North Australian Aboriginal Justice Agency Submission to the

Community Affairs References Committee

Inquiry into Commonwealth Funding and Administration of Mental Health Services

August 2011

About NAAJA

The North Australian Aboriginal Justice Agency (NAAJA) is the legal service chartered with providing high quality and culturally appropriate legal aid services for Aboriginal and Torres Strait Islander people within the Northern Zone of the Northern Territory.

NAAJA serves urban, rural and remote areas from north of Elliott right through the Top End, with offices in Katherine, Darwin and Nhulunbuy. NAAJA attends the bush court circuit of almost 20 remote communities and conducts outreach visits and legal clinics to Northern Zone remote communities.

We frequently represent clients with mental health issues in the criminal and youth justice systems, in both the Magistrates and Supreme Courts. This includes appearing in matters where clients are unfit to stand trial, or who were mentally impaired at the time of offending.

We assist clients with mental health issues in relation to various civil and family law issues, as well as assisting clients who are sectioned under the *Mental Health Act*, subject to Adult Guardianship applications, or making police complaints. We also provide in custody support to prisoners with mental health issues, assisting them to apply for parole and providing them with throughcare support.

Contents

1. Summary

Scope of this submission

Culturally relevant mental health service provision is a significant area of need in the Northern Territory (NT). This submission details areas where the mental health needs of Aboriginal people in the NT are overlooked. This includes a discussion of:

- Lack of mental health service and specialist availability in remote communities;
- Lack of culturally skilled mental health services and staff;
- Lack of broader mental health support for prisoners both within the prison, and being released from prison;
- Lack of appropriate community based accommodation for people with mental health issues;
- Lack of a forensic mental health facility;
- Lack of appropriate mental health services for young people;
- Lack of adequate remote care facilities for people held involuntarily in remote communities; and
- Lack of funding for culturally relevant representation at the Mental Health Review Tribunal.

It is NAAJA's experience that there is a lack of expertise in the area of Aboriginal specific mental health service provision. We consider this an essential area of development. NAAJA is hopeful that the Committee will make valuable recommendations in relation to addressing these large areas of service deficiency.

We recognise that there may be issues in this submission which fall within the responsibility of the NT Government. We consider, however that the Commonwealth should seek to ensure that these issues are addressed through the shared responsibility framework of the Council of Australian Governments' National Indigenous Reform Agreement (Closing the Gap).

2. Summary of Recommendations

Recommendation 1	Mental Health services should be culturally relevant for Aboriginal people. This includes employing Aboriginal people, using interpreters, and providing cross-cultural education to non-Aboriginal staff.
Recommendation 2	More funding should be provided to the Aboriginal Interpreter Service so that more interpreters are trained and available for mental health service needs. Mental Health workers should receive training in the appropriate use of interpreters.

Recommendation 3	Mental health service provision in remote communities should be increased to ensure Aboriginal people living remotely have equal access to quality mental health service provision.
Recommendation 4	Remote clients required to travel to access mental health services should be provided with intensive and tailored support.
Recommendation 5	Where ever possible, community mental health services should employ and be managed by Aboriginal staff.
Recommendation 6	There should be increased funding, support and training for Aboriginal mental health workers.
Recommendation 7	Aboriginal community education and health promotion should be funded. This should include education about the causes of mental health problems, the benefit of prevention and early intervention, and treatment options.
Recommendation 8	Prisoners with mental health issues should have equal access to rehabilitation programs. If they are not suitable for group programs, individual, tailored programs should be provided.
Recommendation 9	Prisoners with mental health issues should have equal access to low and open security classification.
Recommendation 10	All prisoners with mental health issues should be provided with intensive post release planning and support.
Recommendation 11	A wider range of appropriate community based accommodation must be made available for people subject to supervision orders.
Recommendation 12	Urgent priority must be given to developing an appropriate forensic mental health facility in the NT.
Recommendation 13	People subject to custodial supervision orders should be provided with intensive post-release planning and support.
Recommendation 14	Youth specific mental health assessments and services should be available for young people involved in the criminal justice system.
Recommendation 15	Community Health Clinics and Police Stations should be adequately resourced to ensure that someone who has been sectioned under the *Mental Health and Related Services Act* (NT) is appropriately supervised and kept safe.
Recommendation 16	NAAJA and the NT Legal Aid Commission should be adequately funded to represent people at the Mental Health Review Tribunal.

