Public Advocate

ACT Human Rights Commission

Ensuring children and young people's rights through mental health oversight

Findings from a two-year project exploring the intersection between the involuntary mental health and out-of-home care systems.

Ensuring children and young people's rights through mental health oversight: Findings from a two-year project exploring the intersection between the involuntary mental health and out-of-home care systems.

A project by the ACT Public Advocate.

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1. List of abbreviations

Abbreviation	Definition
AIHTT	Adolescent Intensive Home Treatment Team
AMHU	Adult Mental Health Unit
AMOS	Assertive Mobile Outreach Service
C&YP	Children and young people
CAMHS	Child and Adolescent Mental Health Service
CAU	Child and Adolescent Unit
CRC	Convention on the Rights of the Child
CRPD	Convention on the Rights of Persons with Disabilities
CYPS	Child and Youth Protection Services
ECT	Electroconvulsive Therapy
ED3	Involuntary detention and treatment orders of 3 days
ED11	Involuntary detention and treatment orders of 11 days
OOHC	Out-of-Home Care
PTO	Psychiatric Treatment Order
TCH	The Canberra Hospital
UN	United Nations
WHO	World Health Organisation

2. Executive summary

The ACT Public Advocate undertook a two-year project (1 July 2021 – 30 June 2023) to understand the extent to which children and young people, notably those involved with the ACT care and protection system, were being involuntarily detained and treated under the *Mental Health Act 2015* (MH Act) in the ACT.

In accordance with legislation in the ACT, the Public Advocate must be notified and provided with certain documentation when limitations are imposed on the rights of individuals, including children and young people. This includes where children and young people are involuntarily detained and treated in the ACT mental health system, and where children and young people are subject to care and protection proceedings.

This project sought to analyse the documentation provided to the Public Advocate to better understand:

- the extent to which children and young people were being involuntarily detained and treated in accordance with the MH Act, and
- the extent to which those children were *also* residing in out-of-home care (OOHC) arrangements.

This project found that children and young people in the OOHC system were significantly overrepresented in the ACT involuntary mental health system. The project also found that over half of the total number of mental health documents received by the Public Advocate involved a relatively small number of children and young people.

Of this group of children and young people who were subject to repeated involuntary actions under the MH Act:

- Most were involved with Child and Youth Protection Services (CYPS), with some children and young people subject to care and protection orders.
- Most had been or were involved with the justice system, including in civil and criminal proceedings either as a victim or alleged offender.
- Nearly half had a co-occurring disability, such as a cognitive disability or neurodiversity.
- Most had a history of childhood trauma and exposure to family violence.
- Some had unstable housing, including homelessness.

While the ACT is a human rights jurisdiction, noting it was the first state/territory to legislate a Human Rights Act, the findings from this project suggest that significant improvements are needed to better uphold the rights of some of our most vulnerable children and young people.

In addition to making recommendations for change in the ACT, such as more thoroughly embedding human rights in mental health service provision, this project underscores the importance of independent oversight to ensure that any limitations of human rights are reasonable, necessary, and proportionate to the individual circumstances of each child or young person.

3. Introduction

3.1 Role of the Public Advocate

The Public Advocate is one of eight independent statutory positions within the ACT Human Rights Commission (the Commission). Section 27B of the *Human Rights Commission Act 2005* (HRC Act) outlines the legislative responsibilities for the Public Advocate, which broadly involve protecting and promoting the rights and interests of people in the ACT who experience vulnerability.

The role of the Public Advocate extends to persons within the ACT whose situation or condition gives rise to a need for protection from abuse, neglect or exploitation, or a combination of those things. Statutorily, the HRC Act includes provisions for the Public Advocate's responsibilities in respect of children and young people and people with disability (including those with mental health concerns).

The responsibilities of the Public Advocate are underpinned by a range of functions including advocacy (individual and systemic), representation, investigation, and monitoring. Some of these functions are specific to children and young people, and others encompass people with complex disability needs, including those with mental health conditions and/or forensic patients.

The Public Advocate has a strong focus on ensuring that its monitoring and oversight functions (and the recommendations that are made to government and non-government agencies on legislation, policies, and practices) contribute to improvements in the accessibility, responsiveness, and quality of supports and services that are available for people experiencing vulnerability.

In addition to the provisions of the HRC Act, there are several other pieces of legislation and related legislative instruments that include obligations associated with the performance of the Public Advocate role. Notably, for the purposes of this project and report, both the *Mental Health Act 2015* (MH Act) and *Children and Young People Act 2008* (CYP Act) establish statutory oversight and monitoring functions for the Public Advocate. This includes provisions that require certain documents to be provided to the Public Advocate to support the Public Advocate's oversight.

3.2 Human rights

The rights of children and young people are protected and promoted by international and domestic laws that, when read together, require mental health service provision to be underpinned by a human rights framework. The relationship between these instruments and the rights of children and young people who interact with mental health services and systems is briefly outlined below.

3.2.1 United Nations Convention on the Rights of the Child (CRC)

The *Convention on the Rights of the Child* (CRC) is an international human rights treaty that protects and promotes the rights of children and young people. Australia has signed and ratified the CRC[1], conferring a responsibility to ensure that the rights of children and young people are respected, protected and fulfilled.

The CRC contains 54 articles, 42 of which pertain to the rights held by children and young people with the remaining 12 articles detailing the responsibilities of adults and governments to ensure these rights are upheld. While all the rights of children and young people are equally important, the rights listed on the next page are of particular significance to children and young people interacting with mental health services and systems.

