


Act for Change: A Mental Health and Wellbeing Act that realises the vision for change

Submission on the Mental Health and Wellbeing Act Update and Engagement Paper (August 2021)



Acknowledgement of Country

This submission was written on the land of the Wurundjeri and Boon Wurrung people of the Kulin Nation.

We acknowledge and pay our respects to Aboriginal and Torres Strait Islander peoples and Traditional Custodians throughout Victoria, including Elders past and present.

We also acknowledge the strength and resilience of all First Nations people whose social and emotional wellbeing continues to be negatively affected by discrimination, racism, child removal and other devastating ongoing effects of colonisation.

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Executive summary

A system that supports people's choices and their recovery in ways that enable them to live the best lives they can, as determined by them.¹

This quote from Senior Consumer Consultant, Wanda Bennetts, reminds us that this is the system we are striving for, and that the new Mental Health and Wellbeing Act needs to provide the legislative foundation for the transformational change envisioned by the Royal Commission into Victoria's Mental Health System (**Royal Commission**).

This submission has been shaped by the lived experience and expertise of members of our mental health consumer advisory group, Speaking from Experience. Our recommendations are informed by their experiences of the mental health system and its failure to protect and promote their rights and to support and respect their decisions.

This submission is also informed by the work of Victoria Legal Aid's (**VLA**) specialist mental health lawyers and Independent Mental Health Advocacy (**IMHA**) non-legal advocates with people facing or subject to compulsory mental health treatment in every designated mental health service in Victoria. In 2020–21, VLA's mental health and disability lawyers appeared at approximately 1,000 Mental Health Tribunal (**Tribunal**) hearings and provided over 2,200 advices to consumers regarding their Tribunal hearing. Each year, IMHA non-legal advocates assist thousands of Victorians at risk of compulsory mental health treatment to make decisions and have as much say as possible about their assessment, treatment and recovery. In 2019–20, IMHA delivered 12,623 advocacy and self-advocacy services and 22,338 information and referral services.

Through this work we see the disconnect between the intentions of the *Mental Health Act 2014* (Vic) (**2014 Mental Health Act**) and what happens in practice. We also see, as observed by the Royal Commission, that compulsory treatment tends to be the default, rather than the 'last resort', and that many people's experience of compulsory treatment is harmful to their recovery and wellbeing.²

Two pillars for successful reform

To move away from a mental health system which the Royal Commission found has 'catastrophically failed to live up to expectations',³ toward a system that 'encourage[s] a human rights-based culture to flourish'⁴ both of the following are necessary:

- **A new and ambitious Act.** The new Mental Health and Wellbeing Act must provide the strongest possible foundation for the transformational system change envisioned by the Royal Commission. The Royal Commission found that a 'new Mental Health and Wellbeing Act is needed to reset the legislative foundations underpinning the mental health and wellbeing

¹ Victoria Legal Aid, *Submission to the Royal Commission into Victoria's Mental Health System – Roads to Recovery: Building a Better System for Victorians Experiencing Mental Health Issues* (July 2019) 9 (**Roads to Recovery**).

² State of Victoria, *Royal Commission into Victoria's Mental Health System, Final Report, Volume 4: The fundamentals for enduring reform*, Parl Paper No. 202, Session 2018–21 (document 5 of 6), 363–364, 370–372, 387 (**RCVMHS Final Report, Volume 4**).

³ Royal Commission into Victoria's Mental Health System, *Interim Report* (November 2019) 1.

⁴ RCVMS Final Report, Volume 4, 35.

system, [and] reflect contemporary human rights practice and thinking.’⁵ To do this, it must embed mechanisms that go beyond the 2014 Mental Health Act. If we simply tweak the provisions of the 2014 Mental Health Act, we will limit the potential role of the new Act as a foundational component of systemic change and jeopardise the success of this crucial reform.

- **A sustained commitment to effective, consumer-led implementation.** Beyond the wording of the Act, the thought behind, investment in, and dedication to implementation of the new Act must be comprehensive and sustained. This includes investing in the systems and changes that will make improved practices possible, including embedding and resourcing consumer leadership, funding education, providing resourcing, and ensuring accountability.

Through our work, we are deeply aware that a commitment to both these pillars of reform will set up the system to succeed at achieving the aims it has set, providing a rights-based recovery orientated mental health system for consumers.

Priorities for an Act that embeds consumer leadership, rights and accountability

Led by our mental health consumer advisory group, Speaking from Experience, and informed by our work, these are the most significant priorities to make sure the Mental Health and Wellbeing Act embeds consumer leadership, rights and accountability in a way that delivers on the promise of reform.

1. **A regulatory model geared to drive cultural change.** To make sure the new Act has a real impact for consumers, we recommend that a similar framework to the *Gender Equality Act 2020* (Vic), carefully designed to lead and embed cultural change, is included in the Mental Health and Wellbeing Act. This should include both educative and enforcement roles for the Mental Health and Wellbeing Commission through performance targets, timelines and public reporting, with an obligation on mental health services to develop action plans for how they will comply with the new Act. This robust accountability framework should include reporting against targets on the use and duration of compulsory treatment and the use of seclusion and restraint, as well as compliance with the requirements and principles of the Act and strategies to embed supported decision-making and ensure access to non-legal advocacy.
2. **A system where people understand and can exercise their rights.** Mechanisms to simply ‘inform’ people of their rights have not been enough to create a rights-focussed system. Services need to be reorientated to a rights-based culture of supported decision-making, where consumers are proactively supported to exercise their rights.
3. **An opt-out state-wide non-legal advocacy service.** The IMHA non-legal advocacy service plays a critical role in realising a rights-focussed and recovery-oriented system. An independent, state-wide non-legal advocacy service for consumers who are subject to or at risk of compulsory treatment, provided on an opt-out basis, is a crucial part of a system where consumers understand and can exercise their rights and are supported to make decisions about their assessment, treatment and recovery.
4. **Increased access to legal assistance.** Legislative provisions and practice mechanisms for information sharing are essential to achieve the Royal Commission’s recommendation

⁵ Ibid.

for increased access to legal assistance. Legal assistance is a crucial mechanism for rights protection and supported decision-making in the Tribunal, where significant decisions affecting rights are made and consumers experience considerable power imbalance.

