RESPONSE TO DRAFT MENTAL HEALTH BILL
BY CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS)

CAMHS has carefully considered the Draft Mental Health Bill and is pleased to provide the following feedback regarding the impact the Mental Health Bill will have on children and adolescents and service providers.

If you have any specific questions, please do not hesitate to contact Dr Caroline Goossens, A/Clinical Lead, CAMHS on 6389 5810.

PART 15:
It is a great step forward to have acknowledged children and adolescents in the Draft Mental Health Bill. The principle of considering the best interests of the child, whilst being informed by their individual wishes and the views of their parents or guardians is welcome. However in section 256 it refers to the capacity of child under the age of 18 to make decisions for themselves if they “have sufficient maturity”. Thus the concept of the mature minor is implied but not explicated, implying that the grounds for determination of capacity will rely on common law principles, which sets the stage for possible infringements on best practice and legal challenge.

From the perspective of the Child and Adolescent Mental Health Service this is problematic. Standard clinical practice is to involve family and carers in treatment and the decision to treat a child or adolescent without carer consent and involvement is unusual and not made lightly. The concept of the mature minor becomes more complex and difficult to determine in the presence of a significant mental illness. To protect both rights of young people and their families right to be involved in decisions about their care and treatment, it would be preferable to further define the concept of capacity and to delineate the process by which this should be assessed. Due to the complex interplay of biological, psychological and social factors operating on background of differing developmental stages in a young person with a Mental Health Disorder, it is recommended that a Child Psychiatrist must be involved in determining this capacity.

This is particularly important in view of the increasing emphasis on mental health being delivered in community settings by nongovernmental agencies. The framework of involvement of carers and families needs to be strengthened whilst allowing provision for consideration and protection of the right of the child for treatment. This is a balance and it needs to be acknowledged that safeguarding one right can lead to the exclusion of the other. This is not acknowledged or addressed in the act as is evident in Part 2- Objects, section 6.

It is also not clear from the Bill if it applies to all children or just those over the age of 12. Lack of clarity around this may precipitate concerns regarding treatment of those under 12 and how to safeguard their rights, whilst recognising the role of parental authority.

Other Areas of the Act with specific concern to CAMHS:

Part 1: Definition of a Mental Health Service: From the perspective of CAMHS, the definition provided of a Mental Health Service is far too broad and non-specific. If this definition were applied, this would mean that all agencies involved with young people could be designated as a Mental Health Service. (Eg schools, youth groups, sporting clubs, day care). Whilst recognising the important role that support has to a young person with a mental health disorder, it should be made clear in the act that a Mental Health Service is a service that provides therapeutic mental health interventions and care by suitably qualified staff.
Part 4- Informed consent: The major concern regarding Part 4 is that it is dealing with both voluntary and involuntary patients. It sets standards for young people and their families seeking voluntary treatment that are not applied in any other area of health treatment. This is stigmatising and can unnecessarily increased anxiety and distress regarding treatment, and place unnecessary barriers before access to treatment. It implies that all young people and their families who seek voluntary treatment for Mental Health Disorders lack judgement and capacity and need special legal protection.

For example, for a young person with significant trauma or depression to be admitted for voluntary treatment would need (and or their carers would need) to sign a consent form (s14) and, in addition to an exhaustive description of nature, purpose, duration, benefits and possible risks, would also have to be provided with advice that they may obtain independent legal or medical advice re admission and treatment before giving consent. This is likely to be confusing and distressing rather than helpful and contribute to significant delays in emergency departments in timely transfer and admission of young people and their families, in spite of the fact that these kind of delays represent a frequent source of complaints. This could also paradoxically lead to more young people being placed under the act due to escalating risk related to delays and heightened anxiety.

The clinician is also placed under the legal onus (s15(1)(g)) to assist in the process of obtaining independent legal and medical advice without an identified or funded process to do so. This would be practicably unworkable in a Children’s Hospital Emergency Department. These distinctions between treatment of young people and their families presenting with mental rather than physical illnesses is in addition to being discriminatory is insulting to highly professional clinical staff and an inappropriate intrusion of the Act into normal clinical practice.

For young people and their families receiving voluntary community based outpatient treatment-which are largely non-pharmacological in nature, the requirements of section 15 are too broad and open to abuse and challenge. For example, prior to providing psychotherapeutic treatment to a child presenting with anxiety and depression, should the clinician provide information to the carers that during the treatment the child may disclose information that would lead the clinician to notify the Department of Child Protection? In the case of family therapy, does this mean that each member of the family would have to sign a consent form? Should there be a warning to family that there is a risk of disclosure of family “secrets” by family members which could lead to distress for some members of family?

