national policy frameworks including: the United Nations *Principles on the Protection of People with a Mental Illness*; the *International Covenant on Civil and Political Rights*; the Australian Health Ministers' *Mental Health Statement of Rights and Responsibilities*; the *National Mental Health Strategy*; the *National Standards for Mental Health Services* and the *Royal Commission into Aboriginal Deaths in Custody*.

The National Mental Health Strategy acknowledges that forensic populations are a group requiring access to the same range of services as the wider community. The Second National Mental Health Plan identified forensic populations as one of the target groups for which the following reforms are essential:

- Improved service access
- Better service responses
- Further development
- Evaluation of appropriate service models

The Target Group

- Offenders or alleged offenders referred by police, courts, legal practitioners or independent statutory bodies for psychiatric assessment and/or treatment
- Alleged offenders detained, or on conditional release, as being unfit to plead or not guilty by reason of mental impairment
- Offenders or alleged offenders with mental illness ordered by courts or independent statutory bodies to be detained as an inpatient in a secure forensic facility
- Prisoners/young offenders with mental illness requiring secure inpatient hospital treatment
- Selected high-risk offenders with a mental illness referred by releasing authorities
- Prisoners/young offenders with mental illness requiring specialist mental health assessment and/or treatment in prison
- People with mental illness[♦] in mainstream mental health services who are a significant danger to their carers or the community and who require the involvement of a specialist forensic mental health service
- The Principles are not intended to apply to those who suffer intellectual disability or substance abuse without co-morbid mental illness

♦ The diagnostic groups that constitute this group of people for the purpose of the Principles will be determined by each jurisdiction.

Rationale for National Principles

The National Statement of Principles for Forensic Mental Health aims to provide cohesion and credibility so that optimal diagnosis, treatment and rehabilitation can be provided to clients of forensic mental health services. While states and territories are responsible for the delivery of forensic mental health services, the services should be delivered within a framework provided by nationally agreed principles.

The Principles apply to clients in the adult and juvenile justice system. Services must appropriately provide for the special needs of people with comorbid physical and mental disorders and intellectual disabilities. Specific attention should ensure optimal outcomes for special groups such as women, youth, Aboriginal and Torres Strait Islander peoples, culturally diverse peoples, and older persons. The application of these Principles in relation to the particular developmental needs and rights of young people with a mental illness involved in the criminal justice system is crucial. It is recognised that the health status of prisoners/young offenders in general is lower than that of the community and that this should be considered in the determination of services and resource allocation.

These Principles are not intended to apply to clients under civil commitment provisions of mental health legislation or those before the civil courts. These Principles should also apply to individuals detained in custody by legislation other than criminal justice systems. It is recognised that there is a significant frequency of complexity among those who come to the attention of the criminal justice system. This may require the involvement of other government departments and may be the subject of separate principles. These Principles are primarily directed to the assessment, treatment and care of those who suffer mental illness however the underlying values and intent may be of use to those involved in service provision to other groups, including specialised areas such as the management of sex offenders. The Principles do not comment on the adequacy or otherwise of services provided to non-offender groups but should apply to the care and treatment provided to those under correctional based orders residing in the community.

Service Boundaries

Boundaries that confront forensic mental health services provide challenges for staff and clients. These are between:

- **Forensic mental health service and the correctional system** – there are inherent difficulties in providing a mental health service within a correctional facility given the major focus of correctional facilities being secure containment and the focus of mental health services being diagnosis, treatment and rehabilitation.

- **Forensic mental health service and the general mental health system** – a boundary between forensic mental health and general mental health services is created by the client's involvement in the criminal justice system.

- **Forensic mental health service and other human services** – the stigma and fear of forensic clients often creates boundaries between forensic mental health services and other human service agencies. This can result in other agencies being unwilling to provide ongoing support, care and treatment.

Competing Priorities of Professional Cultures

The relationship between the treatment and rehabilitation culture of forensic mental health services and the custodial culture of correctional agencies is often problematic. Similarly, the police, courts, corrections and forensic mental health have different foci and sets of expectations, which can, at times, be difficult to reconcile.