5. **Supported decision-making is understood and embedded.** Unlike in the 2014 Mental Health Act, supported decision-making should be named and explained in the new Act. The obligations of decision-makers and service providers should be clear and widely understood: to support people to make their own decisions, including through strengthened mechanisms of advance statements, nominated persons, accessible rights information and proactive referrals to non-legal advocacy and legal assistance.
6. **Mechanisms to stop defaulting to compulsory treatment.** Statutory guidance should be created for decision-makers at all levels to apply the legislation consistently to preference voluntary treatment in practice and make compulsory treatment a true last resort. This means moving away from a best interests culture and ensuring that equivalent treatment can be accessed on a voluntary or compulsory basis. A person with capacity should only be treated without consent where this is necessary to prevent serious harm to others. Even where a person is subject to a compulsory treatment order, their will and preferences, including those recorded in an advance statement, should be followed as much as possible. Compulsory orders should not be used to compel a person to comply with a particular treatment if it is not actually necessary to prevent serious harm.
7. **Timing and consumer leadership.** It is crucial that the reforms are led and genuinely informed by consumers, and that the re-designed system has consumer leadership embedded. We caution against single consumer roles on oversight and governance bodies and encourage transparency in the appointment of key positions to strengthen the reforms and build trust in the reform process. While recognising the pressures the Department of Health is under, we reiterate the importance of taking time to properly plan and embed legal and cultural change of this significance.

Our **30 detailed recommendations** are set out in **Annexure 1**.

VLA is committed to working with the Victorian Government, lived experience experts, mental health services, oversight and safeguard bodies, and the legal assistance sector to shape and support the successful implementation of reforms needed to achieve the vision of the Royal Commission.

1. Victoria Legal Aid, our work and Victoria's mental health legislation

VLA is a statutory agency responsible for providing information, advice, and assistance in response to a broad range of legal problems through 14 offices across Melbourne and regional Victoria. Working alongside our partners in the private profession, community legal centres, and Aboriginal legal services, VLA assists people with legal problems related to family separation, child protection, family violence, discrimination, criminal matters, fines, social security, mental health and tenancy. More information about our clients and our work is set out in **Annexure 2**.

VLA is the largest provider of legal services to people with mental health issues and disability in Victoria. In 2019–20, VLA provided assistance to over 88,000 clients: 25% – over 22,000 people – disclosed having a disability or experiencing a mental health issue; and 14% were in custody, detention or psychiatric care.⁶

VLA has a legal assistance system coordination role under the *Legal Aid Act 1978* (Vic), including administering baseline and/or special purpose funding to 43 community legal centres, Djirra, the Victorian Aboriginal Legal Service, and the Federation of Community Legal Centres.⁷ The system coordination role also includes system coordination, collaborative planning and service design functions.

VLA's specialist mental health lawyers and IMHA non-legal advocates work with people facing or subject to compulsory mental health treatment in every designated mental health service in Victoria,⁸ including at child and adolescent, adult and aged, and long-term secure extended care units (SECUs), as well as at Thomas Embling Hospital.

Through this work, we see the current disconnect between the provisions of the 2014 Mental Health Act and what happens in practice. It is this direct service provision and consumer leadership that informs our recommendations about what is needed in the Mental Health and Wellbeing Act and in implementing the change the new Act promises.

1.1 IMHA non-legal advocacy

IMHA was established in 2015 as part of the Victorian Government's commitment to a human rights-based mental health system and funded by the then Department of Health and Human Services as part of the implementation of the 2014 Mental Health Act.

IMHA was created through a co-design process involving the Department of Health and Human Services, VMIAC, Tandem, clinicians and independent consumers. IMHA's work continues to be

⁶ See: Victoria Legal Aid, *Annual Report 2019-2020* (September 2020) (**VLA Annual Report 2019-2020**). This includes clients seen by a private practitioner duty lawyer. Unique clients are individual clients who accessed one or more of Victoria Legal Aid's legal services. This does not include people for whom a client-lawyer relationship was not formed, who received telephone, website or in-person information at court or at public counters or participated in community legal education—we do not create an individual client record for these people. This client count also does not include people assisted by our Independent Mental Health Advocacy or Independent Family Advocacy and Support services. We note that, because this figure relies on clients disclosing their disability or mental health issue at the time of receiving legal assistance, the actual number of clients with disability is likely to be significantly higher. We also note that, because of the way our data is collected and recorded, we are not able to accurately separate out mental health from other disability.

⁷ Ibid., 53.

⁸ A designated mental health service is a health service that may provide compulsory assessment and treatment to people in accordance with the *Mental Health Act 2014* (Vic).

informed by a permanent consumer consultant role and a permanent consumer advisory group, Speaking from Experience.

IMHA supports people receiving or at risk of compulsory mental health treatment to make decisions and have as much say as possible about their assessment, treatment, and recovery. To do this, IMHA advocates regularly visit every public mental health service in Victoria to advocate, promote human rights and supported decision-making, support self-advocacy, and actively refer consumers to services they request to support their recovery.

In the 2019–20 financial year, IMHA delivered 12,623 high intensity services (advocacy and self-advocacy) and 22,338 low intensity services (information and referral). IMHA reaches thousands of consumers each year from diverse backgrounds, including Aboriginal and Torres Strait Islander people, culturally and linguistically diverse people, LGBTIQ+ people, younger and older people, and people with a disability or disabilities.

IMHA is the first and currently the only non-legal advocacy service of this kind in Victoria (similar services exist in Western Australia and the UK). It has an instruction-based representational advocacy model, which means IMHA advocates listen to people, support them to make decisions if they request this, and communicate their views and preferences as expressed by them. Its advocacy model is informed by human rights, diversity and inclusion, consumer leadership, and a trauma-informed approach.

