GREEN BILL ON MENTAL HEALTH 2012

Assessing the Impact of the Bill on Young People

Youth Affairs Council of Western Australia
Submission

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I INTRODUCTION & ABOUT YACWA

The Youth Affairs Council of Western Australia (***'YACWA'***) welcomes the opportunity to provide a submission in response to the green Mental Health Bill 2012 (***'the Bill'***).

The following submission provides a specific analysis into how the Bill's provisions will affect young people and their families, peers and carers in Western Australia.

In assessing the extent of the Bill's impact, the following issues will be considered:

- Access to services and support,
- Whether any breaches of child rights exist, and
- The position held by the Stokes review and similar submissions.

The Youth Affairs Council of Western Australia (YACWA) is the peak non-government youth organisation in Western Australia with a membership of over 300 youth service organisations, community organisations, academics, individuals and most importantly young people themselves. Established in 1980, YACWA has worked tirelessly for 30 years to deliver high-level representation and advocacy for the Western Australian youth sector and young people.

Our role is to:

- Act as a lobbying group for the non-government youth sector and Western Australian young people aged 12-25
- Provide information and support to the non-government youth sector
- Work to promote fair and positive outcomes for young people in our community
- Promote equity, equality, access and participation for young people in Western Australia
- Advocate to all levels of government on the best interests of Western Australia's young people
- Encourage the active participation of young people in identifying and dealing with issues that are important to them
- Improve youth services by exchanging ideas, information, skills and resources
- Provide a strong, united and informed voice capable of effectively advocating for the non-government youth sector and the young people with whom they work

II EXECUTIVE SUMMARY & RECOMMENDATIONS

WHAT IS MENTAL HEALTH?

The World Health Organization defines mental health as "a state of well-being in which an individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community."[1] Conversely, mental illness has been defined as a number of diagnosable disorders that can significantly interfere with a person's cognitive, emotional or social abilities.[2] Such problems and illnesses are said to be among the greatest causes of disability, diminished quality of life, and reduced

[1] World Health Organisation, *Mental Health: Strengthening Our Response*, (2010) (cat. No. 220).
[2] Australian Bureau of Statistics, *Gender Indicators – Australia*, Jan 2012 (cat. No. 4125.0), www.abs.gov.au.

productivity. Sufferers also commonly have poorer general health and higher rates of death from a range of causes.[3]

HOW DOES IT AFFECT YOUNG PEOPLE?

In Australia, almost half of the population are said to experience mental health disorders at some point in their lives.[4] Young people aged 18-24 years have the highest prevalence of mental disorders of any age group at 27%.[5] With research indicating that 75% of adult mental disorders present before the age of 25 years,[6] it is thus integral to implement a service and system that ultimately respects the rights and individual considerations in providing support and help for those with mental health problems.

However, previous studies indicate severely low attendance rates regarding mental health services for young people with mental health problems.[7] This has been attributed to barriers such as cost of attending services, stigma associated with seeking help, not knowing where to get help, confidentiality, fear about what the service would do,[8] and factors relating to demographics, emotional competency, social influences, relationships with friends and family members, and attitudes and beliefs towards help-seeking.[9] These barriers have contributed significantly to the poor mental health outcomes experienced by young people.[10]

WHAT IS CURRENTLY BEING DONE?

Mental health problems can be significantly more serious for young people who are still developing, than for people later in life.[11] Hon. Helen Morton MLC, the Minister for Mental Health and Disability Services has recently announced that the Western Australian Government will be committing $15.3 million over three years for youth mental health services, specifically targeting early psychosis intervention and treatment.[12] However, we believe there has been insufficient consideration of the unique needs of children, adolescents and young adults within the Bill's provisions.

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[3] *National Mental Health Plan 2003 -08.*
[4] Australian Bureau of Statistics, *Gender Indicators – Australia*, Jan 2012 (cat. No. 4125.0), www.abs.gov.au.
[5] McLennan A, *Mental Health and Wellbeing: Profile of Adults, Australia.* (1998) Canberra: Australian Bureau of Statistics.
[6] Burns J, Morey C, Lagelee A, Mackenzie A and Nicholas J, 'Reach out! Innovation in service delivery', 187 (7) *Medical Journal of Australia*, s31.
[7] Sawyer MG, Arney FM, Baghurst PA, Clark JJ, Graetz BW, Kosky RJ, Nurcombe B, Patton GC, Prior MR, Raphael B, Rey JM, Whaites LC, Zubrick SR. 'The mental health of young people in Australia: key findings from the child and adolescent component of the national survey of mental health and wellbeing', (2001) 35(6) *Aust N Z J Psychiatry*, 806-14.
[8] Donald M, Dower J, Lucke J & Raphael B (2000), 'The Queensland young peoples mental health survey report' Centre for Primary Health Care, School of Populations Health and Department of Psychiatry, University of Queensland. Brisbane, Australia.
http://www.eric.ed.gov/ERICWebPortal/search/detailmini.jsp?_nfpb=true&_&ERICExtSearch_SearchValue_0=ED457424&ERICExtSearch_SearchType_0=no&accno=ED457424 accessed Feb 2013.
[9] Rickwood, D., Deane, F.P., Wilsom, C.J & Ciarrochi, J. 'Young people's help-seeking for mental health problems' (2005) 4(3) *Australian e-Journal for the Advancement of Mental Health*, 1-34.
[10] B Stokes, *Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia*, (2012), Government of Western Australia – Department of Health.
[11] Ibid, ix.
[12] See http://www.mentalhealth.wa.gov.au/Homepage.aspx (accessed Feb 2013)

HOW SHOULD WE ADDRESS THIS PROBLEM IN THE BILL?

Whilst similarities do exist with respect to other age groups within our community who require mental health services,[13] young people also have their own particular mental health needs, characteristics, challenges and problems that require specific attention by health services. [14] The period between being a child, to adolescence, and ultimately into young adulthood is an integral developmental period.[15] A young person's social and emotional wellbeing is put under intense pressure during this time, as they push away from family and educational dependence into becoming more autonomous individuals. What is required is a more considered and developed Bill, which expressly recognises the diverse needs of young people within our community. The following submission aims to highlight where we believe change is needed most.

RECOMMENDATIONS

Throughout our submission we have made a number of recommendations they are provided here for reference:

Part A – Capacity to consent to treatment

1. That capacity to provide consent under the Bill is amended to three categories of age groups relating to young people. These would be 0-14 (a child), 14-17 (mature minor) and 18-25 (young adult).
2. That in determining capacity, an adequately trained child and adolescent psychiatrist be required to be involved in any assessment regarding children and young people.
3. That the qualifications and training required by such psychiatrists be provided in the Bill.

Part B – Involuntary Treatment Orders

4. That a specific division be inserted regarding the use of involuntary treatment orders on persons under 25. This would reduce the ambiguity and increase the transparency of the current Bill.
5. That only a child, adolescent and young persons psychiatrist be allowed to make any involuntary treatment orders regarding persons under 25.
6. To ensure a more equitable and accessible service, which will reduce the differing levels of service encountered by young people from geographically diverse and vulnerable backgrounds.
7. To ensure that young people will be examined in appropriate facilities, and most importantly, separated from adults during the term of any order.
8. To ensure that young people will be examined in appropriate locations, respecting the cultural, age, gender and other important factors during treatment.

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[13] The National Mental Health Working Group (Cth), *Responding to the mental health needs of young people in Australia – Discussion paper: principles and strategies* (2004), X.
[14] The National Mental Health Working Group (Cth), *Responding to the mental health needs of young people in Australia – Discussion paper: principles and strategies* (2004), 5.
[15] Ibid.

Part C – Community Treatment Orders

See recommendation 6.

Part D – Transport Orders

9. That the Bill be amended to include the required level of training necessary for transport officers, and for this to be in line with Commonwealth and State guidelines. (See Stokes Review 1.3)
10. For the Bill to contain a provision ensuring the separation of young people under 25 and adults based on age and gender whilst under transport orders. This is especially significant in circumstances involving substantial distance and time.
11. For fast-track systems to be implemented when the transfer of a young person is required.

Part E – Apprehension, search and seizure powers

12. That the Bill be amended to ensure that specialist training in mental health issues is undertaken by all police officers in Western Australia, so as to guarantee the highest sensitivity and care in circumstances which require their involvement.
13. To ensure that a second person is present during any search, preferably a medical practitioner of the same sex as the patient.