What impact will this have on other practitioners such as General Practitioners who provide treatment to consenting children and their families?

Part 5- Involuntary patients: in most respects Part 5 was thought to be implementable. However authorisation of detention times prior to transport is impractical.

S27 (1) It is unwieldy for a medical practitioner to have to authorise detention for only 6 hours from time referral is made to enable person to be taken to authorised facility. They are totally reliant on the capacity of service providing transport. This is too brief a time frame especially for rural and remote situations.
Part 6- Detention for Examination or treatment:

(Division 3 s 82) For children and adolescents under the age of 18: The limitation of the period for an involuntary treatment order to 14 days is unworkable and will contribute to unnecessary escalation of risk. It is typical that there is more diagnostic uncertainty in the presentations of young people with first episodes of major mental illness, so that in contrast to the implication in the Act, a longer period of time is required for optimal clinical care and recommendations for ongoing treatment than for Adults. If a treatment plan has to be submitted within 14 days, this will practically mean that this is created on admission, adversely affecting the process of careful clinical assessment, observation and decision making prior to implementation of a treatment plan.

(s84) Currently it is of note that Bentley Adolescent Unit is only funded for one Child and Adolescent Psychiatrist. (s84) (1) implies that the treating psychiatrist requires another psychiatrists opinion prior to the end of the 14 day detention period. This necessitates the employment of a 2nd Child Psychiatrist in the Bentley Unit.

Part 7: Community Treatment Orders:

(S104) Whilst CAMHS recognises the need for precision in the Terms of Order, this needs to be tempered by the recognition that there is significant under-resourcing-with frequently less than 1 FTE of a treating Child Psychiatrist available in Community Clinics. Individualisation of CTOs to a specific Child Psychiatrist is unhelpful, as it does not acknowledge service responsibility for provision of psychiatric review, arrangements for unplanned leave or cover throughout the week.

S.109(4-9) The implication that the supervising psychiatrist is responsible for arranging all types of second opinion (private or public) within 14 days is unworkable and has major resource implication. For this to be achievable the Mental Health Commission will need to take responsibility for the resourcing and organisation of a continuously available panel to provide these opinions.

Part 8 and 9: Transport Orders/ Police Powers:

(s127) It is of concern to CAMHS that this section implies that the Police will cease to be involved in transport and there may be the introduction of an Authorised Transport Provider. Young people who are being involuntarily transported are a highly vulnerable group. They deserve rigorously governed and trained professional staff to transport them, to ensure safety and protection.

By virtue of their training, the framework and structure of the police force, and their day to day experience with de-escalating volatile and high risk situations, the Police remain the most appropriate agency to provide transport and assistance to young people with significant Mental Health Disorders.

Part 10- Provision of Treatment generally

(S.145-) This section, Second Opinions has major implications for the functioning of CAMHS. CAMHS supports the concept of the provision of second opinions by suitably qualified Child Psychiatrists. However, in view of the significant under-resourcing of CAMHS, in particular the low numbers of Child Psychiatrists, there will be significant practical and resource impediments to the implementation of this section. It is not clear from s145 who has the responsibility for the
sourcing, organisation or funding of second opinions. It would be a gross misuse of valuable Child Psychiatric time to have Child Psychiatrists undertaking tasks such as sourcing or organisation of the second opinion, and it may be impossible with current resourcing for them to be reliably involved in the provision of second opinions. For second opinions to be meaningful in protection of patients rights and maintenance of clinical standards it is essential that they be conducted by a Child Psychiatrist who has appropriate experience with comparable patients and settings.

Division 4 Treatment Support and Discharge Planning:

(S148) This section does not acknowledge the practical difficulties faced in balancing patients rights to information regarding their treatment plan with possible negative impact on therapeutic alliance. The need to protect family and carer capacity to provide information regarding their concerns to treating clinicians should also be acknowledged. The treatment plan runs the risk of becoming a bland and sanitised version rather than an individualised and focussed plan that drives Clinician practice and priorities.

Part 11- Regulation of Certain kinds of treatments.

Throughout this part of the draft bill, the issue of capacity of 12-18 year olds to consent is again introduced. The comments made about Part 15 regarding the dangers of including this in the Bill without any framework of how this is to be determined, equally apply for Part 11, and are indeed more controversial. (s 154, 155, s169, s170 S153):

ECT has been banned for children under the age of 12 years is not based on any known scientific grounds, and does not appear to have been in response to a usage in the Under 12 population in Western Australia. It is acknowledged that requirement for ECT in this age group would be extremely rare and unusual, but should be available with safeguards as a lifesaving procedure if all other treatment options have been exhausted.