An independent evaluation by RMIT was undertaken of IMHA's first three years of operation.⁹ The evaluation team included experts in mental health law, service delivery, and research, and was co-produced with people with lived experience of the mental health system. RMIT consulted 69 consumers who had used IMHA, 40 consumers who were eligible for but had not used IMHA, nine stakeholder body representatives, 292 mental health professionals, 31 mental health lawyers, and 16 IMHA staff.

The independent evaluation of IMHA identified that IMHA is a service model that helps protect and promote the rights of consumers, including through consumer leadership, advocacy and self-advocacy, a regional presence and a commitment to rights and recovery. It found that it is overwhelmingly positively received by consumers who use the service.

1.2 Mental Health and Disability Law service

VLA's Mental Health and Disability Law program provides advice and representation to people with a mental health diagnosis or cognitive disability. Our biggest area of practice is providing advice and representation to consumers across Victoria who are subject to compulsory treatment and have a Mental Health Tribunal hearing.

In 2019–20 in Victoria, only 13% of consumers were legally represented before the Tribunal.¹⁰ The Mental Health Tribunal conducts around 8,600 hearings each year, across 80 divisions per fortnight.¹¹

⁹ The evaluation was undertaken by RMIT University's Social and Global Studies Centre. See: Maylea, Chris; Alvarez-Vasquez, Susan; Dale, Matthew; Hill, Nicholas; Johnson, Brendan; Martin, Jennifer; Thomas, Stuart & Weller, Penelope (2019) *Evaluation of the Independent Mental Health Advocacy Service (IMHA)*, Melbourne: Social and Global Studies Centre, RMIT University. Available at <[imha-rmit-evaluation-of-the-independent-mental-health-advocacy-service-03-2019.pdf](#)> (IMHA Evaluation Report).

¹⁰ Mental Health Tribunal (August 2020), *Annual Report 2019-2020*, 30. (MHT Annual Report 2019-2020). The difference in rates of legal representation before Mental Health Tribunals in Victoria and New South Wales is further explored in Victoria Legal Aid, *Response to question on notice to the Royal Commission into Victoria's Mental Health System* (30 July 2019). Available at <<https://www.legalaid.vic.gov.au/sites/www.legalaid.vic.gov.au/files/vla-letter-responding-to-question-on-notice-30-july-2019-redacted.pdf>>.

¹¹ Ibid., 20; Mental Health Tribunal, *Venue Calendar July 2021*.

VLA currently services 47 of those divisions with regular visiting or 'duty lawyer' services at inpatient units. VLA is the main provider of representation at the Tribunal, representing consumers at 11% of Tribunal hearings in the 2019–20 financial year (approximately 1000 hearings).¹² VLA's service is provided through a regular visiting or 'duty lawyer' service. In addition to appearing at over 1000 Tribunal hearings, in 2020–21, VLA's mental health and disability provided over 2,200 advices to consumers regarding their Tribunal hearing.

The Mental Health Legal Centre also provides legal advice and representation for consumers, including through pro bono partnerships.¹³

1.3 Consumer leadership

From the outset, consumer leadership and co-production was central to IMHA, and people with lived experience of the mental health system advised on IMHA's development, including co-production of IMHA's program logic and evaluation framework. Consumers are part of IMHA's work, and they are also part of its workforce. VLA employs a Senior Consumer Consultant to oversee and promote consumer leadership, and two-thirds of IMHA's advocacy workforce identify as having a lived experience of mental health issues.

Established in 2016, the Speaking from Experience advisory group is made up of people who have lived experience of mental health issues and the public mental health system. IMHA's Senior Consumer Consultant supports Speaking from Experience to inform service design, delivery and evaluation for IMHA and across VLA. The Senior Consumer Consultant and Speaking from Experience have also contributed to policy development, been on staff recruitment panels, and developed accessible resources for clients across our legal and non-legal advocacy services.¹⁴

VLA is working toward embedding consumer leadership in its organisational culture, including the establishment of an advisory group for VLA's Independent Family Advocacy Support (**IFAS**) service, which began in January 2019 and consists of people with lived experience of the child protection system. The IFAS Lived Experience Consultant guides the work of the consumer advisory group in advising VLA on its work with people who have contact with the child protection system.

Through this work, VLA sees the value of consumer leadership and the depth and diversity of expertise it provides in shaping services and reform.

¹² MHT Annual Report 2019-2020, 34. People have legal representation at 13% of all Tribunal hearings.

¹³ Ibid., 15.

¹⁴ See also: Roper, Cath; Grey, Flick, and Cagodan, Emma. (5 April 2018) Co-Production: Putting principles into practice in mental health contexts (5 April 2018) <https://healthsciences.unimelb.edu.au/_data/assets/pdf_file/0007/3392215/Coproduction_putting-principles-into-practice.pdf>; Bennetts, Wanda; Cross, Wendy, and Bloomer, Melissa, 'Understanding consumer participation in mental health: Issues of power and change' (2011) 20(3) International Journal of Mental Health Nursing, 155–64, 2.

2. Getting the Act and implementation right this time

In 2014, a new Mental Health Act was introduced with the promise of improving the autonomy, protections, and health and social outcomes for people who use mental health services in Victoria.¹⁵

The 2014 Mental Health Act was intended to move toward a more rights and recovery-focused model. This is captured in the principles of the 2014 Act, which include:

- A focus on least restrictive assessment and treatment, with the least possible restrictions on human rights and dignity.¹⁶
- A preference for voluntary assessment and treatment.¹⁷
- Supported decision-making i.e. people receiving mental health services should be involved in all decisions about their assessment, treatment and recovery and supported to make, or participate in, those decisions, and their views and preferences should be respected.¹⁸
- Choice and respect, and promotion of the rights, dignity and autonomy of people receiving mental health services.¹⁹
- Providing mental health services ‘with the aim of bringing about the best possible therapeutic outcomes and promoting recovery and full participation in community life’.²⁰
- Responding to people’s individual needs (including their health, culture, language, age, disability, religion, sexuality and gender).²¹

Despite containing these principles, under the 2014 Mental Health Act, the Royal Commission found that Victoria’s ‘mental health system has catastrophically failed to live up to expectations’.²²

Yet – as the above summary of the principles in the 2014 Mental Health Act highlights – the proposals contained in the Engagement Paper in many ways replicate the thinking and practices introduced in the 2014 Mental Health Act which, in the words of the Royal Commission, ‘have since evolved’.²³

It is crucial that the new Mental Health and Wellbeing Act reflects contemporary thinking, rather than continuing provisions which the Royal Commission identified as no longer ‘gold standard’²⁴. The new Act needs to be progressive and ambitious to achieve the Royal Commission’s goal of reflecting contemporary human rights practice and thinking.