Part F – Provision of treatment

14. To ensure that children, adolescents and young people have the ability to seek specific opinion from sufficiently trained and experienced child, adolescent and young persons psychiatrists during the provision of treatment.
15. To ensure that the provisions outlined in Part 12 with respect to the treatment of Aboriginal or Torres Strait Islander patients are non-derogable, unless it is at the patient's request.

Part G – Regulations of certain kinds of treatment

16. For the Government to justify its position regarding the use of ECT and psychosurgery on young people. Failing to do this, to remove such procedures from being used on persons under 25.
17. To ensure that review to the Mental Health Tribunal should be mandatory for all procedures under Part 13 for persons under 25.
18. For separate provisions governing the use of emergency psychiatric treatment on young people 25 years or younger be implemented.
19. For the practice of seclusion and bodily restraint to be banned on persons under the age of 18.
20. That in the event of persons aged between 18-25 being subjected to such treatment, only a psychiatrist may make the order, that this order can be authorised for a period up to 3 hours, and that a medical practitioner is required to examine the patient every 30 minutes.

Part H – People in hospitals: Health care generally

21. That young people, and people in general, are ensured respect of cultural and religious factors when assessed on entry into an authorised health service.

Part I – Protection of patient rights

22. To ensure that all children, adolescents and young people are separated from adults whilst in treatment.
23. Failing this, similar to the Recommendation made by the Commissioner for Children and Young People,[16] YACWA recommends the implementing of a statewide review service on the suitability of authorised facilities to treat children and young people.

Part J – Recognition of rights of carers and families

24. To ensure that young people who do not have capacity to consent to treatment, have their views taken into account where reasonably possible when disclosing information of a confidential nature.

Part K – Children

25. See Recommendation 23.
26. That when assessing whether a mental health service can provide adequate treatment, care and support that is appropriate having regard to the child's age, maturity, gender, culture and spiritual beliefs, any assessment must be independently undertaken by a specialist child, adolescent and young persons practitioner, and the primary consideration being the child's best interests.

Part L – Complaints about mental health services

27. That a child, adolescent and young persons Tribunal to be established.
28. For the Bill to establish a 'guideline complaints procedure' for young persons, that will be used across the State at all suitable and authorised service providers.

Part M – Advocacy services available to young people

29. To ensure that any specific 'youth advocacy' service be readily available to all young people across the state to persons below the age of 25.
30. To ensure that the Act provides requirements for the appropriate training of 'youth advocates'.
31. To ensure that the Act provides for the requirement of advocates for the groups outlined in Part III of this submission.
32. That clause 343 is amended to ensure that the 'youth advocate' deals specifically with any matter brought up regarding persons under the age of 25.

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[16] Commissioner for Children and Young People (WA), *Submission to the Mental Health Commission on the Draft Mental Health Bill 2011*, (2012) Recommendation 5.

Part N – Mental Health Tribunal

33. For a specific child, adolescent and young persons Tribunal be established.
34. Failing this, a child, to ensure that an adolescent and young persons psychiatrist be a requirement for all cases involving persons under 18, and for the option to have such a psychiatrist for persons under 25.
35. To ensure that any involuntary treatment order be reviewed 7 days from an order being placed on a person 18 years or under.
36. To ensure that young people under 25 are ensured the option of free representation before the Tribunal.
37. To ensure that parties to proceedings bear no costs relating to the hearing.

Part O – Ministerial inquiries

38. To ensure that children and young people are not unfairly discriminated against during ministerial inquiries.
39. To remove the excessive penalty provision.

III THE VULNERABILITY OF YOUNG PEOPLE

Young people come from many diverse backgrounds, and the following groups show a predominantly higher rate of mental health problems and are said to experience severe barriers preventing them from accessing mental health services. The diversity of young people strengthens calls for particular care and sensitivity to be afforded in our mental health services when treating people below the age of 25.

A. YOUNG PEOPLE OF ABORIGINAL AND TORRES STRAIT ISLANDER DESCENT

Indigenous Australian's are said to be significantly more likely than non-indigenous Australian's to experience mental health issues[17], with a significantly higher rate of suicide, death from mental disorders and self-harm. [18]

Whilst provisions in the Bill contain mechanisms in place to support the needs of Aboriginal and Torres Strait Islander people's who require service and assistance,[19] substantial barriers relating to access (such as those living in rural and remote communities) will no doubt continue to exist without the legislative safe-guarding of proper treatment respecting their particular needs.

B. YOUNG PEOPLE WHO ARE DIVERSE SEX, SEXUALITY AND GENDER (DSSG)

[17] Edwards RW & Madden R, *The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples*, (2001), Australia Bureau of Statistics, Canberra.
[18] Brady M, *The Health of Young Aborigines*, (1991), Australian Institute of Aboriginal and Torres Strait Islander Studies, Canberra.
[19] For example, Green Mental Health Bill 2012 (WA) cl 48 and cl 181.

Research indicates that young people who identify as DSSG are up to six times more likely than heterosexuals to be affected by mental health problems and disorders.[20] Principle 6 of the Charter provides for non-discrimination on the basis of sexuality, sex or gender when accessing a service. However, YACWA is concerned that the needs of young people from this cohort are inadequately addressed in the Bill, especially with regards to confidentiality concerns during treatment.

C. YOUNG PEOPLE FROM CULTURALLY AND LINGUISTICALLY DIVERSE BACKGROUNDS (CALD)

Young people from a culturally and linguistically diverse background are said to experience a lower engagement rate with mental health services than other groups.[21] The introduction of measures to ensure that information be conveyed in a way that is understandable to the person given their cultural and linguistic background is a positive step in the Bill.[22] However, YACWA is concerned that significant barriers affecting service will no doubt continue to exist.

Specifically, refugee young people are said to be at an significantly higher mental health risk, due to their past exposure to traumatic experiences at a time when they are attempting to address the normal multiple developmental tasks of this age group.[23] It is thus integral to implement a service which adequately addresses this groups mental health needs, and YACWA believes that this is best done through care and sensitivity provided specifically to their needs.

D. YOUNG PERSONS IN THE CRIMINAL JUSTICE SYSTEM

YACWA believes that the current system inadequately addresses the needs of young people who suffer from mental health complications in our criminal justice system. The introduction of a diversion scheme in the Western Australia is a positive step towards ensuring proper treatment and early intervention.[24] However, issues concerning the proper identification of the existence of a mental health problem,[25] continued rehabilitation after release,[26] and ensuring access to advocacy services continue to exist. YACWA recommends the establishing of specific mental health courts to provide the required knowledge and sensitivity when young people encounter our criminal justice system.

E. YOUNG PEOPLE EXPERIENCING HOMELESSNESS

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[20] Ferguson DM & Horwood LJ, 'The Christchurch Health and Development Study: a review of findings on child and adolescent mental health' (2001) 35 *Australian and New Zealand Journal of Psychiatry*, 287-296.
[21] Queensland Health and Youth Affairs Network of Queensland Inc, *Coping in a new world: The social and emotional wellbeing of young people from culturally and linguistically diverse backgrounds*, (2001), Queensland Transcultural Mental Health Centre.
[22] See Green Mental Health Bill 2012 (WA) cl 18(4).
[23] Luntz JJ, 'The Centre for Young People's Mental Health: blending epidemiology and developmental psychiatry', (1998) 4 *Australian Psychiatry*, 243-7.
[24] http://www.mentalhealth.wa.gov.au/mentalhealth_changes/mh_legislation/Mental_Health_Court_Diversion.aspx (Accessed Feb 2013)
[25] Human Rights and Equal Opportunity Commission (Cth), *Human Rights and Mental illness, Report of the National Inquiry into the Human Rights of People with Mental Illness*, (1993) 1, Canberra.
[26] Kosky RJ, Sawyer MG & Fotheringham M, 'The mental health status of adolescents released from custody: a preliminary study', (1996) 30 *Australian and New Zealand Journal of psychiatry*, 326-31.