3. Cultural Competency of Mental Health Services in the NT

Recommendation 1:

Mental Health services should be culturally relevant for Aboriginal people. This includes employing Aboriginal people, using interpreters, and providing cross-cultural education to non-Aboriginal staff.

For mental health service provision to be effective in meeting the needs of Aboriginal people, it must be specifically tailored towards the holistic and socio-culturally distinct experience of Aboriginal people.

Aboriginal conceptions of health, and differing world views, should be integrated into mental health client practices and general service provision. The National Consultancy Report on Aboriginal and Torres Strait Islander Mental Health, 'Ways Forward', provided the following definition: 'The Aboriginal concept of health is holistic, encompassing mental, physical, cultural and spiritual health.'[1]

Mental health service provision should also take account of the socio-cultural, historical and political experience of many Aboriginal people. This experience is often characterised by systemic racism and cultural dispossession resulting in lack of communal self worth. These issues are inextricably linked with the mental health issues facing Aboriginal people.[2]

Further, the provision of mental health services must be conscious of issues of cultural safety. Culturally unsafe practices are those that 'diminish, demean or disempower the cultural identity and wellbeing of an individual.'[3] If culturally safe practices are not put in place, there is a risk of misdiagnosis. This might, for example be due to miscommunication issues between doctor and patient for reasons such as the complexity of medical language used or the non-use of interpreters, or where an individual suffers from both mental health issues and substance misuse issues.

It is vital that all individuals who work with Aboriginal people be both culturally informed and skilled in relation to Aboriginal ways of communicating, and Aboriginal conceptions of mental health. The National Strategic Framework for Aboriginal and Torres Strait Islander Health refers to the need for:
'Mainstream services that are more responsive to the emotional and social well-being needs of Aboriginal and Torres Strait Islander peoples, particularly those living with serious mental illness and chronic substance misuse.'[4]

All health professionals working with Aboriginal people should undergo education and training in Aboriginal Mental Health, so they can fulfil their roles with utmost care, respect and diligence.

[1] Patricia Swan and Beverly Raphael, *Ways Forward: National Aboriginal and Torres Strait Islander Mental Health Policy: National Consultancy Report* (1995).
[2] Ibid.
[3] Ibid.
[4] National Aboriginal and Torres Strait Islander Health Council for the Australian Health Ministers' Conference, National Strategic Framework for Aboriginal and Torres Strait Islander Health (2003)

a. Language and Interpreters

Recommendation 2:

More funding should be provided to the Aboriginal Interpreter Service so that more interpreters are trained and available for mental health service needs. Mental Health workers should receive training in the appropriate use of interpreters.

Approximately 11% of Aboriginal and Torres Strait Islander peoples speak an Aboriginal or Torres Strait Islander language as their main language at home.[5] This percentage increases to 42% in many remote areas of Australia.[6] Almost one in five (19%) Aboriginal and Torres Strait Island language speakers report that they do not speak English well or at all.[7] Despite this fact, there continues to be a shortage of interpreters available to assist Aboriginal clients. This can largely be attributed to the insufficient funding received by interpreter services and related problems of inadequate resources available for training, recruitment and retention of staff.

There is real danger that Aboriginal people will

- be provided with inadequate mental health services;
- receive mistaken mental health diagnoses; or
- be excluded from accessing mental health services

unless communication is clear, and interpreters are used appropriately.

4. Remote Communities

Recommendation 3

Mental health service provision in remote communities should be increased to ensure Aboriginal people living remotely have equal access to quality mental health service provision.