Also, as noted by the Royal Commission and in the Engagement Paper, whilst ‘legislative reforms will play an important role in establishing the legal foundations that underpin the new mental health and

¹⁵ Minister Wooldridge (Minister for Mental Health), Mental Health Bill 2014, *Second Reading Speech* (20 February 2014) (**Minister Wooldridge, Second Reading Speech**), Hansard, 470, 473.

¹⁶ *Mental Health Act 2014* (Vic) s 10.

¹⁷ *Mental Health Act 2014* (Vic) s 11(a).

¹⁸ *Mental Health Act 2014* (Vic) s 11(c).

¹⁹ *Mental Health Act 2014* (Vic) s 11(d) and (e).

²⁰ *Mental Health Act 2014* (Vic) s 11(b).

²¹ *Mental Health Act 2014* (Vic) s 11(f), (g) and (h).

²² Royal Commission into Victoria’s Mental Health System, *Interim Report* (November 2019) 1.

²³ RCMHS Final Report, Volume 4, 30.

²⁴ *Ibid.*, 31.

wellbeing system',²⁵ not all changes will be driven through legislation.²⁶ Recovery-focused legislation is only one part of building a recovery-focused system. We see through our work and the experiences of consumers, in the absence of changes in resourcing, training, governance, accountability and culture, the reality on the ground for consumers does not match the objectives and principles of the 2014 Mental Health Act. While the new Act can provide the scaffolding for a mental health system which protects and promotes the rights and dignity of consumers, legislation alone will not deliver this. Oversight and accountability are essential to successful implementation of legislative reforms.

3. Objectives and principles that drive reform

The proposed principles and objectives have an important role to play in underpinning 'concepts of autonomy, supported decision-making, recovery-oriented practice, the protection and promotion of human rights, and the use of compulsory treatment as a last resort', as set out by the Royal Commission.²⁷ The principles in the Engagement Paper go some way to doing this, but our view should be strengthened, to more closely align with the Royal Commission's recommendations.

This part sets out what we welcome about the proposed objectives and principles for the new Act in the Engagement Paper, and what we recommend is needed to realise the Royal Commission's vision for a system that 'encourage[s] a human rights-based culture to flourish'.²⁸

3.1 Mechanisms to give the principles and objectives meaning

As discussed above in part 2, even a perfect set of principles in the new Act will make limited difference on the ground without investment in resourcing, training and a robust framework of accountability. In part 9.1 below, we discuss the mechanisms in the *Gender Equality Act 2020* (Vic). We recommend that a similar framework, carefully designed to lead and embed cultural change is included in the Mental Health and Wellbeing Act. This includes an obligation on mental health services to prepare action plans that comply with the principles, strategies that include measurements, targets and timelines, public reporting, and both educative and enforcement roles for the Mental Health and Wellbeing Commission.

3.2 Recognising and reducing the harm of compulsory treatment

We support the inclusion of objective 1: 'Achieve the highest attainable standard of mental health and wellbeing for people of Victoria'. However, our practice experience is that, in the current system, this type of objective is often relied on as a basis for subjecting people to compulsory treatment against their wishes.

As the Royal Commission recognised, one of the reasons for the overuse of compulsory treatment is that it has become a mechanism for triaging and prioritising access to treatment in an under-resourced system.²⁹

²⁵ RCVMHS Final Report, Volume 4, 38.

²⁶ State of Victoria, Department of Health, 'Mental Health and Wellbeing Act: update and engagement paper', 2021, 25. (**Engagement Paper**).

²⁷ RCVMHS Final Report, Volume 4, 37.

²⁸ *Ibid.*, 35.

²⁹ *Ibid.*, 386.

Justice Bell recognised in *PBU v Mental Health Tribunal*: ‘the right to be free from non-consensual medical treatment and the entitlement to access health-related services are both elements of the right to health’³⁰ and the ‘denial of capacity and paternalistic medical treatment can undermine patients’ dignity, autonomy and prospects of recovery in the long term’.³¹

One of the members of our consumer advisory group, Speaking from Experience, explained the harm of compulsory treatment:

In my experience, being forced to take medications that did not agree with me physically, affected me so severely that I felt like I had no hope. To feel that you have no choice in the matter, where you are being forced to take something that causes so much physical distress is not fair or humane.

We agree with the suggestion made by the Mental Health Tribunal in its submission to the Royal Commission in August 2020 that a principle of ‘equivalence’ be included to ensure that ‘a person’s access to treatment (whether that be the range of treatments, intensity of supports, and/or timeliness of interventions) should be the same regardless of their legal status’ (i.e. whether they are a voluntary or compulsory patient).³² This principle would clarify that a person does not need to be put on a compulsory treatment order in order to access the treatment they want or need. We agree that this would help to reduce rates of compulsory treatment.

We also recommend that an additional point should be added to objective 1 expressly recognising the harm to mental health and wellbeing that can be inherent in compulsory treatment.