[1] *Convention on the Rights of the Child*, opened for signature 20 November 1989, 1577 UNTS 3 (entered into force 2 September 1990).

- **Article 2 – All children and young people have equal rights.** All children and young people should enjoy the rights in the CRC without discrimination; this includes those with mental health conditions.
- **Article 3 – Best interests.** In all actions concerning children and young people, their best interests should be a primary consideration.
- **Article 6 – Life, survival, and development.** All children and young people should enjoy the same opportunities to grow and develop in conditions that do not negatively impact their mental wellbeing.
- **Article 12 – Right to express views and be heard.** All children and young people have the right to express themselves and to be heard, including in relation to decision-making about their access to mental health services.
- **Article 19 – Protection from violence, abuse, and neglect.** All children and young people have the right to protection from all forms of physical or mental violence, injury, or abuse, including in the way they receive treatment for mental health concerns.
- **Article 23 – Support for disability.** Children and young people who have any form of disability (including mental health concerns) should receive special care and support so they can live full and independent lives.
- **Article 24 – Right to health.** All children and young people have the right to the best possible health (including mental health) and to healthcare services that help them attain this.
- **Article 25 – Right to review.** Children and young people whose care, protection, or treatment of physical or mental health is provided outside of the family home are entitled to a periodic review of their treatment and placement.

In applying a human rights lens to the provision of services for children and young people, the CRC underpins the interpretation of local laws to the extent that they involve the rights accorded to children and young people.

3.2.2 United Nations Convention on the Rights of Persons with Disabilities (CRPD)

In addition to the CRC, Australia has signed and ratified the *Convention on the Rights of Persons with Disabilities* (CRPD).[2] The CRPD is the principal instrument recognising the human rights of people with disability.

For the purposes of this project, the following rights are of particular significance:

- **Article 7 – Rights of children and young people with disability.** Children and young people with disability have the right to express their views freely on all matters affecting them and to have their views taken into account in accordance with their age and maturity on an equal basis with other children. They must also be provided with disability-specific and age-appropriate assistance to realise this right.
- **Article 12 – Legal capacity and support for decision-making.** People with disability have the right to enjoy legal capacity on an equal basis with others, and government must take measures to provide access to support for people with disability to exercise their right to be involved in making decisions.

[2] *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008).

- **Article 14 – Right to liberty and security.** People with disability enjoy the right to liberty and security of the person and must not be deprived of their liberty arbitrarily or solely based on their disability.
- **Article 15 – Freedom from torture or cruel, inhuman, or degrading treatment or punishment.** People with disability must not be subjected to torture or to cruel, inhuman or degrading treatment or punishment.
- **Article 21 – Freedom of expression and opinion, and access to information.** Governments must ensure that people with disability can exercise the right to freedom of expression and opinion, including the freedom to seek, receive and impart information and ideas on an equal basis with others.
- **Article 25 – Right to health.** People with disability have the right to enjoy the highest attainable standard of health (including mental health) without discrimination because of disability. Health professionals should provide a service based on free and informed consent.

Importantly, Australia's obligations under the CRPD extend without limitation or exception to state and territory jurisdictions.[3]

3.2.3 Human Rights Act 2004 (HR Act)

The human rights of children and young people in the ACT are not only recognised by international human rights frameworks, but also by domestic laws, including the ACT *Human Rights Act 2004* (HR Act). The HR Act articulates the fundamental framework for human rights in the ACT and provides important statutory protections for the rights of ACT children and young people.

For those children and young people who engage with the involuntary mental health system in the ACT, there are a range of rights recognised in the HR Act that may be engaged. These rights include:

- **Section 10 – Protection from torture and cruel, inhuman, or degrading treatment.** No one may be subjected to treatment without his or her free consent.
- **Section 11(2) – Protection of children.** All children and young people in the ACT have the right to protection because of being a child, without distinction or discrimination of any kind.
- **Section 13 – Freedom of movement.** Everyone in the ACT has the right to move freely within the ACT.
- **Section 16 – Freedom of expression.** Everyone in the ACT has the right to hold opinions and to freely express themselves, including by seeking, receiving, and imparting information.
- **Section 18 – Right to liberty and security.** No-one may be arbitrarily arrested or detained.

While the HR Act provides that human rights may be limited, this can only occur in response to reasonable limits set by laws.[4] One such law that may limit human rights in the ACT is the MH Act, which provides for involuntary detention and treatment. Importantly, public authorities in the ACT (such as government agencies) have a legal obligation to act consistently with human rights.[5] This includes where limits are imposed on the rights of children and young people, including by virtue of involuntary detention and treatment. These obligations will be explored in further detail in the discussion section of this report.

[3] *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008) art 4(5).
[4] *Human Rights Act 2004* (ACT) s 28.
[5] Ibid, s 40B.

4. Project background

4.1 Purpose of this project

The Public Advocate commenced this project in July 2021 to better understand the extent to which children and young people in the ACT were being involuntarily detained and treated under the MH Act. This included building a better understanding of the involuntary detention and treatment of children and young people who were already known to the Public Advocate through its oversight functions in respect of OOHC and youth justice.

The Public Advocate was particularly interested in identifying factors that contribute to (or mitigate against) further instances of involuntary detention and/or recurring admissions under the MH Act, and gaps that might exist in the mental health service system.

In identifying these factors, the Public Advocate was interested in understanding the extent to which these factors contribute to the rates of involuntary action under the MH Act.

4.2 Methodology

In accordance with the legislative provisions of the MH Act and CYP Act, the Public Advocate must be provided with certain documentation. Examples of the documentation that must be provided to the Public Advocate in accordance with these two laws is detailed below in **Table 1**.

