Commissioner for Children and Young People
Western Australia

All enquiries
Telephone: (08) 6213 2205
Email: lynton.bennett@ccyp.wa.gov.au
Our reference: 22/519

Ms Jennifer McGrath
Commissioner
Mental Health Commission

Via email: statutoryreview@mhc.wa.gov.au

Dear Commissioner Jen

Statutory Review of the *Mental Health Act 2014*

Thank you for the opportunity to contribute to the Statutory Review of the *Mental Health Act 2014* (the MH Act).

It is a statutory responsibility of the Western Australian Commissioner for Children and Young People to monitor and review written laws that affect the wellbeing of children and young people in this State. In doing so the *Commissioner for Children and Young People Act 2006* requires that the best interests of children and young people be the paramount consideration, that priority be given to the interests and needs of vulnerable or disadvantaged children and young people, and that regard is had to the United Nations Convention on the Rights of the Child. It is within this context that Attachment A is submitted for consideration by the Statutory Review.

In addition to the matters raised in the attached submission, it is noted that several issues outlined in the Statutory Review Discussion Paper, such as those related to further opinions and to Treatment, Support and Discharge Plans, are likely the result of implementation processes and resourcing rather than inadequate statutory provisions. The policies underpinned by the MH Act must be supported by thorough planning, effective implementation strategies and appropriate resourcing. Successful implementation of the MH Act's statutory requirements also requires the provision of continued support to mental health service providers as they transition to a rights-focused paradigm of care, and a reduced hesitancy by oversight bodies to exercise the full range of entry and access powers they have been provided with.

As a particularly vulnerable cohort of mental health consumers, it is imperative that the MH Act affords appropriate statutory rights and protections to children and young people under the age of 18. However it appears that there have not been targeted opportunities for children and young people under 18 years to contribute to the Statutory Review, noting that the advertised youth consultation opportunities specifically exclude young people under 18 years. Consequently, I suggest that the Statutory Review uses accessible child and young person friendly means to directly engage with people under 18 years who are, or have

Level 1, Albert Facey House, 469 Wellington Street Perth WA 6000
Telephone 08 6213 2297 Country Freecall 1800 072 444
ccyp.wa.gov.au
@CCYPWA

recently been, consumers of public mental health services in this State. This will ensure that any findings or recommendations of the Statutory Review that may impact children and young people are informed by their views and experiences. The following resources are available at www.ccyp.wa.gov.au which could support the Statutory Review to meaningfully engage with children and young people:

- Participation Guidelines: Ensuring children and young people's voices are heard (2021)[1].
- Engaging with Aboriginal Children and Young People Toolkit (2018)[2].

Should you wish to discuss the matters raised in this letter or content of the attached submission in more detail please contact Ms Natalie Hall, Director Policy, Monitoring and Research via natalie.hall@ccyp.wa.gov.au.

Yours sincerely

Jacqueline McGowan-Jones
Commissioner for Children and Young People WA

2 February 2022

[1] Commissioner for Children and Young People WA 2021, Participation Guidelines: Ensuring children and young people's voices are heard, Commissioner for Children and Young People WA, Perth.
[2] Commissioner for Children and Young People WA 2018, Engaging with Aboriginal Children and Young People Toolkit, Commissioner for Children and Young People WA: Perth.

Attachment A

SUBMISSION – STATUTORY REVIEW OF THE *MENTAL HEALTH ACT 2014*

Children and young people have distinct and unique needs in relation to their mental health. Positive mental health provides a vital foundation for children and young people to realise their potential, cope with stresses, develop and maintain meaningful relationships with others and participate in aspects of community life. Poor mental health can impact a person's quality of life and overall wellbeing in a range of ways, such as behavioural issues, a negative sense of worth and lack of coping skills, and impact their capacity to engage in school, community, sports, cultural activities and eventually the workplace.

Children and young people who experience mental health issues have particular vulnerabilities and developmental and age-related needs distinct from other consumers of mental health services. A comprehensive and coordinated approach to service delivery is required to ensure that all children and young people and their families have access to and receive the right level of services and supports they require at the time they will be of most benefit. The achievement of such an outcome requires legislative provisions that support and protect the best interests of children and young people in the mental health system.