3.3 Promoting a consumer focus

A clear understanding of personal recovery

The Royal Commission referred to the Department of Health’s *Framework for Recovery-oriented Practice* as emphasising that “‘personal recovery’ encompasses ideas of self-management, personal growth, empowerment, advocacy, choice and meaningful social participation free from stigma and discrimination; while “clinical recovery” focuses on lessening symptoms’.³³ Lessening symptoms may or may not be connected with personal recovery and many consumers live meaningful lives with symptoms.

We recommend that it should be clarified that ‘recovery’ refers to recovery as determined by people living with mental health issues or psychological distress, rather than by clinicians or others.

To help deliver this, the new Act needs to promote understanding of personal recovery and make promoting personal recovery an objective of the Act.

³⁰ *PBU & NJE v Mental Health Tribunal* [2018] VSC 564 (1 November 2018) [97].

³¹ *Ibid* [257].

³² Mental Health Tribunal, *Further submission from the Victorian Mental Health Tribunal to the Royal Commission into Victoria’s Mental Health System* (August 2020) 11.

³³ RCMHS Final Report, Volume 4, 25.

As we are reminded by our Senior Consumer Consultant, Wanda Bennetts, we are aiming for:

*a system that supports people's choices and their recovery in ways that enable them to live the best lives they can, as determined by them.*³⁴

Centring consumers and the role of families, carers, and supporters

The objectives and principles in the Engagement Paper propose recognition and promotion of the role of families, carers and supporters, including 'recognise, respect and support the role of families, carers and supporters ... in decisions about assessment, treatment and recovery of people receiving mental health and wellbeing services' (proposed principle 5).

Families, carers and supporters can provide important support to consumers experiencing mental health issues. However, guided by our lived experience advisory group, Speaking from Experience, and what we observe through our work, we reiterate the need for the focus on protecting and promoting the rights, dignity, and autonomy of consumers to remain at the centre of the new Act and its implementation framework.

A member of Speaking from Experience explained it in this way:

There needs to be a nuanced understanding of the role of families. It is a support role, not an authority role. Sometimes there is abuse in family relationships, but this isn't disclosed to clinicians. How do you support consumers to identify what they want, including who their support people are and what role they want those people to play? There needs to be a clearer way of thinking about family and boundaries.

It is important that where there are differences or conflict between the views of a consumer and family, carers, and supporters or ambiguity about who are family, carers and supports, the views and preferences of the consumer must take precedence.

A related issue is that, in practice, we frequently see mental health services treating family members as carers, even when they are not in a care relationship with the consumer,³⁵ including by providing confidential information about a consumer without their consent or meeting with them to discuss consumer discharge. Although the 2014 Mental Health Act is clear that disclosure to carers can only be made where it is not contrary to the views and preferences expressed by the person, or it is reasonably required by the carer in relation to the provision of care,³⁶ there is inconsistency in the way that clinicians interpret and apply the definition of a carer.

³⁵ Carers Recognition Act 2012 (Vic) s 4.

³⁶ Mental Health Act 2014 (Vic) s 364(2)(g) and (h).

A member of Speaking from Experience explained it in this way:

It should be made clear who will determine who these people are. From a consumer perspective I would like the choice in who these people are. In the past I have had services assume who my carer was, and give them information without my consent. I've heard from carers that they are carers because they say they are. Services are also unclear as to who these people are. Family means different things to different people (I guess this could apply to carers and supporters too) so I think it a consumer should be able to identify who these people are.

In some cases, families, and even carers, can be abusive towards consumers. For example, a consumer the IMHA non-legal advocacy service worked with informed IMHA that despite disclosing that her partner was using her mental health issues and medication as part of his control and abuse and that she did not want him involved in her care, he continued to be provided with information and asked to monitor her medication compliance. Legislation and systems must recognise these dynamics and risks and ensure that mental health services do not provide an avenue to facilitate abuse.³⁷ We recommend provisions in the new Act to better support an approach consistent with the definition of carers in the *Carers Recognition Act 2012* (Vic) and the will and preferences of consumers about the involvement of family and carers in treatment processes.

Further training is required for mental health practitioners to understand the role of carers, family, and supporters, approaches to working with consumers and carers and the dynamics of family violence.

3.4 Being clear about which decision-makers and consumers the Act applies to

The Royal Commission considered that principles would be useful for decision-makers and noted that 'decision-makers' included: the Department of Health; the new Mental Health and Wellbeing Commission; the new Regional Mental Health and Wellbeing Boards; the Mental Health Tribunal; and wellbeing service providers funded by the Victorian Government, including those that provide mental health and wellbeing services in prison.³⁸ The new Act should articulate this clearly.

The new Act should also articulate clearly that the Act and principles apply to voluntary and compulsory consumers and to consumers who are in police custody and prison.³⁹

³⁷ See, eg, Roads to Recovery, part 4.4 discussing the need for understanding of family violence and mental health across both systems. Available at <<https://www.legalaid.vic.gov.au/law-reform/building-better-justice-system/access-to-justice-for-people-with-mental-illness-and-disability/roads-to-recovery-building-better-system-for-people-experiencing-mental-health-issues-in-victoria>>. See also Victoria Legal Aid (2020) *Paving the roads to recovery: Building a better system for people experiencing mental health issues in Victoria*, part 3 discussing the availability and safety of services, including trauma informed care and family violence. Available at [via-rcvmhs-paving-roads-to-recovery-june-2020.pdf](https://www.vicrcvmhs-paving-roads-to-recovery-june-2020.pdf)>. (*Paving the roads to recovery*). Recommendation 6 in Paving the roads to recovery: 'The Department of Health and Human Services should require and fund mental health services to develop policies to ensure family violence risk screening is undertaken as part of the intake process within the mental health system (e.g. risk identification, referrals to family violence services for safety planning)'.

³⁸ RCVMS Final Report, Volume 4, 40.

³⁹ See, eg, Mental Health and Wellbeing Act Submission to Engage Victoria's Consultation Paper by Forensic Consumers, facilitated by Forensic, 4: Forensic consumers with experience of both systems report that 'prison mental health services and their conditions were significantly worse than Thomas Embling mental health services', reflecting a 'third class system' for prisoners needing mental health treatment (*Forensic Consumers' submission*).