Table 1: *Examples of documentation provided to the Public Advocate in accordance with legislation.*

Mental Health Act 2015	***Children and Young People Act 2008***
Involuntary detention application and orders of 3 or 11 days (also known as an ED3 or ED11).[6]	Applications for care and protection orders.[7]
Notices of restraint, forcible giving of medication, or seclusion.[8]	Child concern/incident reports.[9]
Involuntary treatment orders (e.g., Psychiatric Treatment Orders, Electroconvulsive Therapy Orders, Assessment Orders).[10]	Annual review reports for children and young people subject to care and protection orders.[11]

For the purposes of this project, the Public Advocate examined all mental health documentation received for children and young people (aged 12-17 years) from 1 July 2021 through to 30 June 2023. It is important to note that the mental health documentation provided to the Public Advocate only relates to involuntary detention and treatment under the MH Act. As such, this review did not examine voluntary admissions and treatment in mental health service settings.

[6] *Mental Health Act 2015* (ACT) ss 85 and 89.
[7] *Children and Young People Act 2008* (ACT) ss 427(1), 435(3).
[8] *Mental Health Act 2015* (ACT) ss 65(4)(5), 73(4)(5), 88(4)(5), 107(4)(5), 114(4)(5).
[9] *Children and Young People Act* s 507.
[10] *Mental Health Act 2015* (ACT) ss 58, 149, 37.
[11] *Children and Young People Act 2008* (ACT) s 497(1).

5. Findings

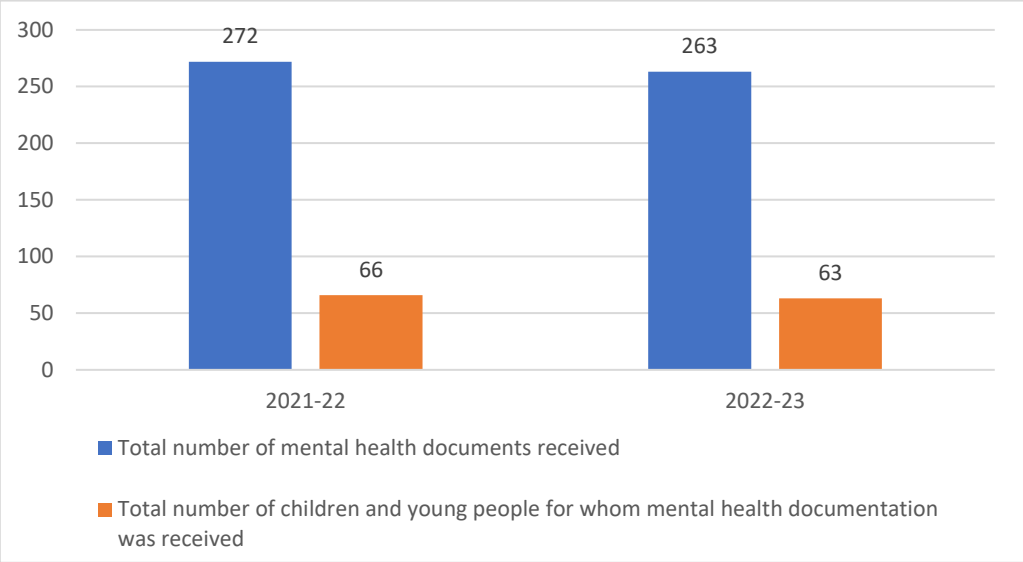
5.1 General findings

5.1.1 Total number of documents for children and young people brought to the attention of the Public Advocate

From 1 July 2021 through to 30 June 2023, the Public Advocate received 535 mental health documents for 116 children and young people.

As shown in **Figure 1**, in 2021–22, the Public Advocate was provided with 272 mental health documents relating to 66 children and young people. The 2022–23 data was consistent in that the Public Advocate received 263 documents for 63 children and young people.[12]

Figure 1: *Total number of mental health documents received by the Public Advocate relevant to the total number of children and young people (C&YP) to whom they relate (2021–22 to 2022–23)*



Note: Some children and young people are counted in both years.

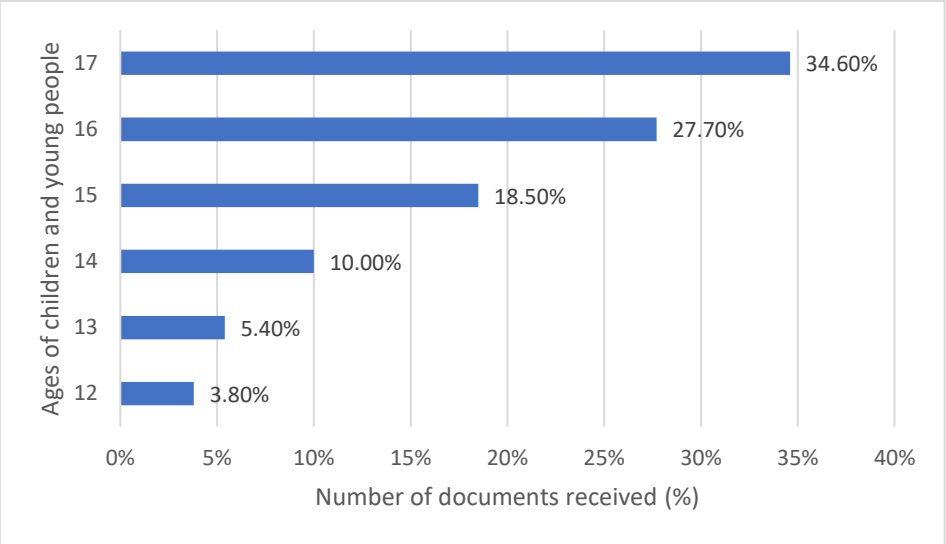
5.1.2 Ages of children and young people who were subject to actions under the MH Act

The 116 young consumers for whom mental health documentation was received across 2021–22 and 2022–23 was aged between 12 to 17 years, and the average age of young people subject to actions under the MH Act was 15.6 years of age.