Approximately 29% of the Australian population, including 64% of the Aboriginal population, live in rural and remote areas.[8] The skewed proportion of Aboriginal people living in rural or remote areas is more pronounced in the NT than other parts of Australia. The Australian Bureau of Statistics points out that '81% of the Indigenous population counted in the Northern Territory lived in Remote/Very Remote areas.'[9]

[5] Australian Bureau of Statistics, *National Aboriginal and Torres Strait Islander Social Survey* (2008) Australian Bureau of Statistics <http://abs.gov.au/AUSSTATS/abs@.nsf/Latestproducts/4714.0Main%20Features52008?opendocument&tabname=Summary&prodno=4714.0&issue=2008&num=&view=#PARALINK4> at 4th May 2010.
[6] Ibid.
[7] Australian Bureau of Statistics, *Population Characteristics, Aboriginal and Torres Strait Islander Australians* (2006) <http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/70E4BD21542AAD18CA257718002A7CC1?opendocument> at 4th May 2010.
[8] National Health and Medical Research Council, *When it's Right in Front of You: Assisting Health Care Workers to Manage the Effects of Violence in Rural and Remote Australia* (2002) 5 <http://www.nhmrc.gov.au/_files_nhmrc/file/publications/synopses/hp16.pdf>.
[9] Australian Bureau of Statistics, *4705.0 - Population Distribution, Aboriginal and Torres Strait Islander Australians* (2006) <http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4705.0Main+Features12006?OpenDocument>.

a. The Pressing Need for Mental Health Services in Remote Areas

In their article, 'Disadvantage and Discontent', the Centre for Rural and Remote Health conclude that Aboriginal peoples living in rural or remote communities experience higher levels of mental illness than Aboriginal people living in metropolitan areas.[10] Widespread socio-economic disadvantage and lack of access to vital social and healthcare services are some of the factors that exacerbate this problem.[11]

Despite the heightened mental health needs of Aboriginal people living in regional and remote areas of the NT, there is a significant lack of services on the ground. This includes mental health treatment and specialist services.

Statistics reveal that '30-50% of residents of discrete Indigenous communities have no access to allied health or mental health care workers'.[12] In addition there is a general lack of crisis intervention services and access to mental health specialists. In one instance, one of NAAJA's clients attempted self harm by cutting his wrists and throat. The police detained the client and took him to the local health care clinic. The clinic tended to the client's injuries; however they offered no mental health assistance or follow up.

Where mental health services do exist, their effectiveness is limited by factors such as under-resourcing, misdiagnosis, adherence to Western models of treatment, language barriers and the failure of medical clinics to refer clients to mental health services for assessment.[13]

NAAJA's experience is that nurses and community liaison workers in remote clinics generally work well to try to ensure that clients with mental health issues receive their prescribed medication. Where an individual has family support, such arrangements may be adequate. But where they lack family support or need mental health assistance beyond the administration of medication, deficiencies can arise. This includes the unwillingness or unavailability of specialists to travel to remote communities.

One way in which NAAJA encounters this issue is when a criminal lawyer requests a report pursuant to s 77 of the *Mental Health and Related Services Act* (NT). Section 77 provides that a Magistrate may dismiss a charge being heard summarily where the court receives a report that at the time of carrying out the conduct constituting the alleged offence, the person was suffering from a mental illness or mental disturbance and this materially contributed to the offending.

We are concerned at instances where report writers under the *Mental Health and Related Services Act* have not travelled to remote communities to provide court ordered reports. This has resulted in clients not being assessed. As a flow on consequence, these clients have then been less likely to receive treatment that might flow from these assessments or have beneficial results in their criminal proceedings such as having charges dismissed under s 77.

[10] Centre for Rural and Remote Mental Health, 'Disadvantage and Discontent: A Review of Issues Relevant to the Mental Health of Rural and Remote Indigenous Australians' (2007) 15 *Australian Journal of Rural Health* 88, 89.
[11] Ibid.
[12] Centre for Rural and Remote Mental Health, 'Disadvantage and Discontent: A Review of Issues Relevant to the Mental Health of Rural and Remote Indigenous Australians' (2007) 15 *Australian Journal of Rural Health* 88, 91.
[13] See for example, Nola Purdle, Pat Dudgeon and Roz Walker (eds), 'Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice' (2010).