Legislation

Legislative reform is required to provide national consistency across mental health legislation, and national consistency across jurisdictions with respect to criminal codes and common law as they apply to forensic mental health clients. In the interim and prior to the achievement of such legislative reform, cross-border arrangements are to be facilitated.

Principle 1:

Equivalence to the non-offender

Prisoners and those in the community who are under the supervision or control of the criminal justice system have the same rights to availability, access and quality of mental health care as the general population. Where health facilities are provided within a correctional facility, there should be appropriate equipment and trained staff, or arrangements made for such services to be available, at a standard comparable to regional and community standards.

Services should ensure equality in service delivery regardless of an individual's age, gender, culture, sexual orientation, socio-economic status, religious beliefs, previous conditions, forensic status and physical or other disability. This Principle of Equivalence applies to both primary and specialist mental health care. Consideration should be given to the special needs of Indigenous offenders.

Prisoners and those in the community who are under the supervision or control of the criminal justice system who are involved with the mental health system should have equivalence with regard to legal rights and protections. They should have access to competent legal representation when appropriate. They should not be subject to longer periods of incarceration than their non-offender counterparts based solely on the presence of mental illness.

Equivalence to the non-offender should extend to those who have been transferred from correctional facilities to come under the responsibility of the health system.

Principle 2:

Safe and Secure Treatment

Treatment and care will be provided in an appropriate environment compatible with the treatment and rehabilitation needs of the individual and the community's need for safety.

People with a mental illness often harm themselves and become victims of violence. Treatment decisions must be cognizant of:

- The legitimate needs of the community for a reasonable level of protection from dangerous or seriously disruptive behaviour.
- The protection of the individual patient from unacceptable risks of serious damage to self or serious deterioration.
- The cultural significance and impact of isolating practices on offenders
- The safety needs of the individual, other patients/prisoners and staff

Principle 3:

Responsibilities of the Health, Justice and Correctional Systems

The provision of mental health care for offenders is the joint responsibility of the Health, Justice (including police and court systems) and Correctional systems and is to be addressed in partnership. The contributions/responsibilities of the agencies involved are to be planned, agreed, documented and freely available. Effective communication between Health, Justice and Corrections (and any external agencies or professional groups engaged by them) is essential to implementing these joint responsibilities.

Mental health services are preferably staffed by mental health personnel employed by a health service (as preferred provider of mental health assessment and treatment services) rather than correctional agencies. Where the model adopted is that both mental health and correctional staff are employed by a single agency it is important to ensure that there is separation of management such that integrity of clinical records and professional responsibilities are maintained.

A prisoner/young offender who requires inpatient mental health care will be transferred from prison to an appropriate mental health facility having regard to the person's mental health needs. Issues such as the offence leading to the person's detention, their social circumstances and the likelihood of their remaining in treatment, may be considered by correctional managers when approving such transfer.

Specialist inpatient forensic mental health services (secure facilities) should be owned, funded and staffed by mental health and located beyond the geographic boundary of a prison and run independently from correctional services. Where such geographical or funding separation cannot exist, there should be clearly separated management responsibilities.

Custodial practices should promote positive mental health and minimise negative impacts on the mental health of those in custody. Correctional services are responsible for providing an environment conducive to mental health within the constraints of needing to maintain a secure and safe environment. Mentally ill persons in custody need to be involved, to the full extent of their capabilities and without discrimination, in the educational, occupational and rehabilitation activities available within prison. Mentally ill persons in prison need access to quality general medical services.

Principle 4:

Access and Early Intervention

A prisoner/young offender, whether remanded, sentenced or in police custody, should have timely referral and access to specialist mental health services when appropriate. Persons attending court who appear to be mentally ill, or about whom there is concern regarding their mental health, should have access to assessment by an appropriately trained mental health clinician. All persons entering a custodial environment should be assessed with regard to their mental health needs and referral arranged accordingly. Prisoners/young offenders should be made aware of the availability of specialist mental health services.