As **Figure 2** on the next page demonstrates, most documents received were for young people aged between 16-17 years. The 'Missing Middle' report (2022) identified that young people aged 16 years and over can experience a reduction in services as they transition from child to adult services.[13] In addition, many young people at these ages may experience less family support or have reduced financial ability to pay for services.[14] As such, these factors may contribute to the higher volume of mental health documentation relating to the involuntary detention and treatment of young people in this age cohort.

[12] Some children and young people were represented across both 2021-22 and 2022-23.
[13] The Office for Mental Health and Wellbeing, *Missing Middle* (Final Report, August 2022) page 20 https://www.youthcoalition.net/publications/understanding-the-missing-middle-child-and-youth-mental-health-in-the-act/.
[14] Ibid, page 20.

Figure 2: *Ages of C&YP for whom mental health documentation was received by the Public Advocate (2021–22 to 2022–23)*

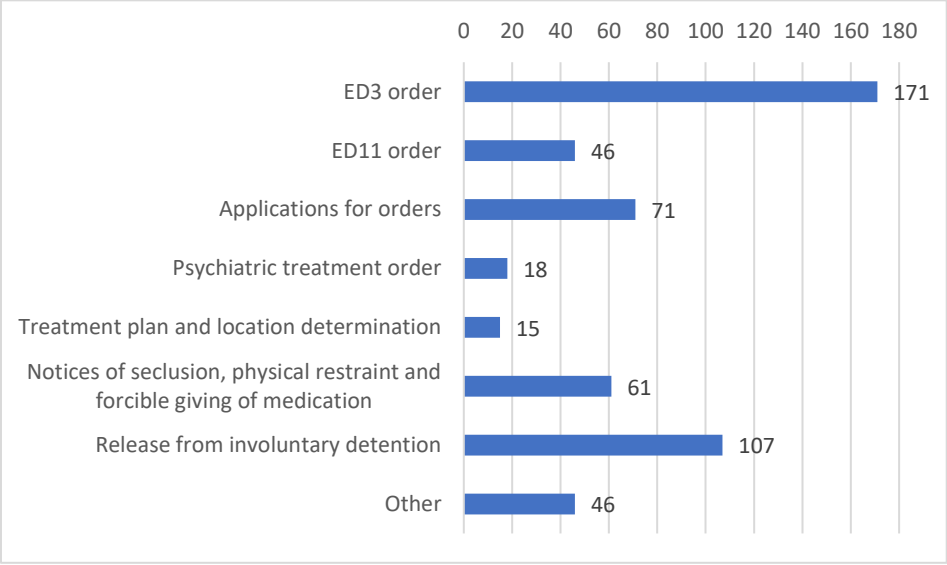


5.1.3 Types of mental health documentation received for children and young people

The types of mental health documentation received for children and young people included documents such as:

- involuntary detention and treatment orders (e.g., ED3 and ED11),
- restraint, seclusion, and forcible giving of medication,
- applications for psychiatric assessments and mental health orders (e.g., PTOs, ECT),
- documents related to mental health treatment plans, and
- releases from involuntary detention.

Figure 3: *Types of mental health documents received by the Public Advocate for C&YP aged between 12 and 17 years (2021–22 to 2022–23)*



As **Figure 3** demonstrates, most mental health documents received by the Public Advocate for children and young people were for involuntary detention orders of three days and subsequent documents associated with their release from involuntary detention.

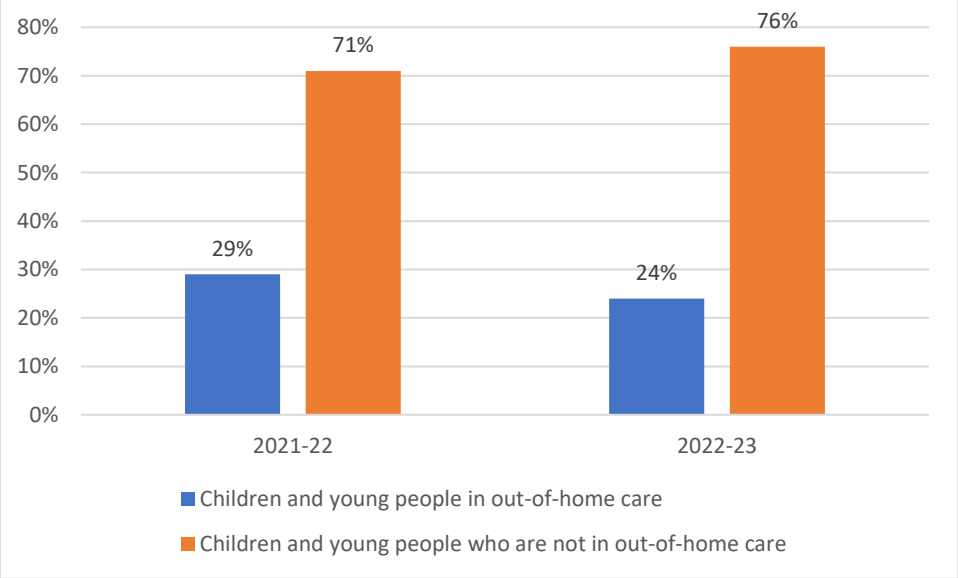
5.2 Over-representation of children and young people in out-of-home care

From 1 July 2021 through to 30 June 2023, the Public Advocate received 242 applications for the involuntary detention and treatment of children and young people, including applications for ED3s, ED11s, psychiatric assessment orders, mental health orders and ECT. Of those 242 applications, 178 were related to children and young people who were *not* in OOHC[15] (74 per cent), and 64 related to children and young people in OOHC (26 per cent).