Another issue is the lack of video link facilities, which further restricts the ability of people to receive mental health assistance in their community. This is described below in the following report by one of NAAJA's criminal lawyers.

Case Study – Lack of Video Link Facilities in Many Remote Communities

There are no video link facilities in most communities so we can't have clients seen by an independent psychiatrist by video link. We would have to bring the psychiatrist to community or take the person to Darwin (which can be difficult if they are unwell). This also means that we can't call such evidence by video link at their court proceedings if that takes place in community.

Aboriginal people living in remote communities should be provided with access to mental health services of the same 'quality, predictability, sustainability and practitioner continuity'[14] as those living in metropolitan areas.

This is consistent with Objective 1.2 of the National Indigenous Law and Justice Framework. This provides that Aboriginal peoples in all social settings should be given greater access to 'effective, inclusive, responsive, equitable and efficient services that are adequately funded and reviewed, so that they ensure just outcomes for Aboriginal peoples.'[15]

b. Travel Required to see Mental Health Professionals

Recommendation 4

Remote clients required to travel to access mental health services should be provided with intensive and tailored support.

Mental health clients from remote communities are routinely expected to travel to Darwin to attend appointments. NAAJA encounters regular instances where remote clients are expected to make their own way to Darwin to attend a psychological or psychiatric appointment and are simply ill-equipped to do this without intensive and coordinated support.

c. Community Controlled Services

Recommendation 5

Wherever possible, community mental health services should employ and be managed by Aboriginal staff.

Recommendation 6

There should be increased funding, support and training for Aboriginal mental health workers.

[14] Ibid.

[15] Standing Committee of Attorneys-General Working Group on Indigenous Justice, *National Indigenous Law and Justice Framework 2009-2015* (2009) <http://www.ag.gov.au/www/agd/rwpattach.nsf/VAP/(8AB0BDE05570AAD0EF9C283AA8F533E3)~IPS+-+National+Indigenous+Law+and+Justice+Framework+-+FINAL+-+PDF+version.PDF/$file/IPS+-+National+Indigenous+Law+and+Justice+Framework+-+FINAL+-+PDF+version.PDF>.

Self determination is integral to Aboriginal well-being and to effective provision of non-marginalising, culturally relevant services. There should be a dedicated focus on utilising external, non-government mental health services that are run by Aboriginal people for Aboriginal people. This is particularly the case given the acknowledged success of community-controlled health services in the NT.[16]

It is crucial that the mental health services have well trained Aboriginal staff that can support Aboriginal people and their families. These staff should be provided with appropriate and recognised training, as well as mentoring and ongoing support.

Successful mental health services must also involve a collaborative partnership between the local health clinic, the local community, the mental health service, and the client's family. Knowledge of family, skin or clan groups, language skills and ensuring trust and building confidence with clients is particularly important for effective community based mental health service provision.

d. Community Education and Health Promotion

Recommendation 7

Aboriginal Community Education and Health Promotion should be funded. This should include education about the causes of mental health problems, the benefit of prevention and early intervention and treatment options.

In addition to providing assessment and treatment services, mental health strategies in regional and remote Aboriginal communities should focus upon community education and mental health promotion.

The 'Ways Forward' Report highlights that, '[a]ny approach to Aboriginal mental health based simply on direct treatment programs, is unlikely to impact significantly on outcomes for Aboriginal communities.'[17] Successful approaches to mental health need to include education about the causes of mental health problems, the benefit of prevention and early intervention and treatment options. For example, Key Result Area Four of the National Strategic Framework for Aboriginal and Torres Strait Islander Health states:

'Promotion and prevention approaches that enhance social and cultural well-being for a range of community groups including children, young people, women, males and elders'.[18]

It is NAAJA's experience that family members and communities who are concerned about mental health wellbeing often have a poor understanding of what constitutes mental illness and how mental illness can be treated. Greater emphasis is needed on education and mental health promotion to help combat these issues.