All custodial facilities should have capacity to assess and treat mental illness within the primary care setting, and to refer to specialist mental health services, both outpatient within the custodial setting and inpatient in a secure mental health hospital, as clinically indicated. The range of treatments and interventions available and the qualifications and experience of mental health staff, should be at least congruent with that available in the general community. There should be access to acute interventions including treatment directed to alcohol and substance dependence, and to psychosocial rehabilitation and pre-release planning, in order to minimise the acute effects of illness and longer-term disability.

It is recognised that persons within the criminal justice system and juvenile justice system have a higher prevalence of mental illness and mental disorder than the general population. Strategies aimed at early intervention and prevention through education, development of social skills and improved coping mechanisms should be available to those within the justice system. This range of services should be available to all those in custody including minority groups such as women and juveniles. Prisoners/young offenders from Aboriginal and Torres Strait Islander backgrounds, or other culturally and linguistically diverse backgrounds, should have access to appropriate cultural support, including access to accredited interpreters and the translation of written documents. Factors in the environment that are known to be detrimental to mental health and wellbeing such as isolation, uncertainty, and inconsistency in management should be minimised wherever possible.

People within the criminal justice system who experience mental illness, or offenders who have been diverted to secure mental health facilities, may at times seek transfer to another State or Territory for personal or family reasons. Where such transfer is seen to be in the best interests of the individual, access to appropriate services will be made available in the receiving State or Territory.

Principle 5:

Comprehensive forensic mental health services

A comprehensive forensic mental health service is a specialised mental health service providing integrated in-patient services, prison mental health services, court liaison services, and community mental health services, in a coordinated clinical and administrative stream. Strong links and partnerships with general mental health services and with consumer and carer organisations are a feature of these services. These services should provide evidence based, multidisciplinary, continuous care, consistent with those of general mental health services. Consideration should also be given to the most effective way to engage services providing intervention relating to homelessness, alcohol and substance use and aggression. There should be an agreed process for the exchange of information and participation by all appropriate agencies in the case management of the offender.

Broadly speaking a comprehensive forensic mental health service should provide the following main ***functions***:

- mental health promotion and prevention
- assessment
- management, including treatment and rehabilitation
- coordination of care across settings, including pre-release planning and linking clients with general mental health and private mental health services
- delivery of care in a culturally sensitive environment
- facilitation of diversion to appropriate treatment settings
- consultation, liaison and support to general mental health services, corrections and other bodies
- provision of expert advice and reports as determined by individual State and Commonwealth requirements
- other functions such as administration, research, education and training

Principle 6:

Integration and Linkages

Forensic mental health services include: in-patient services; prison mental health services; court liaison services; community mental health services; and linkages with general mental health services and consumer and carer organisations. Integration of these elements of the forensic mental health service is required to minimise barriers to the treatment of clients in the most clinically appropriate setting. There should also be close integration with corrective services and parole bodies.

The duty of care in ensuring the safety of prisoners/young offenders, staff and visitors in correctional centres as well as in the community requires a coordinated and integrated approach to the case management of inmates.

Forensic mental health services must be linked with other relevant services in order to provide treatment in the most clinically appropriate manner and setting. Other services are often required by forensic mental health clients, especially drug and alcohol services and disability support services; appropriate linkages between forensic mental health and these services must be ensured.

Similar linkages are required between mental health and general health care services, and social services such as housing and income support, which are necessary to maximise the positive clinical outcomes for forensic mental health clients. Effective inter-agency pre-release planning is vital to successful reintegration into the community following release.

Principle 7:

Ethical Standards

The right of all clients to respect for individual human worth, dignity and privacy is not waived by any circumstance, regardless of an individual's history of offending or their status as a forensic mental health client or a prisoner/young offender. The capacity or right to consent is not forfeited as a result of a history of offending or status as a prisoner/young offender.

The conflicting needs of the client, prison and the criminal justice system demand the highest ethical standards at all times from professionals working in forensic mental health services, but serious ethical dilemmas may be expected to arise on some occasions. Professional codes of ethics provide guidance relevant to such dilemmas and should be adhered to.