To put these figures into context, the Australian Bureau of Statistics (ABS) indicates that as of 30 June 2022, 98,169 children and young people (aged 0-17 years) were living in the ACT.[16] By comparison, at that same date there were 688 children and young people living in OOHC arrangements in the ACT.[17] This means that only 0.7 per cent of children and young people in the ACT are in OOHC.

However, given that more than a quarter (26 per cent) of applications for involuntary detention and treatment received by the Public Advocate in respect of children and young people were for those in OOHC, these figures represent a significant over-representation of children and young people in OOHC in the ACT involuntary mental health system. This means that for every one child or young person living with their family receiving involuntary treatment, there are approximately three children and young people living in OOHC receiving involuntary treatment.

Figure 4: *Applications for involuntary detention and treatment received by the Public Advocate for C&YP mapped against care arrangements of those C&YP (2021–22 to 2022–23)*



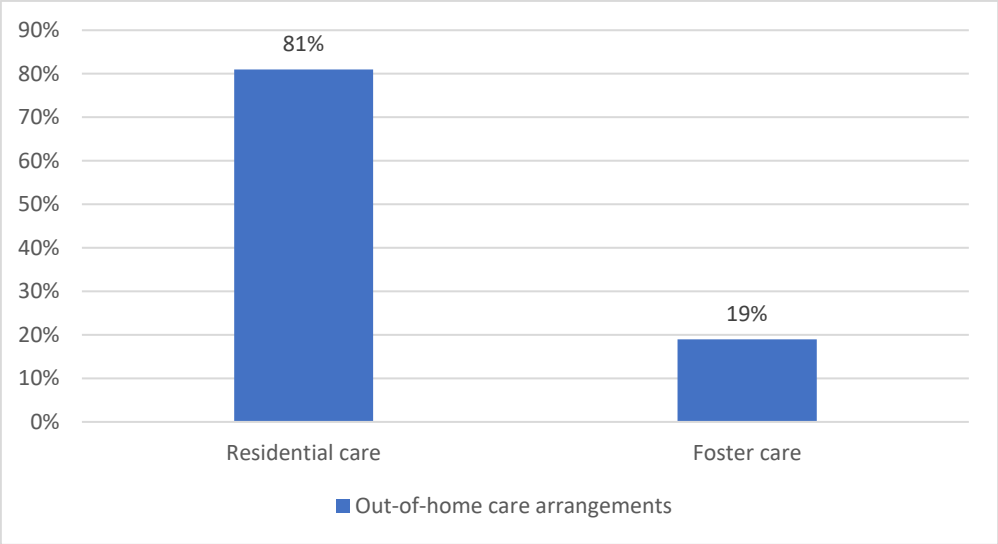
Of those living in OOHC arrangements at the time of their involuntary detention and treatment under the MH Act, most applications for involuntary detention and treatment related to children and young people living in residential care (81 per cent), with the remaining applications relating to children and young people in foster care (19 per cent) (see **Figure 5** on the next page).

[15] Out-of-home care is defined as overnight care for children aged under 18 who are unable to live with their families due to child safety concerns. This includes placements approved by the department responsible for child protection for which there is ongoing case management and financial payment (including where a financial payment has been offered but declined by the carer). Out-of-home care also includes legal (court-ordered) and voluntary placements, as well as placements made to provide respite for parents and/or carers. See: Australian Institute for Health and Welfare (AIHW), *Child protection Australia 2018-19* (Series No. 72, Cat. no. CWS 74).

[16] See: Australian Bureau of Statistics, *National, state and territory population* (Cat. No. 3101.0, Table 58. Estimated Resident Population by Single Year of Age Australian Capital Territory, 14 December 2023).

[17] Australian Institute of Health and Welfare, *Child protection Australia 2021-22* (Cat. No. CWS 92, 11 May 2023).

Figure 5: *Applications for involuntary detention and treatment received by the Public Advocate for C&YP in OOHC arrangements (2021–23)*

