



## **Submission to the**

*Review of the Australian Capital Territory Mental Health (Treatment and Care) Act 1994*

29 February 2008

Submission to ACT Health

© Youth Coalition of the ACT

29 February 2008

Prepared by Youth Coalition staff Sid Chakrabarti and Meredith Hunter.

Thank you to the Youth Coalition team for their support.

Youth Coalition of the ACT

PO Box 5232, Lyneham, ACT, 2602

Phone (02) 6247 3540

Facsimile (02) 6249 1675

info@youthcoalition.net

[www.youthcoalition.net](http://www.youthcoalition.net)

INTRODUCTION	2
SUMMARY OF RECOMMENDATIONS	3
1) DEFINITIONS	4
a) Capacity to Consent	4
b) Fewer Protections	5
c) Gaps in Coverage	5
d) Conclusions	5
2) CHILDREN AND YOUNG PEOPLE	6
a) Best interests	6
b) Definitions of age should not inhibit best practice	6
3) CHILDREN AND YOUNG PEOPLE, AND THE RIGHT TO CONSENT	8
4) CONCLUSIONS	9

## **Introduction**

---

The Youth Coalition of the ACT (the 'Youth Coalition') is the peak youth affairs body in the Australian Capital Territory. We are responsible for representing, promoting and protecting the rights, interests and wellbeing of people aged between 12 and 25 years and those who work with them.

The Mental Health (Treatment and Care) Act 1994 (the 'Act') sets the framework under which the mental health system in the ACT operates. As such, it is just a facet of a system that can have a significant impact on a person's health and wellbeing as well as their freedom.

In the best-case scenario: 'mental health legislation can play a vital role in preventing violations and discrimination against people with mental disorders.'<sup>1</sup> In the worst case, it can be a tool used to actively discriminate against people with mental disorders, actively restricting their movement and taking away their rights to natural justice. Young people, often regarded as incapable of giving informed consent notwithstanding a mental disorder, therefore have a significant interest in how the Act is constructed and applied.

The Youth Coalition endorses the Mental Health Community Coalition submission but makes its own submissions in the following areas:

1. Definitions and Purpose;
2. Children and Young People, Generally; and,
3. Children and Young People, and Capacity to Consent.

---

<sup>1</sup> WHO 2005

## **Summary of Recommendations**

---

### **Recommendation 1**

That ACT Health negotiate for:

1. A two part definition to describe mental health conditions, differentiating between 'Mental Illness' as the stronger definition, and 'Mental Disorder' as the more inclusive definition.
2. That 'mental illness' be the level required to invoke restrictive practices; and,
3. That 'mental disorder' be the level required to access the positive rights under the Act.

### **Recommendation 2**

That there be a dedicated section in the Act dealing with Children and Young People

### **Recommendation 3**

That the caveats provided in the Options Paper for the application of involuntary treatment of children and young people be retained in the Act and care and protection service involvement be retained.

### **Recommendation 4**

That the Act make specific reference to the 'best interests' principle and that the application of that principle be clearly defined, particularly as it relates to culturally appropriate treatment and consent.

### **Recommendation 5**

That the definitions of children and young people and their treatment needs be flexible enough to allow for the best interests of the child or young person to be properly considered.

### **Recommendation 6**

That the Gillick Principle be substituted for the tests in the Options Paper for the 12 -16 and the 16 – 18 year old age groups.

## **1) Definitions**

---

The debate on definitions focuses on the narrowness or the breadth of the definition with mental illness at the narrow end and mental incapacity ostensibly at the other. In this context, the debate surrounding the definitions in the Act seems to sustain itself on the question of whether the Act is one primarily concerned with restricting the freedom of those it applies to or whether it provides access to positive rights.

The Youth Coalition believes that any mental health legislation should be consistent with the Human Rights Act 2004 (ACT), and that it should maximise the autonomy and liberty of people with a mental disorder. However, the Youth Coalition submits that the definition should not be made so narrow as to exclude access to quality mental health care in an effort to maximise the autonomy and liberty of people with a mental disorder.

Further, the Youth Coalition believes that this debate is premature as there is, at this point, an 'Options Paper on the Review of the Australian Capital Territory Mental Health (Treatment and Care) Act 1994' (the 'Options Paper') and an opportunity to create an Act that is focused on rights, positive freedoms and protection rather than one simply concerned with restrictive practices. In this sense, the Options Paper canvasses advanced directives, a rights based approach, access to a mental health tribunal, and young people's consent to treatment, all areas for which there is strong support.

At the core of the Youth Coalition's concern is the fact that medical practitioners generally prefer to diagnose young people with disorders rather than illnesses, and due to this, an excessively restrictive definition would exclude young people from the protections of this Act.

### ***a) Capacity to Consent***

To take an example, the Youth Coalition would like to avoid the situation where a young person's advanced directive has no standing in law because the young person does not have the capacity to consent to treatment.

Given that advanced directives deal with acute periods and given that medical practitioners generally prefer to diagnose young people with mental disorders rather than mental illnesses, it is not unreasonable to say that there will be situations that young people will not be able to exercise their

consent under the Act because at the time they made the directive, they did not have a diagnosed mental illness but rather a mental disorder.

### ***b) Fewer Protections***

In addition, an excessively narrow definition diminishes the significance of the disorders that may be suffered by young people and puts them in the ambit of general health care. A medical practitioner may recommend that a young person with a mental disorder be given similar treatment to a person with a mental illness, and in these circumstances, a young person may be left with a lack of power to consent to her/his own treatment, a lack of access to the tribunal, and a lack of access to those rights that may be available under the Act.