Studies indicate that whilst a high incidence of mental health problems exist in this cohort[27], young people who are homeless have a low rate of service use,[28] indicating significant barriers to service and the need to establish specific planning and services.[29] The unavailability of certainty in permanent accommodation and supportive networks such as family, friends and community services, make the provision of treatment for this group of young people extremely difficult. YACWA hold concerns that young homeless people may be more susceptible to involuntary treatment orders, detention, seclusion, restraint and other right-infringing treatment if the needs of young people are not sufficiently considered in any future Act. [30]

F. YOUNG PEOPLE LIVING IN RURAL AND REMOTE AREAS

There is recognition that young Australians living in rural and remote are more susceptible to psychiatric disorders.[31] With a recognised disparity in equal provision of service by the Australian Government for health services in rural areas, it is integral to recognise the health needs of our young people living away from the metropolitan area. It is internationally recognised that health services be easily accessible for people with disabilities regardless of where they live,[32] and that our Government has an obligation to ensure that children and young people with disabilities have special care and support.[33]

IV OUR INTERNATIONAL HUMAN RIGHTS OBLIGATIONS

The Australian Government, as a party to the United Nations Convention's on the Rights of the Child ('***CRC'***), Persons with Disabilities ('***CPRD'***) and the International Covenant on Civil and Political Rights ('***ICCPR***'), has explicitly agreed to ensure that new laws be enacted or existing laws be applied in a manner that gives proper expression to its treaty obligations. The treaties outlined above are the main conventions defining the rights of young people and person's with disabilities.

Our treaty obligations are voluntary, and our government has an obligation of good faith to comply with the treaty's provisions; and to take the necessary steps to give effect to those treaties under domestic law.[34] Further, the High Court of Australia's decision in *Minister for Immigration and Ethic Affairs v Ah Hin Teoh* held that ratification of a treaty raised a legitimate expectation that executive decision-makers will act consistently with its terms.[35]

It is in this context that YACWA has chosen to assess the Bill.

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[27] Kamieniechki G.W, 'Prevalence of psychological distress and psychiatric disorders among homeless youth in Australia: A comparative review' (2001) 35 Australian and New Zealand Journal of Psychiatry, 352-358.
[28] Reilly JJ, Herrman HE, Clarke DM, Neil CC & McNamara CL 1994, 'Psychiatric disorders in and service use by young homeless people', (1994) 161(7) *Medical Journal of Australia*, 429-32.
[29] The National Mental Health Working Group (Cth), *Responding to the mental health needs of young people in Australia – Discussion paper: principles and strategies* (2004), 9.
[30] *National Health and Medical Research Council Act 1992* (Cth).
[31] Fraser C, Judd F, Jackson H, Murray G, Humphreys J, Hodgins G, 'Does one size really fit all? Why the mental health of rural Australians require further research,' (2002) 1 *Australian Journal of Rural Health*, 288-295.
[32] UN General Assembly, *Convention on the Rights of Persons with Disabilities*, 13 December 2006, United Nations, Treaty Series, Article 24.
[33] UN General Assembly, *Convention on the Rights of the Child*, 20 November 1989, United Nations, Treaty Series, vol. 1577, Article 23.
[34] United Nations, *Vienna Convention on the Law of Treaties*, 23 May 1969, United Nations, Treaty Series, vol. 1155, Article 26.
[35] (1995) 183 CLR 273 at 291.

V KEY PROVISIONS CONCERNING YOUNG PEOPLE

A. THE LEGAL CAPACITY OF YOUNG PEOPLE TO CONSENT TO MEDICAL TREATMENT

The issue of consent for young people is vital as consent is the key to accessing health care, and because of the various individual rights concerning privacy, autonomy and liberty.

Part 5 of the Bill increases the criterion in determining capacity to provide consent. It proposes that children under the age of 18 will be presumed as not having 'capacity' to consent to treatment, [36] unless the child can show that they have an adequate understanding of the most important factors concerning any decision. [37]

These provisions are inherently discriminatory towards young people, as this determination substantially reduces their autonomy in making both serious and substantial decisions concerning their life. The implementation of such provisions will no doubt serve to be barrier to service as it is common for young people to view mental health services negatively, and seek privacy when dealing with their problems for fear of social stigma.[38] In an Australian Law Reform Commission publication titled *'Decision making by and for individuals under the age of 18'*, it was identified that a lack of confidentiality in accessing health services was a key barrier for young people.[39] Further, a study conducted in the United States reported that 25% of high school students would not seek health services because of confidentiality concerns.[40] Under the current provisions, a young person's parent or guardian against their wishes may voluntarily admit a child, if they fail to establish the capacity to provide consent.[41]

Under the CRC, both the State Party and the family are under a duty to respect the evolving capacities of the child, and to give the views of the child due weight according to the age and the maturity of the child in all matters,[42] which it is presumed would extend to medical decision making. There is no universally identifiable age limit regarding consent, and this is intentionally done so as to respect a young person's ability to understand the nature and implications of any proposed treatment; and their ability to be able and willing to make a decision. In Tasmania, Northern Territory and New South Wales, the presumption of incapacity exists, but a child in these jurisdictions mental health systems is defined as a person under the age of 14 years.

Placing onerous legislative hurdles in front of anyone dealing with mental illness must be done so with the utmost care and sensitivity. When dealing with young people whom may feel intimidated, scared and uninformed, we must ensure that their rights are upheld and that our system is sensitive to their needs. The clauses relating to capacity highlight a clear disregard by policy makers in recognising the developmental changes a young person encounters in

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[36] Green Mental Health Bill 2012 (WA) cl 13.
[37] Green Mental Health Bill 2012 (WA) cl 14.
[38] Wisdom, JP, Clarke GN & Green CA, 'What teens want: barriers to seeking care for depression', 22 *Adm Policy Mental Health*, 133-145.
[39] Australian Medical Association, *Submission to the Office of the Privacy Commissioner Review of the Private Sector Provisions of the Privacy Act 1988,* 21 December 2004, 21.
[40] T Cheng and others, 'Confidentiality in Health Care: A Survey of Knowledge, Perceptions, and Attitudes Among High School Students' (1993) 269 *Journal of the American Medical Association* 1404.
[41] Green Mental Health Bill 2012 (WA) cl 13.
[42] Above n, Articles 5 & 12(1).

adolescence and early adult-hood. Furthermore, this provision can be reasonably seen to unnecessarily increase anxiety and distress to a young person's experience during treatment.

In determining the capacity of a young person, a specialist child and adolescent psychiatrist should be required in any assessment. The government has noted that this is unworkable in our Western Australian context.[43] However, the diverse needs of children and young people in an important developmental phase of their life, requires the highest attainable assessment of their mental health needs. Essentially, a substantial barrier to service will exist as the failure to ensure such skilled persons be available in the assessment of capacity fails to prioritise what is in the child's best interests.

YACWA believes that young people may require confidentiality of their treatment in some circumstances, and that the rebuttable presumption of incapacity to consent for persons under 18 is inherently discriminatory to young people. The Australian Medical Association (AMA) provides that if a young person is able to make autonomous decisions about their treatment and wish for it to be confidential, then their practitioner must respect and remain that confidentiality.[44] Under the Bill, persons under the age of 18 are deemed to be incapable of consent, and as such have less control on the sharing of their personal information. If they have highly personal medical information which they have serious confidentiality concerns about, these confidentiality requests should be respected.[45]

The example of a young person, who identifies DSSG and seeks confidentiality in their treatment, may be deterred from seeking help if there is a reasonable chance that such confidentiality concerns will be ignored. The Stokes Review recommended that a service be established for youths with gender and sexual identity concerns,[46] which would go some way in respecting the sensitivity needed in treating young people in this cohort.

The current clauses of the Bill regarding *'capacity'* also raise an issue regarding continuity of care of young people. The transition from child health care systems to adult systems can be extremely difficult.[47] The Stokes review recommended that special provisions should be made for the clinical governance of the mental health needs of youth (16-25 years),[48] and YACWA is supportive of this recommendation in ensuring adequate service to young people.

Recommendations

1. That capacity to provide consent under the Bill is amended with three categories of age groups relating to young people. These would be 0-14 (a child), 14-17 (mature minor) and 18-25 (young adult).

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[43] Mental Health Commission (WA), *Update from Feedback on Draft Mental Health Bill 2011*, (2012), 7. http://www.mentalhealth.wa.gov.au/Libraries/pdf_docs/MH_Bill_response_7_11_12_1.sflb.ashx

[44] Australian Medical Association, *Submission to the Office of the Privacy Commissioner Review of the Private Sector Provisions of the Privacy Act 1988*, 21 December 2004, 21.

[45] See, eg, New South Wales Commission for Children and Young People, *Submission to the New South Wales Law Reform Commission on the Review of Laws Relating to the Consent of Minors to Medical Treatment*, 15 August 2003.

[46] B Stokes, *Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia*, (2012), Government of Western Australia – Department of Health. Recommendation 8.6.3.

[47] The National Mental Health Working Group (Cth), *Responding to the mental health needs of young people in Australia – Discussion paper: principles and strategies* (2004).

[48] B Stokes, *Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia*, (2012), Government of Western Australia – Department of Health, Recommendation 8.6.