[16] Patricia Swan and Beverly Raphael, *Ways Forward: National Aboriginal and Torres Strait Islander Mental Health Policy: National Consultancy Report* (1995).
[17] Ibid 85.
[18] National Aboriginal and Torres Strait Islander Health Council for the Australian Health Ministers' Conference, National Strategic Framework for Aboriginal and Torres Strait Islander Health (2003)

5. Prisons

Prisoners with mental health issues are some of the community's most vulnerable and high needs people. They often present with co-morbid issues such as intellectual impairments, hearing impairments, and substance misuse issues. Properly treating prisoners with mental heath issues involves addressing their holistic, broader social needs.

It is NAAJA's experience that prisoners with mental health issues do not have many of their broader needs met. This includes lack of access to programs, lack of access to interpreters or hearing aides, restricted opportunities to transfer to lower security areas of the prison, and poor repatriation and post-release support practices.

a. Lack of access to programs

Recommendation 8

Prisoners with mental health issues should have equal access to rehabilitation programs. If they are not suitable for group programs, individual, tailored programs should be provided.

People with mental health issues are often precluded from participating in rehabilitation programs at Darwin Correctional Centre (DCC). This is because their behavioral needs are assessed as being too high.

NAAJA has raised this issue with the DCC. The DCC has responded by claiming that this category of offender receives personalised, one-on-one treatment. NAAJA is not aware of any of our clients with mental health issues in DCC being provided with one-on-one treatment by the DCC.

Case Study: lack of access to programs

A NAAJA client has a diagnosis of schizophrenia. He is medicated through the prison clinic. He has a lengthy history of violent offending. He often relapses, and when he does, is transferred to the maximum security section of the prison until he is stabilised.

This client has requested that he be admitted into rehabilitation programs for the past four years. He has consistently been denied. The reasons provided are that he is too dangerous, and that individual treatment is more appropriate. He has not been provided with any individual treatment, and continues to request access to rehabilitation programs. Even when he is stabilised for long periods of time, he is denied access to programs.

NAAJA has written to DCC asking that he be re-assessed for access to programs, once his mental health has stabilised for a period of time. This request has been ignored.

The consequence of this client not being provided with programs is that he is not given an opportunity to gain insight into his offending, and rehabilitate through treatment. He is also unlikely to be classified as a low security prisoner, and is unlikely to be granted parole.

This ultimately means that this client will likely be released unsupervised and unsupported, contrary both to his or the community's needs.

The long-term implications of denying prisoners with mental health issues access to programs is that they are not provided with any rehabilitation treatment. This precludes them from accessing parole. They are, therefore, required to serve their full sentence in the medium security section of the prison, and are likely to be released unsupported. Accordingly, their risk of recidivism remains high.

NAAJA submits that prisoners with mental health issues should have equal opportunities to access rehabilitation treatment whilst incarcerated. If it is not appropriate for them to participate in a group context, they should be provided with individual treatment.

b. Lack of access to low security classification

Recommendation 9

Prisoners with mental health issues should have equal access to low and open security classification.

Prisoners with mental health issues are treated from the medical clinic, which is located in the medium security section of the prison. Prisoners who require regular treatment (such as medication monitoring, or fortnightly depot injections) are not permitted to transfer to the low or open security sections of the prison, as they are required to reside in close proximity to the clinic.

The conditions in the medium security section of the prison are characterized by regular lock-downs (usually for a minimum of 18 hours per day), restricted work opportunities, and restricted reintegration opportunities.

Conversely, the low security section of the prison has few lock down restrictions, opportunities to work both within and outside of the prison, education opportunities, opportunities to progress to open-security classification and reside in cottages as opposed to cells, and more general reintegration support.

Having the opportunity to transfer to the low security section of the prison, and participate in the opportunities provided, is also looked upon favorably by the NT Parole Board. It is difficult for prisoner's in the medium security section of the prison to achieve parole.