All persons accessing mental health services, either within the health system or within the corrective services system, are entitled to the protection of their civil and human rights and freedom from abuse consistent with the United Nations Principles on the Protection of People with a Mental Illness and the relevant jurisdictional privacy legislation.

Likewise, the confidentiality of client information will be respected, other than in exceptional circumstances. Sharing of information between correctional and health providers will only occur to the extent necessary for treatment and care or with the consent of the client. Health records and files should be maintained and stored separately from the correctional files, in accordance with Health Privacy Guidelines.

Mental health treatment should always be provided only with the explicit informed consent of the client except in circumstances where the client is unable to give informed consent by virtue of their mental illness or intellectual impairment. Treatment should only be provided with the consent mechanisms outlined in the relevant jurisdictions' substitute decision-making legislation and/or mental health act, or in accordance with judicially determined conditions under relevant legislation.

Principle 8:

Staff: Knowledge, Attitudes and Skills

The forensic mental health workforce requires a high degree of professionalism and strong clinical leadership. In light of the specialised and often challenging nature of forensic mental health service delivery, it is recognised that appropriate training and support are required to maintain a highly skilled workforce.

Information and training should be made available to all those having contact with and/or responsibility for mentally ill offenders in relation to presentation and principles of treatment and care to enable delivery of appropriate services.

Staff should be provided with opportunities to develop, maintain and increase their skills to enable them to provide high quality professional services to clients, including cultural diversity training. The cultural knowledge of staff from Aboriginal or Torres Strait Islander backgrounds, or other culturally diverse backgrounds, should be drawn on wherever possible.

In addition, strategies will be implemented within the workplace to ensure that appropriate levels of supervision, support, and safety, are available to individual workers, including Occupational Health and Safety requirements.

Principle 9:

Individualised care

Forensic mental health services should meet the changing needs of an individual, taking into account the entirety of their biological, psychological, social, cultural and spiritual context.

Individualised care implies facilitated access, comprehensive assessment, unimpeded treatment, regular review and recognition of the humanity of the person including the involvement of significant others in treatment, support and care. There should be agreed recognition of the role and responsibilities of the involved agencies.

Historically there are population groups for whom it has been difficult to provide such individualised care within the forensic mental health system, and for whom special efforts are needed to ensure such care. These groups include: Aboriginal and Torres Strait Islander peoples; culturally and linguistically diverse populations; children and adolescents; those with intellectual impairment; and women.

Principle 10:

Quality and Effectiveness

Forensic mental health services must have in place a quality improvement process which through performance outcomes identifies opportunities for improvement in the delivery of services and includes action to address identified deficiencies. This improvement process must involve carers and consumers.

Effective treatment and rehabilitation will involve forensic mental health clients as fully as possible in decision-making. Quality mental health services will reduce the risk of re-offending of individuals who have committed offences as a result of having a mental illness.

Quality care and containment should be provided in a cost effective and efficient manner.

Research and evaluation is an important component of quality forensic mental health services. The collection and analysis of routine outcome measures is necessary for the adequate evaluation of services.

Principle 11:

Transparency and Accountability

There is a risk that forensic mental health services will fail to maintain the standards expected of a specialist health service, and will develop idiosyncratic practices. This risk is minimised by services being subject to processes of accreditation against national standards for mainstream services, external and peer review. The National Standards for Mental Health Services provide appropriate benchmarks for forensic mental health services.

Prisoners/young offenders who are detained under mental health legislation and who are provided treatment without their consent, should have access to the same external review and rights of appeal as those who are detained under civil law and compulsorily treated. There should be access to complaints mechanisms and to independent bodies such as the public advocate or ombudsman. The correctional provider should encourage external scrutiny through organisations such as community visitors.

Principle 12:

Judicial determination of detention/release

Decisions to detain, release or transfer mentally ill individuals found not guilty or unfit for trial because of a mental illness or intellectual impairment should be made by courts or independent statutory bodies of competent jurisdiction, not by a political process or the Governor/Administrator in Council.