2. That in determining capacity, an adequately trained child and adolescent psychiatrist be required to be involved in any assessment regarding children and young people.
3. That the qualifications and training required by such psychiatrists be provided in the Bill.

B. INVOLUNTARY PATIENTS

1. The making of orders generally (Division I)

The right to refuse medical treatment is a fundamental civil and political right, enshrined in our common law.[49] YACWA is concerned with the lack of adequate protection regarding young people who are affected by an involuntary treatment order under Part 6 of the Bill, and as such would like to see the implementation of special provisions regarding young people to be added into the Bill.

First, we are concerned that coupled with the presumption of capacity outlined above, young people below the age of 18 will be unfairly discriminated against in the issuing of such orders. An example of this issue arises in clause 24 of the Bill, whereby a person can be subjected to an involuntary treatment order if they do not have the capacity required by clause 17 to make a treatment decision about themselves and the other criterion under this section have been met. To prevent the administration of this order, a young person would need to show 'capacity', an unnecessary burden which would be removed if their needs where adequately dealt with via a separate section specifically for young people.

This can reasonably be seen to be a significant barrier in accessing services. Prospective young patients may be deterred from seeking help voluntarily for fear that they will be subject to involuntary treatment status.[50] Further, studies have reported anger and resentment dominate at the time coercion is applied,[51] with another study focusing on young people with schizophrenia indicating that these were significant risk factors in suicide.[52]

In the Explanatory Memorandum provided with the Bill, under clause 24 a person may be deemed involuntary for unreasonably refusing treatment. We are concerned that a conflict of interest may arise when determining what is 'unreasonable' for the purposes of this clause, notably when it is the psychiatrist proposing the treatment who is making the determination.

Our state government and policy makers have a duty to ensure that no person is subject to torture or cruel, inhuman or degrading treatment or punishment.[53] The Human Rights Committee notes that the prohibition on torture and cruel, inhuman and degrading treatment relates not only to acts that cause physical pain but also to acts that cause mental suffering.[54]

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[49] See Brightwater Care Group (Inc) v. Rossiter [2009] WASC229.

[50] Dennis, D., & Monahan, J. *Coercion and aggressive community treatment: A new frontier in mental health law*. (Plenum Press, Ed, 1996).
[51] Lucksted, A. & Coursey, R. D., 'Consumer perceptions of pressure and force in psychiatric treatments' (1995) Psychiatric Services 46, 146-152.
[52] De Hert M, McKenzie K, Peuskens J, 'Risk factors for suicide in young people suffering from schizophrenia: A long-term follow-up study' (2001) *Schizophrenia Research* 47 (2-3), 127-134.
[53] UN General Assembly, *Convention on the Rights of Persons with Disabilities*, 13 December 2006, United Nations, Treaty Series, Article 15.
[54] *General Comment No. 07: Torture or cruel, inhuman or degrading treatment or punishment (Art. 7) : . 05/30/1982.*

Such orders should be used only as a last resort, and as such the implementation of specific child and young people's services would ensure that proper assessment is given.[55]

Recommendations

4. That a specific division be inserted regarding the use of involuntary treatment orders on persons under 25. This would reduce the ambiguity and increase the transparency of the current Bill.
5. That only a child and young persons psychiatrists be allowed to make any involuntary treatment orders regarding persons under the age of 25.

2. Referrals for Examinations (Division II)

YACWA also holds concerns regarding the provisions regarding the detention of patients whilst referrals for examinations are made.

It is not mentioned within the Green Bill whether young people, especially persons under the age of 18, will be assured separation from adults during this time.[56] As indicated in Part K of this submission, separation must be guaranteed under international law, and is further requested in the Stokes Review.[57]

Further, clause 57 regarding the detention of patients at places outside of the metropolitan area, the detention period may be extended from 24 hours up to an additional 48 hours. When serious breaches of ones civil liberties are infringed upon, there should be minimum exception to the prolonging of these breaches. It can reasonably be seen that indigenous Australians and those living in rural and remote areas, will be unfairly affected by this provision, with a clear discrimination regarding access to services arising.[58]

Recommendations

6. To ensure a more equitable and accessible service, which will reduce the differing levels of service encountered by young people from geographically diverse and vulnerable backgrounds.
7. To ensure that young people will be examined in appropriate facilities, and most importantly, separated from adults during the term of any order.

3. Examinations (Division III)

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[55] B Stokes, *Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia*, (2012), Government of Western Australia – Department of Health, Recommendation 8.6.

[56] Green Mental Health Bill 2012 (WA) cl 27(3), 50-51.

[57] B Stokes, *Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia*, (2012), Government of Western Australia – Department of Health, Recommendation 8.6.1.

[58] UN General Assembly, *Convention on the Rights of the Child*, 20 November 1989, United Nations, Treaty Series, vol. 1577, Article 2.

Clause 76 of the Bill stipulates how examinations must be conducted. Clause 79 provides the legislative protections ensuring the respecting of patient rights, however YACWA would recommend the following amendments be implemented.

Two issues arise concerning barriers to effective service and support. First, what indeed constitutes 'restrictive' for the purposes of this section? Guidelines should be included to ensure that the basic civil liberties of patients regarding infringements on freedom of movement are upheld.

Second, young people will have differing standards as to what 'restrictions' are suitable compared to adult patients. Sensitivity and care need to be a mandatory consideration when implementing such orders on young people. Individual contemplation and further consideration of one's cultural needs, age and sex should be necessary in the assessment and provision of examinations.

Recommendations

8. To ensure that young people will be examined in appropriate locations, respecting the cultural, age, gender and other important factors during treatment.

C. COMMUNITY TREATMENT ORDERS

Clause 111 provides the necessary services that need to be in place in order to satisfy the making of a Community Treatment Order (**'CTO'**) under Part 8 of the Bill.

In respect of involuntary treatment orders, CTO's are a more desirable option as they minimise the infringing of one's liberty. However, it is reasonable to see that some of the requirements will be unrealistic in area's of our state that are currently under-serviced.

YACWA is concerned that in such instances, patients will be placed under and involuntary treatment order at a hospital whereby there human rights are severely infringed due to a lack of services. And at worst, be placed in services that do not abide by Article 37(c) of the Convention on the Rights of the Child. The Stokes Review recommendation regarding a more equitable distribution of community resources would address to some extent this issue.[59]

Recommendations

See Recommendation 6.

D. TRANSPORTATION OF YOUNG PEOPLE WITHIN OUR MENTAL HEALTH SYSTEM

Young people have the right to 'safe transport that minimises interference with their rights, dignity and self-respect, and that reduces the likelihood they will experience the transport as a

[59] B Stokes, *Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia*, (2012), Government of Western Australia – Department of Health, Recommendation 8.8

traumatic event.'[60] The Bill includes an exhaustive list of requirements when making a transport order, which would appear to provide adequate judicial protection of the rights of patients under such orders.[61] However, several sections within the Bill regarding the transportation of patients are of concern to YACWA.

Part 10 of the Bill specifically deals with Transport Orders, which also come up in many of the other Parts, not limited to involuntary treatment orders and further examinations. Clause 140 provides that the regulations may authorise a 'transport officer' to carry out a transport order. Only in circumstances where 'there is a significant risk of serious harm to the person being transported or to another person', or when a transport officer is unavailable or any delay in carrying out an order, can a police officer be authorised to transport a patient.

Whilst YACWA is supportive of the use of transport officers to transport patients generally, the lack of definition as to the required training of such persons stipulated in the Bill and the potential involvement of police in some circumstances is concerning. Given that mental health consumers are often sedated and/or restrained by service providers during transportation, [62] it is integral that sufficiently trained staff are engaged. The Stokes Review in Recommendation 1.3 provides for the adequate training of mental health staff throughout the system.

Further, whilst acknowledging the significant role that the police service of Western Australia plays in minimising harm within our community, the engagement of this option should always be the option of last resort when all other transport options are considered unsuitable.[63] YACWA is concerned that their engagement in some situations may be particularly inflammatory to a person's unstable mental health, due to the more restrictive nature of police vehicles and the stigma attached to being transferred by police. We believe that the care and sensitivity afforded by specially trained mental health transport officers is necessary when transporting children and young people.

During the transportation of young patients, we must ensure that their human rights are upheld and are not diminished.[64] In this sense, YACWA recommends the introduction of provisions ensuring the separation of children, adolescents and young people from adults during transportation, and that this also be extended to gender as well.