3.5 Strengthening specific principles

Our comments on each of proposed principles are below:

Proposed principle	Recommendations to improve and strengthen the principles
1. respect and promote the rights, dignity and autonomy of people living with mental illness or psychological distress and empower people to exercise those rights	To improve consistency with the <i>Convention on the Rights of Persons with Disabilities</i> and the <i>Guardianship and Administration Act 2019</i> (Vic), we propose that 'respect' is replaced with 'protect'. ⁴⁰
2. provide access to a diverse mix of treatment, care and support , taking into account the needs and preferences of people living with mental illness or psychological distress and with the least possible restriction of rights with the aim of promoting recovery and full participation in community life	<p>We suggest that this be split into two separate principles:</p> <ul style="list-style-type: none"> the first to 'provide access to a diverse mix of treatment, care and support, <u>determined as much as possible by</u> the needs and preferences of people experiencing mental health issues or serious distress with the aim of promoting personal recovery and full participation in community life'; and the second to 'provide assessment and treatment in the least restrictive way possible with the least possible restriction on human rights and dignity', mirroring part of objective 2. <p>As set out above, it is important that references to 'recovery' refer to recovery principles, rather than clinical recovery. Similarly, what constitutes 'full participation in community life' must be determined by the person themselves.</p>
3. ensure compulsory treatment and restrictive practices are only used as a last resort	Support. ⁴¹
4. involve people receiving mental health and wellbeing services in all decisions about their assessment, treatment and recovery and ensure they are supported to make, or participate in, those	<p>We recommend this be strengthened and split into two separate principles:</p> <ul style="list-style-type: none"> the first is a standalone principle on supported decision-making, to 'ensure a person receiving mental health and wellbeing services who requires support to make decisions is provided with

⁴⁰ The primary object of the *Guardianship and Administration Act 2019* (Vic) is 'to protect and promote the human rights and dignity of persons with a disability'. Similarly, the purpose of the *Convention on the Rights of Persons with Disabilities* (article 1) is to 'promote, protect and ensure the full and equal enjoyment of all human rights...'

⁴¹ The engagement paper did not define 'restrictive practices', which, unlike 'restrictive interventions', is not defined in the *Mental Health Act 2014* (Vic).

Proposed principle	Recommendations to improve and strengthen the principles
decisions , and respect their views and preferences, including when those decisions involve a degree of risk	<p>practicable and appropriate support to enable the person, as far as practicable in the circumstances to make and participate in all decisions about their assessment, treatment and recovery and have their views and preferences respected; and to develop a person's decision-making capacity'; and</p> <ul style="list-style-type: none"> the second to 'ensure people receiving mental health and wellbeing services are supported to make decisions about their assessment, treatment and recovery that involve a degree of risk'.⁴² <p>The proposal to merely 'involve people receiving mental health and wellbeing services in all decisions about their assessment treatment and recovery...' falls short of the aspiration set out in the final report for people to 'lead and be involved in decisions that affect them'.⁴³</p>
5. recognise, respect and support the role of families, carers and supporters (including children) in decisions about assessment, treatment and recovery of people receiving mental health and wellbeing services	Refer to our comments in part 3.3 above.
6. value the lived experience of people living with mental illness or psychological distress, their carers, families and supporters as leaders and active partners	Support. We recommend this principle be amended to reflect the different experiences of consumers and carers, families and carers. Their experience is not interchangeable and the lived experience expertise of consumers must be prioritised.
7. recognise and respond to the medical and other health needs (including any related to the use of alcohol and other drugs) of people living with mental illness or psychological distress and consider and respond to the ways in which these needs may affect	Support.

⁴² We support efforts to promote a cultural change to support the **dignity of risk**, and avoid the common misconception identified by the Royal Commission that compulsory treatment is 'a way to eliminate the risk of harm occurring to a person and others': see RCMHS Final Report, Volume 4, 390. The focus should be on ensuring through education, professional oversight, practice guidelines, and system management that decision makers can have confidence that decisions taken to support dignity of risk when made in accordance with the legislation and the required 'standard' of professional care will be defended and supported in the event that they result in an adverse outcome: see Carroll, Andrew and McSherry, Bernadette, 'Making defensible decisions in the era of recovery and rights', *Australasian Psychiatry* 2018, Vol 26(5) 474-477.

⁴³ RCMHS Final Report, Volume 4, 37, Box 26.1

Proposed principle	Recommendations to improve and strengthen the principles
their mental health and wellbeing and use of services	
8. recognise that people receiving mental health and wellbeing services may have specific diversity-related needs and experiences (as to age, disability, neurodiversity, culture, language, communication, religion, race, gender, gender identity, sexual orientation or other matters) and ensure that services are provided in a manner that is safe, sensitive and responsive to these needs and experiences and upholds people's rights	Support. We also support recommendations of the Women's Mental Health Alliance in relation to this principle, specifically the need to: recognise structural and systemic inequality and discrimination that affects people's access to and experience of mental health services; recognise the impact of discrimination on mental health; include trauma history in the list of factors that affect people's experiences of services; and include trauma-informed practice as a specific principle.
9. recognise that people receiving mental health and wellbeing services may have specific gender-related safety needs and experiences and ensure that services are provided in a manner that: is safe and responsive to histories of family violence and trauma; recognises how gender dynamics can affect service use, treatment and recovery; and recognises how gender intersects with other types of discrimination and disadvantage	Support. We also support the expertise and recommendations of the Women's Mental Health Alliance in relation to this principle.
10. recognise and respond to the range of circumstances that influence mental health and wellbeing including relationships, accommodation, education, financial circumstances and employment status	Support.
11. provide culturally safe and responsive mental health and wellbeing treatment and care to Aboriginal and Torres Strait Islander peoples that is	We support this principle and recommend that it is strengthened by explicitly naming cultural wellbeing as an outcome and standard for mental health and