With this outcome in mind, the following issues are raised for consideration by the Statutory Review.

The best interests of the child

Section 299 of the *Mental Health Act* (MH Act) requires that a person or body performing a function under the Act in relation to a child or young person must regard what is in the best interests of the child as a primary consideration. This requirement directly aligns with Article 3 of the United Nations Convention on the Rights of the Child and is strongly supported. However, there are acts permitted by the MH Act where the inherent vulnerabilities of children and young people mean that the best interests of the child should be the paramount consideration of decision makers. During the 2013 consultation process for the then draft Mental Health Bill, the Commissioner for Children and Young People (Commissioner) recommended that such a requirement be incorporated into the Bill in relation to the:

- use of electroconvulsive therapy (sections 195-196)
- performance of psychosurgery (section 208)
- physical examination or the provision of blood, tissue or excreta samples in the absence of consent (section 242)
- voluntary admission of a child or young person who does not have the capacity to consent to admission to or treatment in an authorised hospital (sections 255-266, 302) and
- the admission of a child to a non-segregated section of an adult mental health facility (section 303).

This recommendation is maintained for the 2022 Statutory Review. The indivisible nature of individual rights generally requires that decision makers equally weigh the interests of a child against the interests of other members of the community. In the case of the above actions there are no competing interests to override the best interests of an individual child or young person. Treatment or admission to a hospital in these circumstances only directly impacts the child or young person in question, therefore the best interests of the child must be paramount in the associated decision-making processes. Precedent for such an amendment exists in legislation such as section 7 the *Children and Community Services Act 2004* (WA) and section 65AA of the *Family Law Act 1975* (Cth).

In addition to the above, it is recommended that the Statutory Review explore whether the continued availability of electroconvulsive therapy and psychosurgery for children and young people remains appropriate. Consideration of this issue must be informed by consumers of mental health services (particularly those who were administered such therapies when under the age of 18), along with contemporary research and scientific opinion.

Physical safety

Principle 8 of the National Principles for Child Safe Organisations[3] (National Principles) requires that physical environments promote safety and wellbeing while minimising the opportunity for children and young people to be harmed. As a signatory to the National Principles it is incumbent upon the Western Australian Government to ensure that the laws of this state support and promote child safety and wellbeing. Concerningly, as noted above, section 303 of the MH Act permits a child or young person to be admitted to a non-segregated section of an adult mental health facility that does not normally provide treatment or care to children and young people.

As it currently stands, section 303 only requires the person in charge of an adult mental health service to provide treatment, care and support in a separate part of the facility "if, having regard to the child's age and maturity, it would be appropriate to do so." It is recommended, as it was by the Commissioner in 2013, that the MH Act be amended to reverse the onus of the appropriateness test. The MH Act should instead require that a child or young person can only be admitted to a non-segregated section of an adult mental health facility if the person in charge of the facility is satisfied that:

- such admission is in the best interests of the child or young person; or
- such an admission is necessary because there is significant risk to the health or safety of the child or young person or another person; or
- to prevent the child or young person from being seriously injured or seriously injuring another person or persistently causing serious damage to property.

The Commissioner also recommended in 2013 that the MH Act should require a child or young person who is admitted to an adult mental health facility to be moved to a child or adolescent mental health facility as soon as possible, unless such a transfer is not in the best interests of the child or young person. Such a transfer should occur regardless of whether the child is being treated in an area of the facility that is segregated from adult patients, unless such a transfer is not in their best interests. The Commissioner again recommends that this requirement be legislated.

In addition to the above, the Statutory Review Discussion Paper (Discussion Paper)[4] proposes in Amendment 11 that the MH Act provide that if a person's gender is unclear, the person responsible for conducting a search under Part 11 of the Act must ask that person whether a male or female should conduct the search and, where practicable, act in accordance with that response. Amendment 11 further proposes that in the absence of an answer from the person in question, the person must be treated as if they are of the gender they appear to be. While noting Amendment 11 reflects section 22 of the *Criminal Investigation Act 2006*, it is concerning that a person could be legally empowered to assume the gender of a child or young person with a mental illness who is being apprehended, detained or admitted, and act on that assumption in the performance of a physical search. For this reason, the application of Amendment 11 to children and young people in its current

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[3]Commissioner for Children and Young People WA 2019 *National Principles for Child Safe Organisations WA: Guidelines*, Commissioner for Children and Young People WA, Perth.