Regarding the extension of transport orders as provided in clauses 144 and 145, YACWA recommends that separate sections be introduced to ensure that children, adolescents and young people will be transferred as quickly as possible. The Bill provides that a person can be in transit for a period of up to 144 hours (including the extension of transport order), which whilst recognising the tyranny of distance facing our health service, we believe to be too long. In such circumstances, the Royal Flying Doctor Service and other fast-transport options should be engaged to ensure the swift transfer of patients.

Clause 148 provides that it is left up to a transport officer or police officer to assess whether the person 'poses a serious risk to the safety of the person or another person' (ss.3) to continue a

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[60] Department of Health (Vic), *Safe transport of people with a mental illness, Chief Psychiatrist's guideline*, Aug 2011.
[61] Green Mental Health Bill 2012 (WA) cl 141 (1).
[62] National Mental Health Working Group (Cth), *National safety priorities in mental health: a national plan for reducing harm,* Health Priorities and Suicide Prevention Branch, Department of Health and Ageing, Commonwealth of Australia, (2005) Canberra.
[63] Department of Health (Vic), *Safe transport of people with a mental illness, Chief Psychiatrist's guideline*, Aug 2011.
[64] UN General Assembly, *Convention on the Rights of the Child*, 20 November 1989, United Nations, Treaty Series, vol. 1577, Article 4.

transport order. Whilst police officers may be adequately trained in assessing risk to other persons, a specialised mental health officer would no doubt be able to provide a better assessment of whether the person is of harm to themselves.

Recommendations

9. That the Bill be amended to include the required level of training necessary for transport officers, and for this to be in line with Commonwealth and State guidelines. (See Stokes Review 1.3)
10. For the Bill to contain a provision ensuring the separation of young people below 25 years and adults based on age and gender whilst under transport orders. This is especially significant in circumstances involving substantial distance and time.
11. For fast-track systems to be implemented when the transfer of a young person is required.

E. APPREHENSION, SEARCH AND SEIZURE POWERS

YACWA holds concerns as to the requisite level of training given to those who may apprehend a young person with a mental illness. Under the Bill, apprehension, search and seizure powers are outlined in Part 11.

Under clause 149 (1), a police officer may apprehend a person whom they believe has a mental illness and is a danger to themselves and/or others. To allow such powers to be exercised, it is essential to ensure that police officers are sufficiently trained in assessing mental illness, and in adequately identifying the particular and diverse needs of young people with mental health concerns.

The need for specialist training in mental health issues for the police force is highlighted in clause 150(1), where a person can be apprehended by the police on the mere suspicion that they have a mental health problem. People can make mistakes, but by ensuring proper legislative protections and adequate training of staff, incorrect detentions for suspicion of a mental illness can be minimised.

Regarding the conduct of a search under clause 156, a child or young person may be searched by an authorised whilst being admitted or in detention. In order to ensure the integrity of young people within the system, there must be adequate supervision of the search and frisk by another person, preferably a medical practitioner of the same sex.

Recommendations

12. That the Bill be amended to ensure that specialist training in mental health issues is undertaken by all police officers in Western Australia, so as to guarantee the highest sensitivity and care in circumstances which require their involvement.
13. To ensure that a second person is present during any search, preferably a medical practitioner of the same sex as the patient.

F. PROVISION OF TREATMENT

1. Provision of treatment generally

In general, the rights afforded to young people in Part 12 are sufficient. However in clause 174, patients and other persons are afforded the right to request a further opinion from a psychiatrist other than their treating psychiatrist or supervising psychiatrist. YACWA is of the belief that a young person's access to appropriate treatment would be better enhanced by having the opportunity to seek a specialist child and adolescent psychiatrist, who it is reasonable to presume, would be more attentive to their specific needs. The amending of this section could reasonably be seen to reduce consumer dissatisfaction of clause 176.

Recommendations

14. To ensure that children, adolescents and young people have the ability to seek specific opinion from sufficiently trained and experienced child, adolescent and young persons psychiatrists during the provision of treatment.

2. Treatment of young Aboriginal or Torres Strait Islander patients

Aboriginal and Torres Strait Islander Australian's are said to be substantially more likely than non-indigenous Australian's to be treated for mental health complications. [65]

Whilst YACWA is supportive of the introduction of specific provisions regarding the treatment of indigenous and Torres Strait Islander patients, significant barriers relating to access will no doubt continue to exist.

The United Nations *Declaration on the Rights of Indigenous Peoples* was formally adopted by Australia in 2009. The declaration, in conjunction with other key rights protected by international treaties, promotes self-determination, participation in decision-making and free, prior and informed consent, respect for and protection of culture and non-discrimination and equality.

Clause 181(2) of the Bill provides that the treatment provided to patients under clause 180 must be provided in collaboration with Aboriginal and Torres Strait Islander mental health worker, and significant members of the patient's community.

YACWA is concerned with clause 181(2) and the wording that this respect of culture is only necessary 'to the extent that it is practicable and appropriate to do so'. This is concerning as it essentially provides scope for agencies to provide health services in a culturally inappropriate way, which essentially acts as a discriminatory barrier to receiving services, being unable to use those services effectively, and to their overall benefit.

It is not sufficient for our State Government to divert from this requirement if it is not 'practicable and appropriate'. As provided in the Explanatory Memorandum, young persons of Aboriginal and Torres Strait Islander descent should be afforded the opportunity to choose whether they

[65] Australian Red Cross, *Mental Health*, http://www.redcross.org.au/mental-health.aspx.

would require such a service. [66] However, in terms of the Government's obligation to provide it, the obligations outlined in clauses 181 2(a) and (b) should be non-discriminatory, which is line with our international human rights obligations.[67]

Recommendations

15. To ensure that the provisions outlined in Part 12 with respect to the treatment of Aboriginal or Torres Strait Islander patients are non-derogable, unless it is at the patient's request.

G. REGULATION OF CERTAIN KINDS OF TREATMENT

1. Requirements for electroconvulsive therapy (ECT) and psychosurgery

YACWA's submission is focused on ensuring that the rights of young people within our community are upheld and respected, and as such we will not be assessing the medical arguments for the use of different treatment methods in great detail. However, in light of some brief research undertaken there appears to be minimal factual justification as to why the age of 14 years has been set.

Research regarding brain development in children, show that the brain continues to grow and develop into young-adulthood.[68] Both methods of treatment breach significant civil liberties if not consented to by the person affected, and using the procedures on young, developing and growing brains should be done so only with the highest level of medical research supporting it.

Psychosurgery has been banned in New South Wales where an Expert Committee of Inquiry into Psychosurgery[69] in 1977 found that there was little scientific basis for amygdaloidotomy procedures for aggressive behavior. Whilst the continuing development of electroconvulsive shock therapy has led to significant support for the procedure where pharmacotherapy is ineffective. [70] Evidence sought on both methods was inconclusive, and the minimal use of ECT and psychosurgery on children and young people in Western Australia indicate little need for such treatment options. [71]

When assessing the potential use of ECT on young persons between the ages of 18-25, a requirement should be added to ensure that a second opinion from a child and young persons psychiatrist could be sought on request. This will ensure that any potential conflicts of interests arising regarding the efficacy of such treatment will be minimised.

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[66] Office of Mental Health (WA), *Explanatory Memorandum – Mental Health Bill 2012 – A green Bill for comment.* (2012).
[67] UN General Assembly, *Convention on the Rights of the Child*, 20 November 1989, United Nations, Treaty Series, vol. 1577, Article 30.
UN General Assembly, *Convention on the Rights of Persons with Disabilities*, 13 December 2006, United Nations, Treaty Series, Articles 17 and 21.
[68] Child Welfare Information Gateway, Understanding the Effect of Maltreatment on Brain Development, (2009) Issue Briefs, https://www.childwelfare.gov/pubs/issue_briefs/brain_development/how.cfm#sensitive.
[69] Parliament of New South Wales (NSW), *Report of the Committee of Inquiry into Psychosurgery (The Foster Report*), (1977).
Shoirah H, Hamoda HM. 'Electroconvulsive therapy in children and adolescents.' (2011) 11(1) *Expert Rev Neurother.* 127-30.
[71] Teh SP, Xiao AJ, Helmes E, Drake DG, 'Electroconvulsive therapy practice in Western Australia'. (2005) 21(3):*J ECT*. 145-50.

2. Emergency Psychiatric Treatment

Clause 188 provides for Emergency psychiatric treatment on adult involuntary patients and mentally impaired accused persons with approval from the Chief Psychiatrist the only formality. YACWA is concerned that young people above the age of 18 will be given inadequate service in such circumstances, and is specifically apprehensive about the Chief Psychiatrist holding the power. Whilst recognising the practical difficulties in accessing the MHT at short notice, greater scrutiny and further opinion should be sought when administering such invasive procedures.