Proposed principle	Recommendations to improve and strengthen the principles
<p>appropriate to, and consistent with, their cultural and spiritual beliefs and practices and in having regard to the views of their families and, to the extent that it is practicable and appropriate to do so, the views of significant members of their communities, including Elders and traditional healers, and Aboriginal and/or Torres Strait Islander mental health workers</p>	<p>wellbeing services for Aboriginal and Torres Strait Islander peoples.</p> <p>We reiterate the importance of direct engagement with Aboriginal Community Controlled Organisations and with First Nations communities to make sure the new Act and its implementation are informed by First Nations expertise in making decisions about their communities' health and wellbeing.</p>
<p>12. recognise and promote the best interests of children and young people receiving mental health and wellbeing services, including providing treatment and support in age and developmentally appropriate settings and ways</p>	<p>Support.</p>
<p>13. recognise and protect the needs, wellbeing and safety of children, young people and other dependants of people receiving mental health and wellbeing services.</p>	<p>We consider that this principle could be improved by including a focus on supporting people with a mental health issue and their children and other dependants.</p>

RECOMMENDATIONS: OBJECTIVES AND PRINCIPLES THAT DRIVE REFORM

Recommendation 1: Mechanisms that will give the principles and objectives

meaning. To ensure the principles and objectives have a real impact for consumers, we recommend a similar framework to the *Gender Equality Act 2020* (Vic), carefully designed to lead and embed cultural change, is included in the Mental Health and Wellbeing Act. This should include an obligation on mental health services to prepare action plans that comply with the principles, strategies that include measurements, targets and timelines, public reporting, and both educative and enforcement roles for the Mental Health and Wellbeing Commission.

Recommendation 2: Recognise and reduce the harm of compulsory treatment. To reduce the risk that compulsory treatment is relied on to prioritise access to treatment in an under-resourced system:

- a) Include an additional point in the objective to ‘achieve the highest attainable standard of mental health and wellbeing for the people of Victoria’, which recognises the harm to mental health and wellbeing that can be inherent in compulsory treatment.
- b) Include a principle that a person’s access to treatment (whether that be the range of treatments, intensity of supports, and/or timeliness of interventions) should be the same regardless of whether they are a voluntary or compulsory patient.

Recommendation 3: Promote a consumer focus. Consistent with the principle of protecting and promoting the rights, dignity and autonomy of consumers:

- a) **A clear understanding of personal recovery.** Clarify that ‘recovery’ refers to personal recovery, as determined by a consumer themselves, rather than clinical recovery.
- b) **Centre consumers in considering the role of families, carers and supporters.** Include provisions that support an approach consistent with the definition of carers in the *Carers Recognition Act 2012* (Vic) and the will and preferences of consumers about the involvement of family and carers in treatment processes. Accompany this with training for mental health practitioners to understand the role of carers, family, and supporters, approaches to working with consumers and carers and the dynamics of family violence.

Recommendation 4: Clarity about which decision-makers and consumers the Act applies to. Clearly articulate in the Act that ‘decision-makers’ includes the Department of Health, the new Mental Health and Wellbeing Commission, the new Regional Mental Health and Wellbeing Boards, the Mental Health Tribunal and wellbeing service providers funded by the Victorian Government, including those providing mental health and wellbeing services in prisons. Clarify that the Act and the principles apply to voluntary and compulsory consumers.

Recommendation 5: Strengthen specific principles. Strengthen and clarify specific principles as described in the table in part 3.5. Our recommendations are aimed at improving consistency with the *Convention on the Rights of Persons with Disabilities* and the *Guardianship and Administration Act 2019* (Vic), strengthening consumer autonomy, including a standalone principle on supported decision-making and better recognising cultural wellbeing, systemic discrimination and the need for trauma-informed practice.

4. Achieving the ‘gold standard’ in supported decision-making

The Royal Commission identified that while the 2014 Mental Health Act was ‘considered an improvement on previous mental health legislation’ and ‘reflected contemporary principles when it was introduced, thinking and practices in relation to supported decision-making have since evolved’.⁴⁴ We see through our work that the legislative mechanisms in the 2014 Mental Health Act to enable supported decision-making – advance statements, nominated persons, and the right to seek a second psychiatric opinion – have low take up rates.⁴⁵ And, where they are used by consumers, we see that the views of nominated persons and preferences expressed in advanced statements are often disregarded, both by mental health services and the Mental Health Tribunal.

These legislative mechanisms have not delivered the cultural change they promised, and we need an ambitious re-think to make sure this Act is able to do this successfully.

The Royal Commission also found that ‘recent legal reforms in Victoria in related sectors highlight that current legislation does not represent the ‘gold standard’ in terms of ... enabling supported decision-making practices.’⁴⁶ By recommending proposals that continue practices around supported decision-making from the 2014 Act, when this area has, in the view of the Royal Commission ‘since evolved’,⁴⁷ the position in the Engagement Paper falls short of the goal of the Royal Commission to ‘reduce the circumstances in which substituted decision-making can occur in the medium term’.⁴⁸

4.1 Embedding supported decision-making in legislation

We support the intention of the proposals in the Engagement Paper to strengthen supported decision-making, but more is required to ensure that, in practice, consumers are supported make and participate in all decisions about their assessment, treatment and recovery and have their views and preferences respected.

As a starting point, unlike the 2014 Act, supported decision-making should be named (see our recommendation for a standalone principle regarding supported decision-making in part 3.5 above) and the types of supports that should be provided should be listed in the Act, for example:

- Advance statements
- Nominated persons
- Accessible rights information
- Support to understand and exercise your rights
- Non-legal advocacy
- Legal assistance
- Second psychiatric opinions.

⁴⁴ RCVMHS Final Report, Volume 4, 30.

⁴⁵ See, e.g., figures regarding advance statements below. See also: RCVMHS Final Report, Volume 4, 399 and Paving the roads to recovery, 15.

⁴⁶ RCVMHS Final Report, Volume 4, 31.

⁴⁷ Ibid., 30.

⁴⁸ Ibid., 428.