Information provided by the Office of Chief Psychiatrist indicates that between July 2007 and June 2010, no child under 12 years of age had ECT and less than 5 young people aged between 12-17 had ECT.

S.158 The requirement for the Mental Health Review Tribunal to authorise ECT is considered by CAMHS to be an inappropriate intrusion into a clinical decision making process. Whilst s160 does allow ECT in an emergency with Chief Psychiatrist approval this appears to be contradicted by S.163 2(c) which precludes ECT as emergency treatment. The need for the Chief Psychiatrists to be thus available 365 days per year and the reporting to OCP regarding ECT raises resource implications.

(S163, s164, s165) These sections have promoted considerable concern regarding implications for paperwork and resourcing in other services eg Emergency Departments who act under a Duty of Care to provide Emergency treatment without informed consent to young people with mental health disorders.

Division 5 Seclusion at authorised hospitals:

CAMHS has a commitment to minimising the practice of seclusion and restraint. All CAMHS staff are in process of being trained in de-escalation techniques (Therapeutic Crisis Intervention TCI) We predict this will reduce the current seclusion rates, however seclusion will still be
required as a therapeutic clinical Intervention. With the current Mental Health Act there are six forms that are required to be filled out primarily by nursing staff which are then processed by the administrative staff. With the introduction of the new bill and the recommendations that have been made the numbers of forms have escalated markedly.

Whilst agreeing with the principles driving increased regulation around seclusion, it is of significant concern that this will further impact on clinical staff time to be actually available to young people. To continue to provide the same level of service provision, whilst coping with increased administrative demands of numbers of forms, providing documentation for and coordinating MHB reviews will have significant resource implications. It is estimated that an additional 1 FTE of Child Psychiatry, 1 FTE of Nursing and 1 FTE of Administration will be required to meet the increased regulations.

Part 12- Authorised hospitals- health care generally

S.208 Sterilisation procedures are dealt with in this section, which is a very rare event in a young person under the age of 18. There is no process identified for the more frequent issue of temporary but medium term infertility with processes such as depot contraceptives or use of agents to prevent onset of puberty in young people with Gender Identity Disorder. There are clinical guidelines in use for these situations, but inclusion in the Bill should be considered.

S209b should not be included in the Bill and is likely to invoke considerable opposition.

Part 13- Protection of patients’ rights

CAMHS welcomes an emphasis on patient’s rights and note this is a significant improvement on previous act. However these rights should be balanced by ensuring the rights of carers to be able to provide information confidentially that will not be released as it may irretrievably jeopardise future relationships.

S218: With this in mind restrictions on access must always be guided by clinical review of material. Lawyers acting on behalf of patients are not trained to be able to judge the sensitivity of the material or the impact on individual if revealed.

Part 14 Recognition of Carer’s rights: 

This section is welcomed by CAMHS and note that is consistent with current clinical practice.

Part 18- Tribunal: The Tribunal is proposed to replace the Mental Health Review Board and in addition to reviewing the Tribunal will also have the new roles of reviewing treatment, support and discharge plans, authorising the administration of ECT to involuntary patients and issuing compliance notices.

S.302(b) As a result it is viewed by CAMHS that it is mandatory that a member of the MHRT be a Child Psychiatrist in active clinical practice- a generalist psychiatrist or Medical Practitioner is NOT a suitable replacement for its specific role given the complexity of the bio-psycho-social and developmental issues that need to be addressed and understood in making clinical judgements about young people with Mental Health Disorders. The Tribunal will not be competent and should not have any role in reviewing treatment and discharge plans or authorising clinical procedures if a Child Psychiatrist is not present. As such CAMHS does not support 302 (b) and 309 (2).
S.304 (3) Whilst having the capacity to review treatment the Tribunal should NOT ever be able to specifically direct clinical treatment. If the Tribunal asks for a treatment plan to be reviewed it is also of note that this could significantly delay discharge and could contribute negatively to patient flow.

**Subdivision 4-** Likewise in this subdivision, the Tribunal could not complete a review regarding the in-patients psychiatric condition, medical and psychiatric history and social circumstances without the benefit if a Child psychiatrist being part of the Tribunal.

**Part 20- Chief Psychiatrist**

CAMHS views the role of the Chief Psychiatrist as vital in setting clinical standards and thus is a key part of quality assurance. This office should be able to objectively assess and report on the quality and standards of Mental Health provision purchased by the Mental Health Commission. As a result it is difficult to see how such independence could be maintained if this office was located within and reporting to the Mental Health Commission.

On behalf of CAHS CAMHS, thank you for the opportunity to provide comment.

Dr Caroline Goossens  
A/Clinical Lead  
Child and Adolescent Mental Health Service  
Child and Adolescent Health Service  

9 March 2012