Clause 191 of the Bill allows for the use of emergency psychiatric treatment on voluntary patients. The criteria for assessing what is an emergency are broad. Whilst persons under the age of 18 have been excluded in the emergency provisions, YACWA is concerned that young people with a mental health illness will be discouraged from accessing services if they quite reasonably believe they will be subject to such treatment without their consent.

Recommendations

16. For the Government to justify its position regarding the use of ECT and psychosurgery on young people. Failing to do this, to remove such procedures from being used on persons under 25
17. To ensure that review to the Mental Health Tribunal should be mandatory for all procedures under Part 13 for persons under 25.
18. For separate provisions governing the use of emergency psychiatric treatment on young people under the age of 25 be implemented.

3. Seclusion and Bodily restraint

Part 13 Division 5 of the Bill contains provisions which authorises the restraining and secluding of person's, including those under the age of 18. It provides for the use of seclusion and restraint for the purposes of treatment or to prevent the patient from injuring themselves or others. The use of seclusion and restraint are some of the most controversial practices used in mental health services,[72] with studies indicating that the practices cause significant psychological and physical harm to patients and staff.[73] Further, the Cochrane Review confirmed a recognised lack of data regarding the effects of seclusion and restraint, and was unable to justify the use of such treatment methods.[74]

The CRC provides that every child is entitled to the respect of his or her private and family life;[75] the right to not be subjected to inhumane or degrading treatment;[76] the right to liberty and

[72] Wynaden D, Chapman R, McGowan S, Holmes C, Ash P, Boschman A. 'Through the eye of the beholder: to seclude or not seclude' (2002) *Int J Ment Health Nurs* 11, 260-8.
[73] Busch AB, Shore MF. 'Seclusion and restraint: a review of recent literature.' (2000) 8 *Harvard Rev Psychiatry*; 261-70.
[74] Salias E, Fenton M, 'Seclusion and restraint for people with serious mental illnesses.' (2000) 1 *The Cochrane Database of Systematic Reviews* Art. No.:CD001163. DOI: 10.1002/14651858.CD001163, see Cochrane Library online, http://mrw.interscience.wiley.come/cochrane/clsysrev/articles/CD001163/pdf_fs.html - accessed Feb 2013.
[75] UN General Assembly, *Convention on the Rights of the Child*, 20 November 1989, United Nations, Treaty Series, vol. 1577, Article 9.
[76] UN General Assembly, *Convention on the Rights of the Child*, 20 November 1989, United Nations, Treaty Series, vol. 1577, Article 37.

security;[77] and the right not to be discriminated against in their enjoyment of those rights.[78] Seclusion and restraint impact severely on the above considerations, with reported instances of bruising, scratching, choking, dehydration and psychological distress arising during the provision of such treatment.[79] The use of these measures needs to be rigorously legislated as to prevent potential scope of abuse of these powers and to ensure the minimal infringing upon a person's basic civil liberties.

It can be reasonably seen that seclusion and restraint may lead to further trauma, [80] and the use of such practices highlights an under-resourced system that such breaches of human rights are accepted practices.[81] Seclusion and restraint may also serve to be barrier to service, as young people may fear being subjected to such treatment.

Whilst recognising the fundamental need to protect staff within our mental health system, we must adhere from creating a confrontational environment in which abuses of our civil liberties is common practice. The ensuring of proper training and specified-age service improvements can reasonably be seen to reduce the need for such treatment.[82]

Recommendations

19. For the practice of seclusion and bodily restraint to be banned on persons under the age of 18.
20. That in the event of persons aged between 18-25 being subjected to such treatment, only a psychiatrist may make the order, that this order can be authorised for a period up to 3 hours, and that a medical practitioner is required to examine the patient every 30 minutes.

H. PEOPLE IN HOSPITALS: HEALTH CARE GENERALLY

Clause 228 3(b) provides for samples of a person's blood, tissue and excreta to be taken without consent. This can be done to voluntarily, involuntarily and mentally impaired accused patients. There are no specific provisions relating to such samples being taken with regards to children. The taking of such samples is an extremely invasive measure, and whilst recognising the medical importance of such samples, there are minimal legislative protections ensuring that a young persons civil liberties are upheld in instances where it may conflict with religious and cultural requirements of patients.

Recommendations

[77] UN General Assembly, *Convention on the Rights of the Child*, 20 November 1989, United Nations, Treaty Series, vol. 1577, Article 16.
[78] UN General Assembly, *Convention on the Rights of the Child*, 20 November 1989, United Nations, Treaty Series, vol. 1577, Article 2.
[79] Above n, Busch.
[80] El-Badri SM, Mellsop G. 'A Study of the use of seclusion in an acute psychiatric service' (2002) 36 Aust N Z J Psychiatry, 299-403.
[81] National Mental Health Consumer and Carer Forum, *Ending Seclusion and Restraint in Australian Mental Health Services: A position statement by the National Mental Health & Consumer Carer Forum*, (2009), Foreword.
[82] Delaney K, 'Evidence base for practice: reduction of restraint and seclusion use during child and adolescent psychiatric inpatient treatment' (2006) 3 *Worldviews Evid Based Nurs* 19-30.

21. That young people, and people in general, are ensured respect of cultural and religious factors when assessed on entry into an authorised health service.

I. PROTECTION OF PATIENT RIGHTS

The protection of patients' rights as outlined in Part 15 of the Bill are comprehensive and ensure the respect of those who are within our mental health system. However, YACWA would like to see the following provisions revised to reduce potential ambiguities in their application.

First, under clause 247(b), a psychiatrist may refuse a patient's request for an interview under sub-clause (1) if the psychiatrist believes that the person is acting 'unreasonably'. What defines 'unreasonableness' in such circumstances? Also, a conflict of interest arises in that the person may have a legitimate claim for an interview, however their treating psychiatrist may believe otherwise and thus not approve. It is important to ensure that the non-treating psychiatrist or practitioner assess any application to have an interview.

Second, clause 248 establishes the rights of patients to participate in lawful communication. The term 'reasonable' is used in most sub-clauses, however what is 'reasonable communication' for adult patients and young patients will no doubt differ. It is thus important to have a separate section dealing with the rights of young patients, which increase a young persons participation within the system.

Finally, in clause 249 it provides that a patient's rights to freedom under clause 248 (a), (b) or (e) may be limited by a psychiatrist if satisfied that making the order is in the best interests of the patient. There are no guidelines establishing what circumstances may constitute a reduction in rights for a patients best interests, and further, no legislative mechanism punishing those that do not respect a patient's rights, other than a complaint to the MHT.

Whilst the provisions outlines in Part 15 are somewhat comprehensive and no doubt represent an improvement from the previous Act, YACWA believes that the ambiguities within the Bill's provisions can be alleviated with the introduction specifying between the treatment of adult, young people, adolescents and children.

Recommendations

22. To ensure that all children, adolescents and young people are separated from adults whilst in treatment.
23. Failing this, similar to the Recommendation made by the Commissioner for Children and Young People,[83] YACWA recommends the implementing of a statewide review service on the suitability of authorised facilities to treat children and young people.

J. RECOGNITION OF RIGHTS OF CARERS AND FAMILIES

[83] Commissioner for Children and Young People (WA), *Submission to the Mental Health Commission on the Draft Mental Health Bill 2011*, (2012) Recommendation 5.

Currently, families and carers of children, adolescents and young people treated for mental health complications are inadequately afforded opportunities in the planning, development and execution of treatment programs.[84]

The Bill proposes to involve families and carers more intimately within the system, and has clearly recognised the value of such involvement. Families and/or carers of children and young people are now entitled to be heard in relation to any decision affecting the child or young person, if they do not have capacity.[85]

Whilst understanding the integral role played by families and carers in the successful treatment plans and rehabilitation of young mental health problem sufferers, the views of children and young people should be held with the highest regard, regardless of capacity, and an assessment of the patient's wishes should be sought and given considerable weight.

Recommendations

24. To ensure that young people who do not have capacity to consent to treatment, have their views taken into account where reasonably possible when disclosing information of a confidential nature.

K. CHILDREN

The Bill introduces for the first time specific legislation regarding the treatment of children in Part 17 however, further provisions should be added ensuring the right of children to be separated from adults during treatment.