Because prisoners with mental health issues are denied access to both programs and the low security section of the prison, they are subsequently also denied parole. Again, this results in prisoners with mental health issues being released unsupported and unsupervised when they reach their full term date.

NAAJA submits that it is important that prisoners with mental health issues have the same classification opportunities as prisoners without mental health issues. The prison should accommodate for medication requirements in the low and open security sections of the prison. This will ensure prisoners with mental health issues have rehabilitation and reintegration opportunities.

c. Lack of post-release support and repatriation assistance

Recommendation 10

All prisoners with mental health issues should be provided with intensive post release planning and support.

There is a marked lack of post-release support and repatriation assistance for prisoners with mental health issues. This is a significant area of need because, as discussed above, prisoners with mental health issues are less likely to achieve a supported release through parole, having been denied rehabilitation and low security classification opportunities. Additionally, because many prisoners with mental health issues are likely to have previously breached suspended sentences, or other supervisory orders, they are more likely to be sentenced to an actual, rather then suspended, term of imprisonment. Prisoners with mental health issues are therefore often in a situation of also being released without court ordered supervision.

Accordingly, without supervision from parole, or a court order, it is essential that prisoners with mental health issues be provided with sufficient post release support and proper repatriation assistance.

Case study: inappropriate repatriations

A NAAJA client has a diagnosis of schizophrenia. He was medicated through the prison clinic. Two weeks prior to release, he was asked where he wanted to be repatriated to. He advised he wanted to return to his home community, on an island two hours flight from Darwin. The prison booked and paid for his airplane ticket.

G was not explained the process of catching an airplane. He was not provided with an escort to the airport, or provided with assistance at the airport. He was released outside the prison with a taxi voucher.

NAAJA is not aware of whether he had explained his medication regime. NAAJA is also not aware of whether arrangements were made between the prison clinic and the community clinic for his medication to be available upon his arrival. G was not provided with any medication upon release.

G failed to catch his flight, and rather caught the taxi to the Long Grass. Given that G is not under any supervisory orders, there are no services who can take responsibility for G's welfare.

NAAJA has had a number of clients released without their medication. Lack of post release clinical and broader social support exposes prisoners with mental health issues to a high level of risk.

NAAJA recommends that all prisoners with mental health issues be provided with comprehensive post release support. This would ensure they are not exposed to high levels of unacceptable risk. It would also assist in their reintegration, and reduce the likelihood of reoffending.

6. People found not guilty due to mental impairment

a. Supervision orders

Recommendation 11

A wider range of appropriate community based accommodation must be made available for people subject to supervision orders.

Recommendation 12

Urgent priority must be given to developing an appropriate forensic mental health facility in the NT.

Part IIA of the *Criminal Code* (NT) provides for the defence of mental impairment and contains provisions for dealing with accused persons who are not fit to stand trial.

In practice, a finding of not guilty because of mental impairment or unfitness to be tried results in a person being placed on an indefinite 'supervision order'.

Supervision orders may be custodial or non-custodial and subject to such conditions as the court considers appropriate.

There are very limited community based accommodation options for people subject to supervision orders. NAAJA is very concerned that this results in people being subject to custodial supervision simply because there is no feasible alternative.

Where a person is subject to a custodial supervision order, they are held in prison – there is no other place available for such people to be held. There is no forensic mental health facility in the NT. This is completely unsatisfactory and inappropriate. Jail is a punitive, non-therapeutic environment that makes treatment of people's mental illness harder. Where people have not been found to be criminally responsible for an offence, they should not be subject to imprisonment.

This situation will not change until at least 2014 when a new prison precinct is to be built on the outskirts of Darwin, at Holtze. The precinct is to include a Mental Health Behavioural Management Facility. In NAAJA's view, this is too long to wait for people to be held in appropriate conditions. NAAJA is also concerned that this facility will be a 'one size fits all' model that will not ensure that people are subject to the least restrictive conditions necessary to maintain community safety.

a. Lack of Appropriate Throughcare assistance

Recommendation 13

People subject to custodial supervision orders should be provided with intensive post-release planning and support.

