Eligibility to be a Mental Health Practitioner

2.3 Subsection 19(1)(b) of the WA Act should be amended to clarify that a nurse under either division 1 or 2 of the Nurses Act 1992 may be eligible to be a mental health practitioner. In addition, the reference to "*at least 3 years' experience in the management of persons who have mental illness"* at the end of subsection 19(1) should be replaced with the criterion that a mental health service has designated the person as a mental health practitioner using criteria published by the CP.(Chief Psychiatrist)

ACCEPTED.

Comment: Nurses under Division 2 of the Register (Enrolled Nurses) in a number of circumstances, under supervision, carry out similar tasks to those carried out by Nurses under Division 1 of the Register and would be enabled to contribute in a more significant way to the care of patients subject to functions under the Act. The length of service of a clinician does necessarily reflect appropriate experience.

Y. Minors

New Part to the Act on Minors

Y.1 There should be a new part to the WA Act, entitled *Part 11 – Minors*, dealing with specific provisions to protect children and adolescents receiving treatment and care for mental illness from a mental health service.

ACCEPTED.

Comment: It is recognised that special provision should be made for children and adolescents receiving treatment which legislate for more frequent reviews and reduced time frames.

Definition of a Competent Minor

Y.2 The new part 11 of the WA Act should define a *competent minor* as a person aged 14 to 17 years, who in the view of a psychiatrist, medical practitioner or authorised mental health practitioner acting in accordance with the provisions of this Act, exhibits maturity in their behaviour sufficient to regard them as functioning at an adult level of decision making. An *adolescent* should be defined as any other person aged 14 to 17 years and a *child* should be defined as any person under the age of 14 years. A new section would clarify that a competent minor may be able to seek voluntary admission to a mental health service and may be able to consent to treatment. A further new section would clarify that a competent minor who refuses voluntary admission to a mental health service or refuses voluntary treatment cannot be forced to accept admission or treatment because it is the wish of a parent or guardian.

ACCEPTED.

Comment: This new part would define a process for managing the difficulties arising for persons under the age of 18 who may be competent to choose particular options in health care.

Rights of Parents or Guardian of a Minor

Y.3 The new part 11 of the WA Act should contain a section listing the rights of

parents or a guardian with respect to a child or adolescent and with respect to a competent minor who receive mental health services as follows:
- for the parents or guardian of a child or adolescent: a right to request services from a mental health provider with or without the child or adolescent's consent; a right to remove the child or adolescent from receiving a mental health service, with or without the child or adolescent's consent and with or without the agreement of the service (provided that the child or adolescent is not an involuntary patient or a ward of the State); a right to give informed consent on behalf of the child or adolescent to treatment or care; a right to detailed information about the child or adolescent's illness and treatment; and a right to be involved in the child or adolescent's treatment and care; and for the parents or guardian of a competent minor: a right to request services from a mental health provider; a right to receive information about the competent minor's illness and treatment and to be involved in their treatment or care, provided that the treating practitioner has not made a determination that this is not in the competent minor's best interests.

PARTIALLY ACCEPTED.

Comment: The importance of the involvement of parents and guardians in the care of minors is supported with this inclusion. It gives rights, which recognise the primary importance of parents and guardians in the overall care of children and adolescents. However the second parental right requires further clarification, Having decided a person under 18 is a mature minor and competent to make decisions in their own best interests it is essential that this extends to other decisions such as confidentiality. This recommendation has the potential to undermine the decision-making ability of the mature minor.

Voluntary Admission of Minors

Y.4 The new part 11 of the WA Act should deal with the conditions under which minors (children, adolescents or competent minors) may be admitted to psychiatric inpatient care in a hospital (whether an authorised hospital or otherwise) as voluntary patients. The new sections should contain the following elements:

- a competent minor may apply to a mental health service be admitted as a voluntary patient;
- a parent or guardian of a minor (child or adolescent or competent minor) may apply for the person to be admitted to a mental health service as a voluntary patient;
- a medical practitioner must refuse a minor (child, adolescent or competent minor) voluntary admission unless the medical practitioner is satisfied that the person will benefit from the admission;
- a medical practitioner must refuse a competent minor voluntary admission, unless the medical practitioner is satisfied that the competent minor has given informed consent to the admission;
- a medical practitioner who admits a competent minor as a voluntary patient must take all reasonable steps to notify the parents or guardian

as soon as practicable after the admission; (* CCHR Note: This means the minor may be having treatment before the parents are contacted)

- if a parent or guardian applies to the person-in-charge of a hospital for a child or adolescent who is a voluntary patient to be discharged, the person-in-charge must discharge the child or adolescent.