[4] Mental Health Commissioner 2021 *Statutory Review of the Mental Health Act (2014) Discussion Paper,* Perth.

form is not supported. It is recommended that Amendment 11 be redrafted to include the following safeguard in relation to a child or young person who is being detained or admitted:

> Where the gender of a child or young person is unclear, and the child or young person does not provide a response when asked whether a male or female should conduct a search of them, a search of the child or young person is not to proceed unless there is a serious risk to the safety of the child or young person or a serious risk to the safety of another person.

Capacity to consent to treatment

Australian common law recognises that a child or young person's capacity to consent to medical treatment will generally increase as they move closer to 18 years of age, and allows for persons aged younger than 18 to be found legally competent to make such decisions. The MH Act, through the application of the section 4 definition of 'child' to section 14, enacts a consistent presumption that all children and young people aged under 18 years do not have the capacity to make decisions about matters relating to themselves unless they are otherwise shown to have such capacity.

However, in New South Wales the age at which this presumption applies has been lowered to 14 years via section 49(2) of the *Minors (Property and Contracts) Act 1970*. In South Australia section 6 of the *Consent to Medical Treatment and Palliative Care Act 1995* lowers the age at which a young person can make decisions about their own medical treatment to 16 years of age. Such laws are broadly consistent with research that has found by the age of 16 a young person's general cognitive abilities are "essentially indistinguishable" from those of an adult, thereby rendering decisions requiring logic, reasoning and basic information processing (such as consenting to medical treatment) within the capabilities of the average 16 year old.[5]

It is recommended that the Statutory Review give consideration to whether 18 years remains the appropriate age at which to presume a young person possesses the capacity to make treatment decisions about in the context of the MH Act. Particular regard should be had to scientific literature in this area of study and the practical impact that altering the presumption has had in both New South Wales and South Australia. Should it be determined that capacity to make decisions under the MH Act can be presumed to exist at a younger age, it is further recommended the following legislative safeguards be incorporated into the MH Act:

- The capacity of the young person to make a treatment decision under the MH Act must be confirmed by the medical practitioner who is providing the treatment. The medical practitioner is to assess the young person's capacity in accordance with the criteria set out in section 15 of the MH Act and in consultation with the young person's parent(s) or guardian(s).
- Confirmation by a medical practitioner that a young person has the capacity to make a treatment decision under the MH Act cannot be relied upon to confirm capacity to make a future treatment decision, irrespective of whether the decision relates to a treatment that has been previously provided to the young person.

Where a child or young person is found to have the capacity to consent to treatment under the MH Act, it is critical they receive all the information they require to make the treatment decision. Under section 20 of the MH Act, a person cannot be asked to make treatment decisions unless they are given a reasonable opportunity to obtain advice or assistance in relation to the treatment decision from persons other than the health professional proposing

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[5] Steinberg et al, 2009, *Are Adolescents Less Mature Than Adults?,* American Psychologist, Vol. 64, No. 7, pp583-594.

the treatment. However, not all children and young people found to have the capacity to consent will have the knowledge, confidence or ability to independently seek relevant advice as envisioned by section 20. To ensure children and young people making treatment decisions possess all relevant information, it is recommended the MH Act be amended to provide that a child or young person must be explicitly informed of their right to discuss and seek advice regarding a proposed treatment from any person they wish, and that they must be provided with reasonable assistance to obtain such advice.

Charter of Mental Health Care Principles

As stated in Schedule 1 of the MH Act, the purpose of the Charter of Mental Health Care Principles is to provide a rights-based set of principles that mental health services must make every effort to comply with in providing treatment, care and support to people experiencing mental illness. The principles contained within the Charter are given legal recognition through sections 11 and 12 of the MH Act.