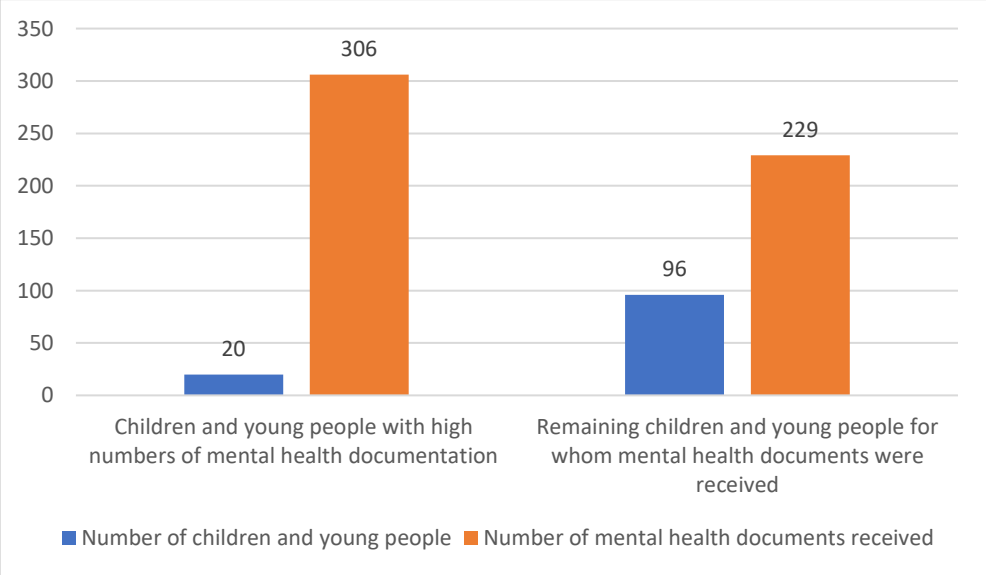


Of those children and young people residing in residential care, 31 per cent had also been engaged with youth justice services, including some who had been detained at the Bimberi Youth Justice Centre.

5.3 Over half of the mental health documents received by the Public Advocate involved a relatively small number of children and young people

As noted earlier in this report, from 1 July 2021 through to 30 June 2023, the Public Advocate received 535 mental health documents for 116 children and young people. Of concern, 20 children and young people made up for more than half (57 per cent) of all mental health documentation received by the Public Advocate for children and young people.

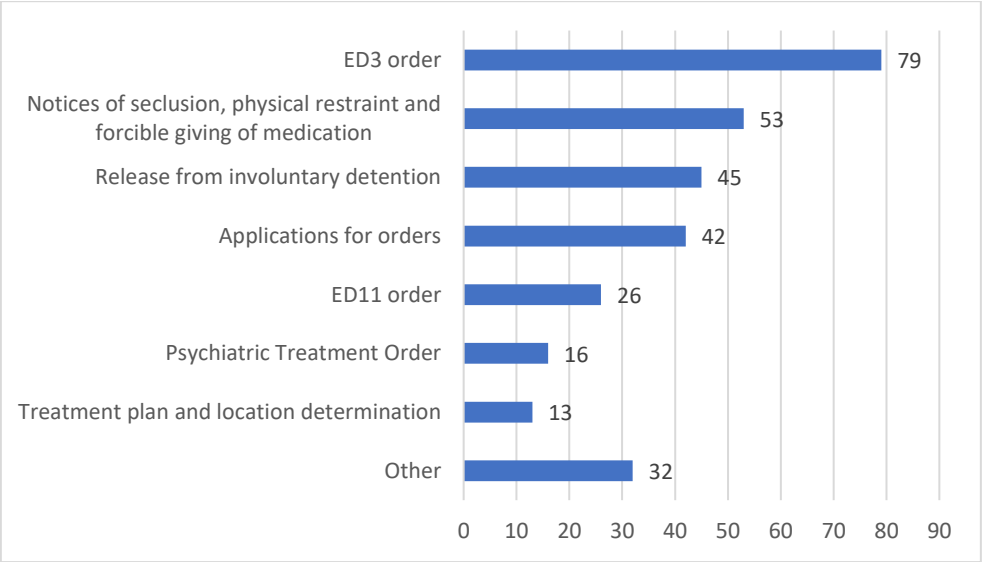
Figure 6: *Comparison of mental health documents received by the Public Advocate for those C&YP for whom the most documents were received versus all remaining C&YP (2021–22 to 2022–23)*



Of the 20 children and young people for whom the Public Advocate received the highest number of mental health documents, those children and young people received anywhere between 7 to 38 mental health documents across 2021–22 to 2022–23.

As demonstrated in **Figure 7**, most documents received by the Public Advocate for this cohort of children and young people included involuntary detention orders of three days and notices of seclusion, physical restraint, and forcible giving of medication.

Figure 7: *Types of mental health documents received for the 20 C&YP for whom the Public Advocate received the highest numbers of mental health documentation (2021–22 to 2022–23)*



Of the 20 children and young people who were subject to the highest numbers of involuntary actions under the MH Act:

- Most were involved with CYPS, with some children and young people subject to care and protection orders.
- Most had been or were involved with the justice system, including in civil and criminal proceedings either as a victim or alleged offender.
- Nearly half had a co-occurring disability, such as a cognitive disability or neurodiversity.
- Most had a history of childhood trauma and exposure to family violence.
- Some had unstable housing, including homelessness.

Of concern, a number of these children and young people were not able to have their health needs adequately met in the ACT and required interstate transfers.

6. Discussion

6.1 Rights of children and young people underpinning service delivery

In respecting and upholding the rights of children and young people, the Public Advocate is committed to promoting a rights-based approach to mental health service delivery in the ACT, including by ensuring that practitioners understand their public authority obligations when making decisions involving involuntary actions under the MH Act. Such actions, albeit supported by law, limit the human rights of those children and young people, for example, their right to provide free and informed consent to medical treatment.

Importantly, children and young people must be provided opportunities to:

- be involved in the development and delivery of mental health services (including in relation to the reform of services, legislation, and policy).
- be actively involved in their mental health treatment, care, and support.

Public Advocate's position and recommendations

As the World Health Organisation (WHO) and United Nations established in their guidance and practice document released in 2023,[18] and in recognition of Article 12 of the CRC, mental health services must respect children's evolving capacities.