In clause 286, exception is given to this right if 'the person in charge of the mental health service is satisfied that –

> *(a) The mental health service can provide the child with treatment, care and support that is appropriate having regard to the child's age, maturity, gender, culture and spiritual beliefs; and*
> *(b) The treatment, care and support can be provided to the child in part of the mental health service that is separate from any part of the mental health service in which persons who have reached 18 years of age are provided with treatment and care if, having regard to the child's age and maturity, it would be appropriate to do so.*

First, concern is held with regards to the ability of the person 'in charge' of the mental health service to objectively assess the suitability of the service for a child. It would reasonable to suggest that a conflict of interest may arise, and as such only an independent specially trained child, adolescent and young persons psychiatrist should make any assessment. Enhancement of this provision could be made by providing an independent review assessing the suitability of all mental health authorised places to treat young people.

Currently, the Australian Government has a reservation to Article 37(c) of the CRC that requires that children not be detained with adults. The Government defends this reservation by

[84] Mental Health Council of Australia, *Recognition and Respect: Mental Health Carers Report 2012*, (2012).
[85] Green Mental Health Bill 2012 (WA) 272(2).

claiming that Australia's geography and demography make it difficult to always detain and treat children in age appropriate facilities whilst simultaneously allowing a child to maintain contact with their family.[86] However, they still have an obligation to ensure the maximum extent possible the survival and development of a child.[87]

Second, Article 24 of the CRC provides that a state must 'provide for the best and highest attainable standards of health care for children'. In derogating from the rights outlined in Article 37, the Government's obligations under Article 24 are also brought into question. Patient's receiving treatment in such circumstances may not be afforded the highest attainable standard of mental health when placed in the care of staff that are not specially trained in dealing with young people.

The experience of children in such environments has been negative,[88] and at the very least children should only be put in such circumstances if it is in their 'best interests'. Where children and young people are not detained in separate facilities from adults, they should at the very least be detained in separate units or wings within mixed age facilities, and this should be a legislatively articulated right. However, if treated in an adult ward and separated from adults this may amount to solitary confinement.[89]

It can be reasonably assumed that the main purpose of the exceptions outlined in clause 286, are that they will be engaged mainly in rural areas of Western Australia. The fact that there is only one specialist child mental health facility in Western Australia, highlights a failure by our current mental health system and Government to adequately provide a consistent and non-discriminatory health service to the Western Australian community.[90] Whilst acknowledging the practical difficulties that may exist in providing such a service, YACWA believes that access to the best and highest attainable standards of health care should be available to all young people at a consistent level, regardless of where in our state they live.

The derogation from this right highlights a significant barrier to access for young people seeking treatment for mental health related issues. As stated previously, evidence suggests that young people in adult mental health wards encounter a generally negative experience,[91] and an increased risk in statutory protections being infringed by service providers in such instances.[92] Further, as a result of these limitations in existing services, young people are likely to be neglected from receiving no effective intervention, and that their needs may go undetected.[93]

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[86] Cited in *Australia's Report under the Convention on the Rights of the Child,* (1994) Attorney-General's Dept. Canberra, 345.
[87] UN General Assembly, *Convention on the Rights of the Child*, 20 November 1989, United Nations, Treaty Series, vol. 1577, Article 6.
[88] McDougall T, Oherliny A, Pugh K, Parker C, 'Young people on Adult mental health wards', (2009) *Mental Health Practice* 12.8, 16-21.
[89] *Australia's Report under the Convention on the Rights of the Child*, (1995) Attorney-General's Dept. Canberra, 356-378.
[90] UN General Assembly, *Convention on the Rights of the Child*, 20 November 1989, United Nations, Treaty Series, vol. 1577, Article 2, 24.
UN General Assembly, *Convention on the Rights of Persons with Disabilities*, 13 December 2006, United Nations, Treaty Series, Articles 5, 9, 25 and 26.
[91] Office of the Children's Commissioner (UK), *Pushed into the Shadows: Young People's Experience of Adult Mental Health Facilities*, (2007), published by 11 million. http://www.teespublichealth.nhs.uk/document.aspx?id=4721&siteID=1012 Accessed Feb 2013.
[92] McDougall T, Oherliny A, Pugh K, Parker C, 'Young people on Adult mental health wards', *Mental Health Practice* 12.8 (May 2009): 16-21.
[93] Department of Health and Ageing (Cth), '*National Mental Health report 2005: Summary of 10 years of reform in Australia's Mental Health Services under the National Mental Health Strategy 1993-2003,*' (2005) Canberra: Commonwealth of Australia.

This section should also outline the procedures and safeguards that must be met for children and young people with a parent/s, who have mental health problems that require treatment under the Act. Currently, no safeguards are outlined in the Bill, this should be addressed. The Commissioner for Children and Young People commented that the identifying and supporting of a strategic and coordinated approach with relevant agencies to ensure proper service and programs, would go some way in addressing the above issue.[94]

Young people should also be supported in their transfer from child to adult services, and if requested, to continue treatment in such services until they feel that they are ready to be transferred. Such a service recognises the differing developing needs of young people, and would ensure sensitive and appropriate treatment and care.[95]

Children and young people require age-appropriate environments to fulfill their personal, educational and social developments whilst in treatment and care.[96] YACWA supports the recommendations made in the Stokes Review regarding the addition of special provisions to be made for the clinical governance of mental health needs of young people (between the ages of 16-25 years of age),[97] and that they must be separated from adults at all times during treatment.[98]

Recommendations

25. That when assessing whether a mental health service can provide adequate treatment, care and support that is appropriate having regard to the child's age, maturity, gender, culture and spiritual beliefs, any assessment must be independently undertaken by a specialist child, adolescent and young persons practitioner, and the primary consideration being the child's best interests.
26. See Recommendation 23.

L. COMPLAINTS ABOUT MENTAL HEALTH SERVICES

Part 18 of the Bill provides for a comprehensive complaint system to be provided for mental health service users. This is an important mechanism in the realisation of patient rights, however YACWA is concerned that significant barriers to equal access will arise.

First, children and young people who experience adverse service and support whilst completing mental health treatment may be discouraged from submitting their complaint to the relevant body, due to a lack of knowledge regarding the full extent of their rights.

Second, it is reasonable to suggest that the nature of complaints made by children and young people require a higher degree of sensitivity and engagement on behalf of those hearing the

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[94] Commissioner for Children and Young People (WA), *Report of the Inquiry into the Mental Health and Wellbeing of children and young people in Western Australia: Chapter 5 – Children and young people who are vulnerable and disadvantaged*, (2011), 87.
[95] B Stokes, *Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia*, (2012), Government of Western Australia – Department of Health, Recommendation 8.10.1 (Recommendation from the Commissioner for Children and Young People).
[96] McDougall T, Oherliny A, Pugh K, Parker C, 'Young people on Adult mental health wards', (2009) *Mental Health Practice* 12.8, 2.
[97] Above n, Recommendation 8.6.
[98] Above n, Recommendation 8.6.1, Stokes.

complaint. To this extent, clause 306(a) requiring the complainant to first try and resolve a matter with the respondent should be removed with regards to young people. Under international law, our state has an obligation to ensure the full realisation and protection of rights of young people with disabilities. [99]Article 12 of the CRPD provides that people with disabilities should be able to exercise their legal capacity on an equal basis with others. In the normal judicial process, a complainant will not have their case thrown out on the basis of failure to attempt mediation.

The system proposed by the Bill would be significantly improved if a specific child, adolescent and young persons complaint system was established. The Commissioner for Children and Young People, Michelle Scott, recommends that a specific child friendly complaints system will ensure more adequate protection of children within our mental health system.[100] The Stokes Review similarly recommends the advent of a comprehensive youth stream with a range of services, such as complaint tribunals.[101]

By establishing a specific complaints procedure for young people, a more user-friendly system will be available removing a significant barrier to access. Further, the rights and concerns of young people will be afforded more weight and adequate consideration inline with their specific developmental requirements via the assessment of specifically trained tribunal members.

Recommendations

27. That a child, adolescent and young persons Tribunal to be established.
28. For the Bill to establish a 'guideline complaints procedure' for young persons, that will be used across the State at all suitable and authorised service providers.

M. ADVOCACY SERVICES AVAILABLE TO YOUNG PEOPLE

It is imperative that young people within our mental health system have easy and accessible access to their full array of legal rights whilst being treated.

In Part 19 of the Bill, clause 331(3) establishes the requirement of at least one 'youth advocate' to be available to mental health service users. The introduction of such a service is a welcome change from the current Act. However, YACWA holds concerns regarding the minimal requirement of just one such advocate, and whether they will be able to adequately address the significant number of children, adolescents and young people currently within the care of our mental health system.