Children and young people as a cohort have developmental needs that are recognised and responded to by governments, families and the broader community. Of critical importance to the growth and maturation of a child or young person is that they receive an appropriate standard of education and health care, are given a level of agency over decisions that is commensurate with their age and level of maturity, and are supported in their physical, emotional and psychological development. However, receiving treatment, support and care from a mental health service, particularly following crisis events or where long-term hospital admissions are required, has the potential to disrupt the provision of these critical developmental supports to children and young people with mental illness. To address this it is recommended that the Charter of Mental Health Care Principles be expanded to include the following principle specific to children and young people:

> A mental health service must provide treatment and care to children that is age appropriate and responds to their particular needs, including, but not limited to, appropriate health care, access to education and training, preparation for employment, maintaining relationships with friends, promoting the participation of children and their families in decision making, and access to recreation and sport.

Precedent for including principles recognising the rights and needs of a particular cohort of people has already been established within the Charter, with Principle 7 acknowledging that Aboriginal and Torres Strait Islander people are entitled to receive treatment and care that is consistent with their cultural and spiritual beliefs and practices, and that mental health services must have regard to the views of family, significant community members, and Aboriginal or Torres Strait Islander mental health workers.

Restrictive Practices[6]

There is a discrepancy between the statutory safeguards afforded to people experiencing mental illness who are participants in the National Disability Insurance Scheme (NDIS), and people experiencing mental illness who are not participants in the NDIS regarding the use of restrictive practices. Under the NDIS, the authorisation and application of chemical

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[6] It is recognised that the term 'restrictive practice' has a specific meaning under the *National Disability Insurance Scheme Act 2013*. In the context of this submission it refers to the use of any practice or intervention that has the effect of restricting the rights or freedom of movement of a person experiencing mental illness.

restraints, environmental restraints, seclusion and bodily restraints is regulated through the National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018. By contrast, the MH Act is silent on the authorisation or application of chemical or environmental restraints. This situation creates an ongoing risk that children and young people who are not NDIS participants may be subject to chemical or environmental restraints without appropriate oversight and controls.

During the 2013 consultation process the Commissioner recommended that consideration be given to regulating the use of chemical restraint in relation to children and young people. The decision to not include such safeguards in the MH Act must now be revisited. To afford children and young people with mental illness the same level of protection they would be provided if they were NDIS participants it is recommended that the MH Act be amended to regulate the use of chemical and environmental restraints. For consistency these amendments should be modelled on the seclusion and bodily restraint provisions contained within Part 14, Divisions 4 and 5 of the MH Act.

Employing restrictive practices as behavioural management tools risks retraumatising people who have experienced physical, sexual or psychological trauma that are often antecedents for the mental health issues leading to admission. It also risks creating new trauma, fracturing trust between a patient and their care team, and potentially causing physical injury to a patient or a care team member. Due to their inherent vulnerabilities and developmental needs, where the patient is a child or young person, such practices must only be used as an option of last resort.

Raising the threshold at which restrictive practices can be authorised for a child or young person will support the use of such interventions in only the rarest of circumstances. It is therefore recommended that Part 14 be amended to provide that where the patient in question is a child or young person, a restrictive practice that is permitted by the MH Act can only be employed where there is a risk of the patient causing serious injury to themselves or another person or, in the case of bodily restraint, where there is a serious and likely risk of harm to the patient's health should they not receive treatment within a defined period of time.

This links with concerns expressed in the Discussion Paper about the use of restraints during naso-gastric feeding of children with eating disorders in non-authorised hospital wards. No amendments have been suggested in the Discussion Paper and the Commissioner strongly encourages the Mental Health Commission to specifically engage with children, young people and their families with lived experience of receiving treatment for eating disorders. Application of restraint is a serious incursion on the rights of children and young people, and it is an untenable situation that they continue to be restrained in places where the law does not allow it, and where such practices are not subject to the safeguards that would apply in an authorised ward.

Mental Health Tribunal

As noted within the Discussion Paper, the MH Act does not define the qualifications or experience required to be considered a Child and Adolescent Psychiatrist. Yet it is a requirement under section 383 of the MH Act that the Mental Health Tribunal (MHT) include a member who is a Child and Adolescent Psychiatrist where the patient who is the subject of proceedings is a child or young person.