Consistent with the guidance from the WHO and UN,[19] the Public Advocate recommends that:

- Children and young people be given the opportunity to provide free and informed consent to mental health care, in a manner consistent with their age and maturity.
- Children and young people be provided with age and disability appropriate decision-making support, in a manner consistent with their evolving capacities (e.g., accessible and child friendly materials for children and young people subject to involuntary actions).

6.1.1 Rights of children and young people in out-of-home care

As detailed in the findings of this report, ACT children and young people in the OOHC system were overrepresented in the involuntary mental health system. Given the additional limitations often experienced by children and young people subject to interventions across multiple government systems, the Public Advocate emphasises their right to be actively involved in decision-making about their mental health treatment, care, and support as well as their OOHC arrangements.

It is also important to note that Aboriginal and Torres Strait Islander children and young people are overrepresented in both the ACT OOHC system and nationally.[20] The causes of over-representation have repeatedly been described in reports and literature but have largely gone unaddressed, including the intergenerational impacts of separation from family and culture, and systemic racism.[21]

Given the high rates of First Nations children and young people in the ACT OOHC system and noting that children and young people in OOHC are largely overrepresented in the involuntary mental health system, the Public Advocate supports the comprehensive reform that is underway in relation to care and protection services in the ACT. Further, any reforms to reduce the number of children and young people who enter the involuntary mental health system must be considered alongside these care and protection reforms.

[18] World Health Organisation and the United Nations (represented by the Office of the United Nations High Commissioner), *Mental health, Human Rights and Legislation: Guidance and Practice* (Guidance, October 2023) page 54 (who.int).
[19] Ibid, page 54.
[20] As of 30 June 2022, 45,400 children were in OOHC. Of those children, 19,300 were Aboriginal and Torres Strait Islander children (57 per 1,000 Indigenous children) and 25,900 were non-Indigenous children (4.8 per 1,000 non-Indigenous children). See: Australian Institute for Health and Welfare, *Child Protection Australia 2021-22*.
[21] Human Rights and Equal Opportunity Commission, *Bringing Them Home* (Report, April 1997) bringing_them_home_report.pdf (humanrights.gov.au) page 374.

Public Advocate's position and recommendations

In recognising and furthering the rights of children and young people who are subject to dual-government systems and interventions (i.e., CYPS and Mental Health), the Public Advocate recommends that government:

- Work collaboratively across systems to respect and further the rights of these children and young people.
- Provide children and young people the opportunity to participate in decisions that affect their lives, including involving their supporters, families, and kin.

To address the over-representation of First Nations children and young people in the ACT OOHC system, the Public Advocate supports the implementation of the recommendations of the *Our Booris, Our Way* review.[22]

6.1.2 Human rights obligations of public authorities

The Public Advocate notes that in the ACT, public authorities (such as Canberra Health Services and CYPS) have a legal obligation to act consistently with human rights.[23] Practically, this means acting in a way that is compatible with human rights and giving proper consideration to relevant human rights when making decisions.

The Public Advocate alongside other Commissioners in the ACT Human Rights Commission is frequently offered the opportunity to provide comments and feedback on draft CHS policies, procedures, models of care, etc. Of note is that, more often than not, these documents fail to include information to assist readers to understand the relevance of human rights to health care practices. They also fail to provide information to assist CHS staff to understand their public authority obligations and how these apply to their decision-making and other actions.

Public Advocate's position and recommendations

To better support public authorities to act consistently with human rights, the Public Advocate asserts the need for all practice and guidance documentation (e.g., policies and procedures) to explain the legal obligations of CHS staff (as public authorities) to act consistently with human rights.

In addition to explicit and consistent references to human rights in these documents, continuous learning and development opportunities must be available for staff to ensure practical understanding of their public authority obligations.

6.2 Prioritise mental health services for children and young people in the community

While this project focussed primarily on involuntary detention and treatment in inpatient facilities, clinicians frequently emphasise the value of community-based mental health services for children and young people in preventing admissions and/or readmissions to hospital.

This project found that the most common type of mental health documentation received for children and young people was an ED3. ED3s provided to the Public Advocate also include reasons as noted by the authorising doctor. While these are brief, the reasons noted in documents that were the subject of this review mostly involved risk of harm to self, suicidal ideation, self-harm, or a suicide attempt.

[22] *Our Booris, Our Way* review (December 2019) Reports and Recommendations - Community Services (act.gov.au).
[23] *Human Rights Act 2004* (ACT) s 40B.

Of note, in 2020, the ACT Children and Young People Death Review Committee released a report on young people who died because of intentional self-harm. The review found that young people who presented to hospital following a suicide attempt and were later discharged were often left with the obligation to engage with supports, as opposed to receiving proactive engagement by a community service.[24]

The review made several recommendations including the following:

> *5. Implement a support plan process in clinical settings that actively engages young people following a suicide attempt.*
>
> *6. Implement evidence-based, assertive outreach guidelines into ACT Government policy that include face-to-face contact with young people who have attempted suicide.*[25]

While Child and Adolescent Mental Health Services can provide services to children and young people upon discharge – either through its community teams, Adolescent Mobile Outreach Service, or Adolescent Intensive Home Treatment Team – the Public Advocate understands that not all children and young people are actively engaged in their discharge plan and that assertive outreach options are not consistently available to ACT children and young people. This is notable given the subset of children and young people referenced in this report who were the subject of repeat involuntary interventions.

Without improvements to and/or increased capacity in community-based mental health services and initiatives, the ACT is likely to continue to see a 'revolving door' of children and young people entering and exiting inpatient mental health facilities.