### ***c) Gaps in Coverage***

Finally by adopting a mental illness definition, we leave a gap in coverage, a gap that will most significantly affect young people. To provide an example, if the Act contains sections on voluntary treatment, it would be ironic if a young people was excluded because they had a mental disorder and not a diagnosed mental illness.

### ***d) Conclusions***

The Youth Coalition acknowledges that there is no easy answer on how to reconcile this question, but submits that it is not a question of definition but rather one of application. Thus there is no reason why a mental disorder definition could not distinguish between those cases where restrictive provisions apply and where a broader class of cases where the restrictive practices do not apply. This approach is consistent with WHO recommendations, is not onerous and does not leave a gap in mental health legislative coverage.

Thus the Youth Coalition recommends:

#### **Recommendation 1**

That ACT Health negotiate for:

1. A two part definition to describe mental health conditions, differentiating between 'Mental Illness' as the stronger definition, and 'Mental Disorder' as the more inclusive definition.
2. That 'mental illness' be the level required to invoke restrictive practices; and,
3. That 'mental disorder' be the level required to access the positive rights under the Act.

## **2) Children and Young People**

---

The Youth Coalition supports the view that a dedicated section on children and young people must be included in the revised legislation. In this sense, we also believe that the Act should allow for distinct and evolving policy responses to mental health treatment amongst young people.

Further, we accept that the provisions for the involuntary treatment of children and young people should be included.

The Youth Coalition agrees with the options paper that the Act contain provisions covering:

1. Referral to the relevant area of the Office of Children, Youth and Family Services for circumstances where there is no obvious responsible adult or guardian for young people aged less than 16 years and for people aged between 16 and 18 and who are assessed as being at considerable risk; and,
2. The best interests of the child or young person as described in the United Nations Convention on the Rights of the Child<sup>2</sup> and the Children and Young People's Act 1999.

### ***a) Best interests***

If the best interests principle is included in the Act, it should be expanded upon as recommended in the Options Paper to reflect the requirement of culturally appropriate treatment. Further, it should be the basis for guaranteeing that the views of children and young people are always considered in their own treatment.

### ***b) Definitions of age should not inhibit best practice***

The Youth Coalition also supports the view that a child be defined between the ages of 0 -12 and a young person as being aged 12 years to the 18<sup>th</sup> birthday. This is consistent with the Children and Young People's Bill 2007 and is therefore acceptable. However, the Youth Coalition notes that, in practice, there must be a continuity of treatment for a young person moving from adolescence to adulthood. This is supported by practice and by emerging literature that highlight that many mental health conditions develop between the ages of 17 and 23 and that treatment that does not properly provide for the continuity between adolescence and adulthood is unlikely to succeed as quickly or completely.

---

<sup>2</sup> The United Nations Charter on the Rights of the Child (20 November 1989) UNTS 27531

**Recommendation 2**

That there be a dedicated section in the Act dealing with Children and Young People

**Recommendation 3**

That the caveats provided in the Options Paper for the application of involuntary treatment of children and young people be retained in the Act and care and protection service involvement be retained.

**Recommendation 4**

That the Act make specific reference to the 'best interests' principle and that the application of that principle be clearly defined, particularly as it relates to culturally appropriate treatment and consent.

**Recommendation 5**

That the definitions of children and young people and their treatment needs be flexible enough to allow for the best interests of the child or young person to be properly considered.

### **3) Children and Young People, and The Right to Consent**

---

The Youth Coalition submits that the tests for competence should be dropped in preference of the test developed in the English case of Gillick<sup>3</sup>.

The Gillick Principle was developed in a British case<sup>4</sup> and was accepted into the common law of Australia through Marion's Case<sup>5</sup> It provides that children who are under the age of 16 years who have the intelligence and understanding to be competent to give consent to a particular treatment, may give consent for themselves. Further, the parental right to consent terminates when a child is deemed Gillick-compliant. Finally the assessment of Gillick competence is a question of fact for the medical practitioner to determine in each case.

In general, most medical decisions concerning children are dealt with by doctors, parents and in consultation with the children and thus Gillick is not often used. Further when competence assessments have been made in Australia and in New Zealand, they have rarely been controversial<sup>6</sup>. However, Gillick is an important aspect of recognising the capacity of a child or young person to consent to treatment and represents the modern opinion in the United Kingdom, Australia and New Zealand.

The Youth Coalition approves the use of Gillick for the 12 -16 age group as well as the 16 -18 age group, effectively making the principle from Gillick applicable to that whole age group. This would make it consistent with the common law, and the new Children and Young People's Bill 2007.

Thus, the Youth Coalition recommends:

#### **Recommendation 6**

That the Gillick Principle be substituted for the tests in the Options Paper for the 12 -16 and the 16 - 18 year old age groups.

---

<sup>3</sup> Gillick v West Norfolk and Wisbech Area Health Authority and another [1986] 1 AC 112 (HL)

<sup>4</sup> Gillick v West Norfolk and Wisbech Area Health Authority and another [1986] 1 AC 112 (HL)

<sup>5</sup> Department of Health and Community Services v JWB and SMB (Marion's Case) [1992] HCA 15; (1992) 175 CLR

<sup>6</sup> Children and Competence to Consent: Gillick Guiding Medical Treatment in New Zealand [2000] VUWLR 31

## **4) Conclusions**

---

The Act is an important instrument that can have a significant impact on the lives of children and young people. Further, it is an Act that contains both rights and restrictions. The Youth Coalition advocates for a balanced Act that reflects best practice and acknowledges the capacity of children and young people to consent to their own treatment.