People held on custodial supervision orders often receive little rehabilitation and reintegration support. The quality of mental health care provided to persons held in prison is

also vastly inadequate. This means they are less likely to have their supervision order revoked at the court review date. NAAJA considers it essential that people subject to supervision orders be provided with intensive rehabilitation, post-release planning, and step-down from custody programs, so as to facilitate their reintegration into the community.

NAAJA currently has a prisoner Throughcare program that provides intensive pre- and post-release support to prisoners, but we lack the specialist expertise to assist clients with high-needs due to mental impairment.

Case Study – Lack of Throughcare Support

A NAAJA client was found not guilty due to mental impairment three years ago. He has a diagnosis of schizophrenia. He has being housed at the Darwin Correctional Centre as there are no appropriate community based accommodation options.

The client has been provided with no rehabilitation programs, or reintegration support whilst incarcerated. NAAJA is concerned that he is becoming institutionalised and will likely find any transition back into the community difficult. NAAJA is also concerned that the longer this client remains in custody, without rehabilitation programs and reintegration support, the less likely the court will release him from the custodial supervisory order.

7. Young People

Recommendation 14

Youth specific mental health assessments and services should be available for young people involved in the criminal justice system.

The connection between youth offending, mental illness and intellectual disability is an under-explored area in the NT. A NSW study found that intellectual disability was particularly high amongst Aboriginal young offenders, and that over 88% of young people in custody reported symptoms consistent with mental illness.[19]

It is NAAJA's experience that many Aboriginal young offenders have never had their mental health properly assessed, despite the presence of obvious symptoms. These young people cycle through the youth justice system without receiving the specialist interventions which could identify and begin to address the underlying causes of offending.

Over 90% of young people in juvenile detention in the NT are Aboriginal. Mental health responses must be tailored to the specific socio-cultural needs of Aboriginal young people.

Alcohol consumption is a major, well known social issue in the NT. Despite this, foetal alcohol disorders are markedly undiagnosed and unaddressed in the NT. The prevalence of such disorders amongst Aboriginal young offenders is unknown. We note the comprehensive discussion of Foetal Alcohol Spectrum Disorder contained in the 'Doing Time – Time for Doing' report.

[19] Kelly Richards, *Trends in Juvenile Detention in Australia* (May 2011) Australian Institute of Criminology <http://www.aic.gov.au/documents/D/6/D/{D6D891BB-1D5B-45E2-A5BA-A80322537752}tandi416.pdf>.

The NT requires accessible mental health services for young people involved in the youth justice system. If the court's priority is a young person's rehabilitation, and ultimately to prevent recidivism, young people must have ready access to mental health services and court must be able to structure their responses to offending to reflect the limitations, needs and capacities of the young person before it.

a. Other Jurisdictional Practices

Both NSW and Victoria have incorporated mental health responses into the administration of the youth justice system. The Victorian Children's Court has a 'Children's Court Clinic', staffed by specialist psychologists and psychiatrists. Clinic practitioners provide assessment and reports recommending specific treatment needs, and also act as a referral service.[20]

In NSW mental health nurses are available at youth courts. They provide assessment and referral services, ensuring the court is fully informed of a young person's mental health status at the time of sentencing. This means that court processes and sentences can be tailored to a young person's developmental and cognitive needs.

8. Involuntary Detention

Recommendation 15

Community Health Clinics and Police Stations should be adequately resourced to ensure that someone who has been sectioned under the *Mental Health and Related Services Act* (NT) is appropriately supervised and kept safe.

a. Apprehension under Section 32A of the Mental Health and Related Services Act

The *Mental Health and Related Services Act* (NT) contains provisions for the apprehension and assessment of a person to determine whether they are in need of treatment. There are particular issues that arise where a person is involuntarily apprehended in a remote community.

NAAJA's experience is that there is a lack of appropriate resources, staff and facilities in remote health clinics and police stations to ensure that someone who has been apprehended under the *Mental Health and Related Services Act* is appropriately supervised and kept safe.