Public Advocate's position and recommendations

In recognising the right of children and young people to the best possible health and standard of healthcare[26] and their right to development,[27] the Public Advocate recommends that mental health care should be provided within community settings that are accessible to children and young people, including in their home where appropriate and preferred.

Investment and expansion of outreach and community-based services should be prioritised, to make it easier for children and young people to maintain relationships and education, while receiving treatment, care, and support in the community.[28]

6.3 Ensuring children and young people receive care in age-appropriate facilities

Drawing on the qualitative information also available to the Public Advocate during the data collection period for this project (1 July 2021 to 30 June 2023), most children and young people who were subject to involuntary action under the MH Act were treated either in:

- the Emergency Department (ED) and/or Mental Health Short Stay Unit (MHSSU) at the Canberra Hospital; or
- the Adult Mental Health Unit (AMHU) at the Canberra Hospital (which is inclusive of the Low Dependency Unit, High Dependency Unit and Ward 12B).

[24] ACT Children and Young People Death Review Committee, *Review of ACT children and young people who have died as a result of intentional self-harm: 2017-2019* (Review Report, 2020) page 19 Review of Children and Young People Who Have Died as a Result of Intentional Self-Harm (act.gov.au).
[25] ACT Children and Young People Death Review Committee, *Review of ACT children and young people who have died as a result of intentional self-harm: 2017-2019* (Review Report, 2020) page 19 Review of Children and Young People Who Have Died as a Result of Intentional Self-Harm (act.gov.au).
[26] *Convention on the Rights of the Child*, opened for signature 20 November 1989, 1577 UNTS 3 (entered into force 2 September 1990) art 24 and the *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008) art 25.
[27] Ibid, art 6.
[28] World Health Organisation and the United Nations (represented by the Office of the United Nations High Commissioner), *Mental health, Human Rights and Legislation: Guidance and Practice* (Guidance, October 2023) page 82 Mental health, human rights and legislation: guidance and practice (who.int).

Of concern, most of the units listed above are predominately adult mental health units. Children and young people were seldom admitted to the Women and Childrens Hospital (Paediatric Ward) for mental health treatment, care, and support.

On 5 July 2023, shortly after the data collection period for this project concluded, the Child and Adolescent Unit (CAU) was opened for children and young people who require an inpatient mental health admission. The Public Advocate has welcomed the opening of the CAU, noting the importance of children and young people receiving age-appropriate mental health treatment, care, and support.

Having said that, it is concerning that the Model of Care for the CAU precludes admission for adolescents who require "higher dependency care". Further, the Public Advocate also notes that the CAU only has six inpatient beds, which may mean that some children and young people who are eligible for the CAU may not be admitted due to bed capacity at the time of their admission.

Noting that those children and young people who are subject to repeat involuntary actions under the MH Act often have a trauma history and/or involvement with another government system (such as care and protection or youth justice), the Public Advocate retains concerns that children and young people will continue to be transferred to and treated in acute adult mental health settings, which may exacerbate their mental distress.

Public Advocate's position and recommendations

In line with the right of children and young people to have the best possible health and healthcare,[29] and in recognition of their right to additional protections by virtue of being a child,[30] the Public Advocate is of the view that treatment in an inpatient mental health facility should be avoided to the maximum extent possible.[31]

Where an admission is required, children and young people should be treated in an age-appropriate facility, such as the CAU, and admission should be limited in time and occur only in exceptional circumstances.[32]

[29] *Convention on the Rights of the Child*, opened for signature 20 November 1989, 1577 UNTS 3 (entered into force 2 September 1990) art 24 and the *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008) art 25.
[30] *Human Rights Act 2004* (ACT) s 11(2).
[31] World Health Organisation and the United Nations (represented by the Office of the United Nations High Commissioner), *Mental health, Human Rights and Legislation: Guidance and Practice* (Guidance, October 2023) page 83 Mental health, human rights and legislation: guidance and practice (who.int).
[32] Ibid, page 83.

7. Concluding comments

Viewing these findings through a human rights lens and with consideration for the dual-system impact on those with engagement with both the involuntary mental health and OOHC systems provides an important reminder for both policymakers and practitioners about the need to resource and enhance preventative solutions that enable 'the right support at the first time in the right place' for children and young people experiencing vulnerability.

Notwithstanding the dedicated staff who work with children and young people in the care and protection and mental health service systems every day, it is clear that there is still more to be done to ensure timely and responsive support for children and young people who experience mental health challenges, ideally *before* they find themselves receiving involuntary treatment, care, and support.

While the Public Advocate appreciates the unique position of this office and the insights that are able to be garnered through its oversight functions, it is likely that those working within these systems will not be surprised by the findings of this review. In view of the attention that has been given to improving mental health services for children and young people over recent years, and the risks and repercussions that result when their needs are not well served, it is anticipated that this report will supplement the existing evidence-base and usefully inform the continued focus on this important area of support for children and young people.

In closing, these findings remind us that we cannot be complacent when it comes to the mental health and wellbeing of our children and young people. Because acknowledging and responding to these findings is not just something we *should* do, it is something we *must* do in seeking to uphold our obligations in respect of the human rights of our children and young people.

8. References

8.1 Reports

ACT Children and Young People Death Review Committee, *Review of ACT children and young people who have died as a result of intentional self-harm: 2017-2019* (Review Report, 2020) Review of Children and Young People Who Have Died as a Result of Intentional Self-Harm (act.gov.au).

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8.2 Legislation

Children and Young People Act 2008 (ACT).

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8.3 Treaty

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8.4 Other

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