ACCEPTED

Comment: In respect to the parent or guardian applying for discharge of the minor, if discharge is not in the minors best interests the medical practitioner would need to consider other legislative alternatives such as Guardianship, wards of court or involuntary status.

If the medical practitioner has decided that the minor is competent to make decisions in their own best interests, informing parents or guardians should only be made with the permission of the mature minor. If it is clear that the minor is unable to make appropriate informed decisions the medical practitioner may need to review whether the minor is mature enough to warrant that category.

Involuntary Admission of Minors

Y.5 The new part 11 of the WA Act should contain a section to require that before an order for referral or to be an involuntary patient is made in respect of a child or adolescent, the practitioner making the order must consider if the interests of the child would be better served by recourse to the powers given in the *Child Welfare Act 1947*.

It is intended that the process for making a competent minor an involuntary patient would remain the same as for an adult.

NOT ACCEPTED.

Comment: It may be in the long term benefit of the child for them to be subject to Child Welfare legislation, however in managing the mental illness of the minor the preferred intervention should be through mental health legislation. Involvement of the Child Welfare Act directs mental health matters in the direction of the justice system which may be inappropriate. There is also an expectation that mental health professionals will have a detailed knowledge of other legislation which may not be met.

Segregation of Children and Adults

Y.6 A section should be included in the new part 11 of the WA Act, requiring that a minor (child, adolescent or competent minor) must not be admitted to an authorised hospital or other psychiatric health service unless the person-incharge is satisfied that the minor can be cared for and treated in a manner that gives due regard to the minor's age, culture, gender and maturity and, in the case of a child or adolescent, in a facility that is separate from adult patients. If it is necessary for a competent minor to be admitted to an adult facility, it must be ensured that they are separated from severely mentally ill adults and provided with treatment programs suitable for their age and level of development.

ACCEPTED, however the matter requires further clarification.

Comment: The section outlines the preferred way that minors should receive treatment, however at times this may not be possible. Sound clinical practice

that is directed by service guidelines determines the care minors receive in authorised facilities. Legislating in this area may give rise to unintended breaches when there may be no other alternative than caring for a minor in a facility with adults. An alternative way of managing this issue would be that the Chief Psychiatrist conduct a review of the minors admission when the agreed guidelines are unable to be complied with.

Review of Involuntary Status of Minors

Y.7 The WA Act should require a faster-track review process for competent minors, adolescents and (rarely) children, which includes the following elements:

- amend subsection 48(2) of part 3 such that an initial period of detention (presently up to 28 days) is for no more than 14 days for a minor; (*CCHR note: That means minors may be held with adults for up to 14 days, and parents may still not be involved, or able to be involved) and advise those responsible for the SAT legislation, in relation to part 6, to –
- provide a shortened timeframe for reviews of involuntary status, being a maximum of seven days before the initial review and 28 days for subsequent reviews;
- require that the composition of the MHRB or similar tribunal should include members with child and adolescent psychiatric expertise.
- require that a minor's (child's, adolescent's or competent minor's) parents or guardian be requested to be present at a review hearing unless the MHRB or similar tribunal approves an application from the treating psychiatrist requesting, on reasonable grounds, that it is not in the best interests of the minor for the parents or guardian to be present at the hearing; however, a review should not be postponed because no parent or guardian attends;
- provide that a competent minor may exercise the right to be present at a review hearing and may express their views freely on all matters affecting their involuntary status, but that for a child or adolescent, either the child or adolescent's parent or guardian are present or, in the absence of a responsible parent or guardian, an independent person shall be present to represent the child or adolescent; and
- require that a competent minor or the parents of a child or adolescent have the right to legal representation without payment.

ACCEPTED.

Comment: Child and adolescent psychiatrist's are a rare resource and to have them appointed as MHRB members may leave the Board unable to conduct reviews if the psychiatrist was not available. Whilst the preferred person should be a child and adolescent psychiatrist there needs to be other options if this type of specialist is not available

ECT and Minors

Y.8 Subsection 104(1) of part 5 of the WA Act should be amended such that children, adolescents and competent minors (regardless of their status or where they are treated) are included in the groups of patients for whom ECT is not to be performed unless it has been recommended by the treating psychiatric and approved by the independent second opinion of another psychiatrist.