Including a definition of 'Child and Adolescent Psychiatrist' within the MH Act would address the lack of clarity that exists around which psychiatrists may properly be considered a Child and Adolescent Psychiatrist for the purposes of the MHT. Given the nature of matters that may come before the MHT, it is in the best interests of children and young people that the definition of Child and Adolescent Psychiatrist is based on a psychiatrist having undertaken further appropriate training provided by an accredited institution. Proposed Amendment 2 as outlined at page 37 of the Discussion Paper is therefore supported in principle, subject to the draft definition of Child and Adolescent Psychiatrist being finalised in consultation with relevant stakeholders.

Mental Health Advocacy Services

As noted in the Discussion Paper, the MH Act limits the classes of voluntary patients to whom the Mental Health Advocacy Service (MHAS) may provide support. Children and young people who have been voluntarily admitted to a mental health facility or who enter a step up/step down service do not currently fall within one of these classes. The Commissioner raised this as a concern in relation to mental health facilities during the 2013 consultation process, recommending the creation of a statutory obligation for MHAS to visit or contact a child or young person who has been admitted in these circumstances within 48 hours of their admission.

Amendment 19 as outlined on page 42 of the Discussion Paper would partially resolve this issue by prescribing children and young people admitted as voluntary inpatients as 'identified persons' for the purposes of sections 348 of the MH Act. However, Amendment 19 specifically rejects the idea of requiring health service providers to notify MHAS that a voluntary patient has been admitted - MHAS would only be obliged to see those voluntary patients who have requested they be contacted. Nor does Amendment 19 cover step up/step down services.

An obligation for MHAS to visit a child or young person who is a patient in a mental health facility or a step up/step down service is critical to ensuring they are provided with the opportunity to access timely advocacy supports. Moreover, it ensures that those children and young people who may not possess the knowledge, confidence or ability to request advocacy supports will be visited by MHAS at the earliest opportunity. Amendment 19 is therefore supported, subject to the incorporation of the following requirements:

- The person in charge of a mental health facility or a step up/step down service is to notify the Chief Mental Health Advocate as soon as is practicable, but not later than 24 hours, after admission/entry of a child or young person.
- Such notification is to occur irrespective of:
    - whether the child is admitted as a voluntary or involuntary patient; and
    - whether the child is admitted to a mental health facility that ordinarily provides treatment or care to children who have a mental illness.
- A mental health advocate must visit or otherwise contact the child or young person in question within 24 hours of that notification being received unless the child or young person declines permission to be visited or contacted.

Oversight of mental health services

Oversight of mental health services in Western Australia is the responsibility of a largely comprehensive framework of independent bodies that carry out a number of discrete oversight functions ranging from the provision of specialist child and youth advocacy support

to the monitoring of clinical service provision. While no single body is responsible for the systemic inspection of mental health facilities, the Chief Psychiatrist's oversight of seclusion and restraint, as well as their specific focus on clinical standards and general rights of entry, access and inspection, combined with MHAS's right to enter facilities and meet with children and young people, mean that mental health service providers are subject to a level of preventative oversight and monitoring. With this in mind, consideration should be given to legislatively empowering a specific body to perform a systemic monitoring and advocacy function in relation to mental health services that support children and young people. This body could be a new statutory position granted a clearly defined systemic remit and appropriate powers, or be part of an expanded role for a pre-existing body such as MHAS.

Previously proposed amendments

In addition to Amendments 2 and 19 discussed above, the following previously proposed amendments, as outlined in the Discussion Paper, are supported in principle:

- Amendment 14 – insert in the definition of seclusion words to the effect of 'a patient's seclusion is not taken to have been interrupted or terminated merely by reason of a scheduled observation or examination or the giving of necessary treatment or care'.
- Amendment 17 – amend the MH Act to expressly state that regardless of whether a voluntary inpatient is placed in a locked or unlocked ward, a voluntary patient has the right to leave the ward and/or hospital at any time without permission.
- Amendment 41 – add a requirement to notify MHAS within a certain timeframe regarding the admission into and detention of a mentally impaired accused person in an authorised hospital.