Similarly, it is welcoming that the Explanatory Memorandum anticipates that the Chief Mental Health Advocate will engage further advocates specific to differing community groups, such as indigenous people.[102] However, indigenous persons and other minority groups in the community deserve non-discrimination in services and such advocates should be a requirement under the proposed Bill.

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[99] UN General Assembly, *Convention on the Rights of Persons with Disabilities*, 13 December 2006, United Nations, Treaty Series, Article 4.
[100] Commissioner for Children and Young People (WA), *Media Statement*, (2012) 15 September 2012.
[101] Above n, Recommendation 8.6.
[102] Office of Mental Health (WA), *Explanatory Memorandum – Mental Health Bill 2012 – A green Bill for comment.* (2012), 66.

In rural areas there would be no guarantee of such a service being readily available to young people seeking mental health treatment. By increasing the requirement of 'youth advocates' to be readily available in our state, a significant barrier to participation, access and support within our health system will be dramatically reduced. A short-term solution to this problem could the setting-up of a video-link advocacy service and utilisation of other available technologies.

YACWA is also concerned that no legislative guidelines have been provided stipulating the required level of training that the 'youth advocate' must hold before assuming such a role. This should be included in Division 2 of Part 19.

The fulfilling of the above would ensure that young people with mental health concerns would have equal access to advocacy services provided under our mental health system. By ensuring that young people have immediate access to an advocate, their engagement with treatment and the system is likely to improve. This would compliment our international human rights obligations of ensuring integrity of the person[103] and to equal access regarding service.[104]

Recommendations

29. To ensure that any specific 'youth advocacy' service be readily available to all young people across the state to persons below the age of 25.
30. To ensure that the Act provides requirements for the appropriate training of 'youth advocates'.
31. To ensure that the Act provides for the requirement of advocates for the groups outlined in Part III of this submission.
32. That clause 343 be amended to ensure that the 'youth advocate' deals specifically with any matter brought up regarding persons under the age of 25.

N. MENTAL HEALTH TRIBUNAL

1. Structure of the tribunal

YACWA supports the introduction of a Mental Health Tribunal for mental health users in Western Australia. However, the following concerns should be addressed in the final Bill.

Clause 363 provides that in the event of a child psychiatrist not being available during a matter concerning a person under the age of 18 years, a psychiatrist is all that is required to form the Mental Health Tribunal. This is not enough. Under international law, our state has an obligation to provide and ensure the highest attainable health standards for all of its children,[105] and to take all available measures to ensure that a child's rights are respected, protected and fulfilled.[106]

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[103] UN General Assembly, *Convention on the Rights of Persons with Disabilities*, 13 December 2006, United Nations, Treaty Series, Article 17.
[104] UN General Assembly, *Convention on the Rights of Persons with Disabilities*, 13 December 2006, United Nations, Treaty Series, Article 9.
[105] UN General Assembly, *Convention on the Rights of the Child*, 20 November 1989, United Nations, Treaty Series, vol. 1577, Article 24.
[106] UN General Assembly, *Convention on the Rights of the Child*, 20 November 1989, United Nations, Treaty Series, vol. 1577, Article 4.

This provision also inherently acknowledges a lack of sufficient resources within the mental health system that will negatively affect young mental health patients. Ideally, the establishment of a specific Child and Young Persons Mental Health Tribunal should be established. However, there should at least be a non-derogable obligation that the MHT must consist of at least one member who specializes in child, adolescent and young persons needs, which would be consistent with the program established in the United Kingdom.

Further, relating to the review of involuntary treatment orders, clause 366 (1) provides that the Tribunal has 10 days to review such orders with regards to the specified criteria in clause 24. The placing of such orders on a person significantly infringe on their basic civil liberties and as such, any review should be completed within the shortest amount of time possible.

Exemplifying the points raised above is clause 389 (b), which provides that the Tribunal must consider the 'most appropriate treatment for the health and well-being of the patient'. It can be reasonably seen that by not ensuring that the Tribunal has a child psychiatrist as a member, then consideration of the appropriateness of treatment may not be given to the highest attainable extent.

YACWA recommends that any future Act must ensure that a sufficiently trained child, adolescent and young persons psychiatrist be present on the tribunal. The effect of such a requirement would be widespread in providing a more equal and efficient system to the young people of Western Australia.

Recommendations

33. For a specific child, adolescent and young persons Tribunal be established.
34. Failing this, a child, to ensure that an adolescent and young persons psychiatrist be a requirement for all cases involving persons under 18, and for the option to have such a psychiatrist for persons under 25.
35. To ensure that any involuntary treatment order be reviewed 7 days from an order being placed on a person 18 years or under.

2. Representation before the Tribunal

Clause 421 states that each party to a proceeding must bear their own costs, representing a significant barrier to accessing a right to service. It is recognised that concerns relating to the cost of services have restrained mental health consumers from engaging fully with services.[107] Young people, who have little financial resources, will be discriminated against using this service, especially those from disadvantaged backgrounds.

Clause 427 of the Bill provides that a child who has 'sufficient maturity and understanding to make reasonable decisions about matters relating to himself or herself may appear in person.' Regarding decisions that ultimately impact upon ones liberty and life choices, it should be made mandatory that young people appearing before the Tribunal are given suitable opportunities to seek representation and information regarding their rights. Similarly, research

[107] Cohen, A, Medlow, S, Kelk N, Hickie, I, 'Young people's experiences of mental health care: Implications for the headspace National Youth Mental Health Foundation,' 28 *Youth Studies Australia* 1, 2009, 17.

indicates that persons appearing before mental health tribunals encounter heightened anxiety.[108] The providing of representation would facilitate greater participation within the Tribunal process through clarification of the process and its objectives. This would ensure that the experience be somewhat less intimidating and confusing for young people.

Additionally, the introduction of such a service would also be reasonably seen to minimise conflicts arising under clause 442 of the Bill, which stipulates the offences relating to answering questions, producing documents and other information if not provided or provided incorrectly or inconsistently.

Recommendations

36. To ensure that young people under 25 are ensured the option of free representation before the Tribunal.
37. To ensure that parties to proceedings bear no costs relating to the hearing.

O. MINISTERIAL INQUIRIES

YACWA is concerned that the offences outlined in clause 531 concerning the interfering with investigations are discriminatory against young people with mental health problems.

Our concerns arise with regards to the potential involvement of young people within the system and ensuring that they are given equal access, treatment and due process during any ministerial inquiry.

For example, what is a 'reasonable excuse' when not answering a question or providing information? Does it take into account a child or young persons capacity? If a young person is encountering a negative experience within the system, it is reasonable to suggest that they may react adversely when asked to facilitate any process concerning their wellbeing. We must ensure that children or young people are given extra consideration in such circumstances before being explained their legal rights or having access to free legal representation?

Further, the penalty of a $6000 fine is unreasonable, unjustified and could have dire flow-on effects to a young person coping with a mental illness.

Young people dealing with mental illness require the care and consideration that is required to be assured to them by the state,[109] and as such the arbitrary mechanisms outlines in clause 531 to facilitate ministerial inquiries should be amended to provide adequate consideration for those persons under the age of 25.

Recommendations

38. To ensure that children and young people are not unfairly discriminated against during ministerial inquiries.

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[108] Fisher, S, Kilcullen D, Schriber G, Hughes B, 'Widneing the Circle: Making Mental Health Review Tribunal hearings accessible in Indigenous, rural and remote settings' (2009) 17 *Australiasian Psychology* S83, S84.
[109] UN General Assembly, *Convention on the Rights of the Child*, 20 November 1989, United Nations, Treaty Series, vol. 1577, Article 23.

39. To remove the excessive penalty provision.

V CONCLUSION

It is imperative that the Western Australian Government immediately increases the scope and provision of mental health services across Western Australia. The continuing development of young people socially, mentally and physically requires specific care so to not interrupt social developments, education, family relationships and future employment opportunities.[110]

Many of the clauses in contention recognise the difficulties in providing services to those living outside the metropolitan area. However, the shortages do not exist only in rural areas. Our current system is under-resourced, under-staffed and under-prepared to deal with the mental health needs of our community.

Implementing a Bill, that ensures specific rights to particularly vulnerable groups in our community, such as young people, is an essential start to ensuring a more efficient and accessible mental health system.

[110] The National Mental Health Working Group (Cth), *Responding to the mental health needs of young people in Australia – Discussion paper: principles and strategies* (2004), 1.