Case Study – Lack of Secure Supervision

NAAJA has a client from a remote community who was suicidal. The police apprehended him under the *Mental Health and Related Services Act* and took him to the clinic for supervision. He managed to abscond from the clinic on two or three occasions. He was chased by police and whilst running away from the police due to paranoia, fell down an embankment and sustained serious injuries.

He then was secured in the back of a paddy wagon because the police officer was unwilling to take him back to the clinic.

[20] See: Children's Court of Victoria, *Children's Court Clinic* (2009) <http://www.childrenscourt.vic.gov.au/CA256CA800017845/page/Family+Division-Clinic?OpenDocument&1=20-Family+Division~&2=90-Clinic~&3=~>.

b. Inappropriate Conditions

NAAJA has concerns around the conditions in which patients deemed to be at risk to themselves or others are kept. A NAAJA solicitor provided the following example.

Case study – Shackling

'I represented an Aboriginal man from a remote community in an Adult Guardianship application at the Darwin Local Court. On visiting him at Royal Darwin Hospital (RDH), I observed him to be in a solitary room. Three of his limbs were shackled to the bed. A patient care assistant was assigned to him 24 hours a day. Hospital staff advised that the man had occasional random violent outbursts and had assaulted a nurse without provocation, hence the shackles. Communication was very difficult – I assumed it was due to a combination of his limited English and his mental health issues.

Apparently the man had been assessed as not meeting the criteria to be admitted to Cowdy Ward and accordingly, there were no Mental Health Review Tribunal orders (or from any other Court or Tribunal). However, RDH explained that they were restraining him "under common law for the protection of himself and others" as there were no suitable services to care for someone with such high care needs and violent tendencies. An adult guardianship order was made but it was likely going to take quite some time for arrangements to be made for the man to be released from RDH.'

c. Culturally Relevant Representation Before the Mental Health Review Tribunal

Recommendation 16

NAAJA and NT Legal Aid should be adequately funded to represent people at the Mental Health Review Tribunal.

The Mental Health Review Tribunal is established to make decisions about the care and treatment of people who have a mental illness or mental disturbance. The Tribunal decides whether a person needs to be treated as an involuntary patient and provides clients an opportunity to challenge an involuntary admission.

NAAJA and the NT Legal Aid Commission previously provided duty lawyer services to the Mental Health Review Tribunal. NAAJA's service sought to provide a culturally relevant approach for our clients. It included an Aboriginal Client Service Officer as well as a solicitor. Importantly, we were also able to provide advice to clients not only on the day of their Tribunal hearing, but also in advance.

NAAJA and NT Legal Aid are no longer able to provide this service as we have no specific funding for such service provision. We recently submitted a joint funding proposal to the NT Government which would have allowed us to resume this service. This was declined. The NT Government is funding a panel of private solicitors to provide a duty lawyer service to Aboriginal and non-Aboriginal clients.

In our submission, this arrangement is unsatisfactory because private solicitors are not able to bring the culturally relevant approach which NAAJA specialises in. Clients are also not

provided with continuity of care, as many clients with matters before the Mental Health Review Tribunal, also have ongoing criminal matters, for which NAAJA or NT Legal Aid provide representation.

This was pointed to by the Tribunal President in his 2009 Annual Report:

> [I]t is preferable that legal representation comes from both organizations… NAAJA are better geared to representing indigenous patients in any event. Not only are lawyers employed by NAAJA more experienced in general terms with cultural and other relevant issues, the availability of an Aboriginal Client Service Officer is often a great advantage in the preparation process. The previous duality of representation fostered efficiency at Tribunal hearings, especially at times when reports have been provided late by MHS, as it then enabled the sequence of hearings to be alternated so that lawyers had sufficient time to prepare for their next hearing without the need to delay hearings. That option is now no longer available.

There are other operations of the Mental Health Review Tribunal that are disadvantageous to Aboriginal clients. The Tribunal does not have the capacity to sit in remote locations. This means that family and community members of the person concerned are not able to attend proceedings to better inform Tribunal proceedings.