Where transfer decisions between prison and hospital are the responsibility of the executive arm of government, these should be guided by relevant legislation.

These decisions should only be made in accordance with the applicable legislation and legal principles, on the advice of suitably qualified mental health practitioners and in accordance with best practice principles contained in this statement.

Judicial and Review Board hearings which determine detention, transfer, release or discharge are to be transparent, accountable and accessible to families, carers, victims and appropriate support services.

Principle 13:

Legal reform

Legislation must recognise the special needs of people with a mental illness involved in the criminal justice system and comply with the International Covenant on Civil and Political Rights, the United Nations Principles on the Protection of People with a Mental Illness and the Improvement of Mental Health Care.

- Mentally ill offenders must have the same standard of protection that the justice system offers everyone else.
- A formal legal process will determine the type of disposition but reserve flexibility that will permit those responsible for the health of the person to provide treatment.
- Courts or independent statutory bodies will consider expert evidence on the medical condition of the person. Courts or independent statutory bodies may consider material from a person who is not a party to a proceeding (eg. a victim), if it is relevant to the determination of the court.
- Release decisions must be made by the relevant court or independent statutory body not by political process.
- Legislation must permit the notification of next of kin, carers and victims about decisions regarding detention, release or transfer.
- Consistency of legislation throughout the States and Territories is desirable. Legislation must allow the Minister in any State or Territory to enter into an agreement with another State about the application of that State's mental health laws - such that persons can be apprehended, detained, treated or transferred.
- Legislation must not allow the detention of a person in a mental health facility merely on the basis of intellectual impairment, antisocial or illegal behaviour, sexual preference, or political or religious conviction.
- Legislation should not allow coercive treatment for mental illness in a correctional facility. Where there is no alternative place for treatment coercive treatment should only occur subject to strict criteria and appropriate review of decision-making in accordance with relevant legislative provisions, external review and ethical guidelines.

GLOSSARY OF TERMS

CIVIL COMMITMENT PROVISIONS
Legislative provisions contained within a jurisdiction's mental health legislation that allow for the involuntary treatment of a person with mental illness under specified criteria and circumstances.

COERCIVE TREATMENT
Treatment provided against the express wishes of the individual.

CORRECTIONAL FACILITY
A premise or place required or authorised under the relevant state legislation to detain a prisoner/young offender (May include a prison hospital).

CORRECTIVE SERVICES
The government department responsible for overseeing the custody and/or supervision of prisoners/young offenders.

CUSTODY
The guardianship or care of individuals who are detained in relation to specified legislation.

GOVERNOR/ADMINISTRATOR IN COUNCIL
The executive arm of Government

INTELLECTUAL IMPAIRMENT
Significantly sub-average general intellectual functioning that is accompanied by significant limitation in adaptive functioning, regardless of the cause. By definition, must occur before attaining adult status; does not include any cognitive decline that occurs in adult life. May be referred to in legal terms as natural mental infirmity or mental retardation.

MENTAL DISORDER
A clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom.

MENTAL ILLNESS
A recognised, medically diagnosable, clinically significant behavioural or psychological syndrome that occurs in an individual and that is associated with distress or disability or with a significantly increased risk of suffering death, pain or disability.

PRIMARY CARE IN THE FORENSIC CONTEXT
General Practice and other Primary Care Services, which are the first point of health contact provided to those in custody, should have an emphasis on illness prevention and early detection.

PRISONER
A person required to be in lawful custody on a charge of an offence, awaiting sentence on conviction of an offence, or serving a sentence of imprisonment or detention on the order of a court. It applies to a person of any age. In some jurisdictions, the person may be referred to as a detainee or inmate.

SPECIALIST MENTAL HEALTH SERVICES
An organisation that provides, as its core business, specialist level mental health treatment and support to people with mental illness and/or mental health problems. This is distinguished from primary care services that provide a range of assessment and treatment services.