Furthermore, it should be required that the independent second opinion in the case of a child, adolescent or competent minor is sought from a psychiatrist with specialist training in child and adolescent mental illness.
ACCEPTED.
Comment: ECT is recognised as an effective treatment however this recommendation reflects community concern about the unregulated use of ECT with minors. While permitting the use of the treatment the caveats suggested by the recommendation will ensure that it is used appropriately and with the decision being confirmed by an expert in the area. If the psychiatrist prescribing the treatment is a Child and Adolescent Psychiatrist the confirming second psychiatrist need not have that specialty background.

Banned Treatments of Minors

Y.9 Provisions should be enacted to ban the use of ECT and psychosurgery on a child under the age of 12 years. (*CCHR note: Yet 12yo and above apparently have need of it. It should be banned on all children at the very least)
These bans may be best achieved by the
insertion of new sections in part 5 of the WA Act. Specifically:
- insert a new section following section 104 in division 5 of part 5 stating that a person is not to perform ECT on a child under the age of 12 years; and
- insert a new section following section 101 in division 5 of part 5 stating that a person is not to perform psychosurgery on a child under the age of 12 years.

Offences should be created for breaching these sections with heavy penalties
ACCEPTED.
Comment: There is limited evidence that ECT would be beneficial for children under the age of 12 and community concern would indicate that ECT for children under 12 should be prohibited.

Youth Advocate

Y.10 A division should be included in the new part 11 of the WA Act entitled *Youth Advocate* and should include the following provisions:
- define a youth advocate as a member of the COV who has been nominated by the head of the COV as a visitor who has received specialised training for that role;

ACCEPTED

- require that for every minor (child, adolescent or competent minor) admitted to psychiatric inpatient care in a hospital (whether an authorised hospital or otherwise) there must be either the involvement of their parents or guardian, or a youth advocate, or both;
- require that every competent minor admitted to psychiatric inpatient care is offered a youth advocate; and that every parent or guardian of a child or adolescent is offered a youth advocate;

PARTIALLY ACCEPTED.
Comment: Mature minors may decide that they wish no involvement with parents, guardians or youth advocates and if competent to make decisions they may exercise that right. With adolescents and children it is imperative that either

parents or guardians are involved. A Youth Advocate may additionally offer their services.
- provide that the treating psychiatrist may request the involvement of a youth advocate where the psychiatrist considers it to be in the child or adolescent's best interests;
ACCEPTED.
- require that if a minor (child, adolescent or competent minor) is received at an authorised hospital, or admitted to any other form of psychiatric inpatient care, they must be visited by a youth advocate as soon as practicable;
ACCEPTED.
Comment: The decision to involve a Youth Advocate should ultimately lie with the mature minor, the child or adolescent or the parent or guardian. As with the COV a patient should have the right not to involve a Youth Advocate in their care. As part of the treatment plan a psychiatrist may suggest the involvement of a Youth Advocate but the choice as to whether the services of a Youth Advocate are accessed lies with the patient, his or her parents or guardians.
- define the functions of a youth advocate as to: meet with the minor (child, adolescent or competent minor) as soon as is practicable; act as an advocate on their behalf; acquaint themselves with the circumstances of the admission and nature of involvement of their parents or guardian in their care and treatment; where appropriate, to advocate for the rights of the parents or guardian to be involved in the minor's care and treatment, including provision of information and advice; ensure that a minor (child, adolescent or competent minor) is appropriately represented at hearings of the MHRB or similar tribunal; be involved in treatment decisions and discharge planning; be involved in the decision-making process when ECT is proposed as a form of treatment; and make submissions as necessary to clinicians regarding reviews, child welfare issues and a need for a second opinion, where the youth advocate considers a second opinion to be in the minor's best interests;
PARTIALLY ACCEPTED.
Comment: The role of the Youth Advocate should be similar to that of an Official Visitor. Although they may have training in the role the Youth Advocate may not have the degree of expertise to assist the treating team in making decisions regarding treatment and discharge planning. As an advocate they may present to the team the views of the patient and assist the patient in understanding the reasons for particular treatment approaches. It is not the purpose of the role to be another health worker or member of the treating team. The role is confined to the principles of advocacy. If social work intervention is required a social worker with those appropriate skills should be appointed. If referral is necessary for welfare considerations then that referral should be to the Department of Community Development. The role as described by this recommendation requires further review.
- state that a youth advocate is not a legal guardian of a minor.
ACCEPTED.