The legislative changes should not just be about strengthening supported decision-making in isolation, they also need to be made to relevant provisions regarding treatment decisions so that there is a requirement that people are supported to make their own decisions.⁴⁹

To entrench the primacy of supported decision-making, the circumstances in which substituted decision-making can occur must be restricted. The new Act should limit the circumstances in which substituted decision-making can occur to when the person does not have capacity to give informed consent to the treatment, or the treatment is necessary to prevent serious harm to others, and the person is refusing to consent to the treatment.⁵⁰ In those circumstances, a substitute treatment decision should only be made where it is the least restrictive treatment option to prevent serious distress or serious harm.

4.2 Implementation of supported decision-making – moving beyond well-intentioned legislation

The Royal Commission identified that '[e]nsuring that these changes are implemented in practices, culture and approaches to treatment, care and support will require significant support for the mental health workforce'.⁵¹

The Royal Commission found:

*There is currently limited oversight and no public reporting on how mental health services are complying with the principles of the Mental Health Act or with its practical requirements such as seeking informed consent, presuming capacity, supporting consumers to make decisions, providing statements of rights or providing treatment consistent with a person's advance statement.*⁵²

The Royal Commission identified further that 'the effectiveness of the legal reforms will depend on how well the new laws are implemented and applied in practice',⁵³ so 'it is essential that training and education is provided on an ongoing basis'.⁵⁴

This education and training should draw on IMHA's supported decision-making training package, which has been rolled out across all designated mental health services, with executive directors supporting delivery of this training. Informed by consumers, and recognising the low levels of understanding of supported decision-making amongst clinicians, IMHA's supported decision-making training modules have played a role in improving the on-the-ground focus on rights and recovery. It is an example of the kind of initiative and investment required to translate the well-intentioned legislation into meaningful change for consumers through participation in decisions about their treatment, discharge planning, risk assessment, or recovery.⁵⁵

⁴⁹ See *Mental Health Act 2014* (Vic) part 5, div 1 and 2 (Treatment). Section 72 says patients must be given treatment for mental illness 'in accordance with this act'; section 70 provides that informed consent must be sought; section 69 provides that informed consent requires a reasonable opportunity to make a decision and reasonable opportunity includes being given a reasonable amount of support. This is convoluted and so the centrality of supported decision-making is lost.

⁵⁰ See *Mental Health Act 2014* (Vic) s 71.

⁵¹ RCMHS Final Report, Volume 4, 42.

⁵² *Ibid.*, 407.

⁵³ *Ibid.*, 46.

⁵⁴ *Ibid.*

⁵⁵ IMHA's supported decision-making training does not have ongoing funding.

IMHA training significantly increases mental health staff's understanding of supported decision-making and confidence to integrate it into their services

IMHA's training about supported decision-making under the 2014 Mental Health Act has been rolled out to all designated mental health services in Victoria. More than fifty sessions have been carried out across the State to date.

Outcomes reported from participants demonstrate:

- 85% report an increase in knowledge of supported decision-making.
- 85% report an increase in knowledge of how to put supported decision-making into practice.
- 80% report an increase in understanding of the benefits of supported decision-making.

The new Act should require (as opposed to 'offer') anyone exercising powers under the Act to undertake ongoing mandatory training on the new Act (including supported decision-making, recovery, and least restrictive treatment) and application of the *Charter of Human Rights and Responsibilities Act 2006* (Vic).

The new Act could stipulate that the Chief Officer for Mental Health and Wellbeing will co-produce guidelines on mandatory training and services should have to report compliance with training (as they do for other mandatory training).

In addition to training and education, to support the necessary cultural change occurring and being maintained, supported decision-making should be incorporated into the regulatory framework discussed in part 9.1 below, based on the *Gender Equality Act 2020* (Vic) and including mechanisms for planning, measuring, reporting and oversight.

4.3 Making the statement of rights proactive and consumer-led

Through our IMHA non-legal advocacy service and specialist mental health lawyers, we receive feedback from many consumers that they were not provided with a statement of rights or that they did not realise that they had certain rights, despite the requirement in the 2014 Mental Health Act for the statement of rights to be provided. This indicates the current provisions are not having the desired effect of ensuring that consumers understand and can exercise their rights.

The obligation on services to support people to understand and exercise their rights should not be confined to the one-off provision of a written statement of rights, particularly given that admission to a mental health unit can be very distressing, and a person may be overwhelmed with new information and by the situation.

A member of our consumer advisory group, Speaking from Experience, explained her experience:

When I got admitted into the in-patient unit, everything happened really suddenly. Within 10 minutes I went from being in the middle of an appointment with a case manager to being admitted. I had no sleep for several days and was given a whole heap of papers to read through and sign at the same time the psychiatrist was telling me my admission plans. I did not understand what was written on the paperwork and I was not provided copies of anything to take to my bedroom. No one mentioned anything about rights or helped go through the paperwork with me - the psychiatrist just rushed me to sign everything. If there was any mention of my

rights, I had no comprehension of it. It wasn't until after I was discharged that I found out any information about what my rights had been.

A more proactive approach by services to support consumers to understand and exercise their rights should require embedding access to rights information and supports at various points across the period of engagement with the person, whether compulsory or voluntary, inpatient or community based. It should also include mechanisms for rights information to be provided by non-legal advocates and, if preferred by consumers, other professional groups such as peer workers and Aboriginal Liaison Officers. Proactive linking of consumers to advocacy and legal assistance is an important part of supporting them to understand and exercise their rights. Non-legal advocacy and legal assistance are important supported decision-making mechanisms.

We support the proposals in the Engagement Paper:

- To require a statement of rights to be given to both compulsory and voluntary consumers when admitted as inpatients. The Act should also require that statements of rights be provided to voluntary consumers in the community.
- For the statement of rights to be co-produced with consumers. The current statement of rights is inaccessible to many consumers and is not written from a consumer point of view.
- That the person providing the statement must ensure the consumer understands their rights, which would be given effect via ongoing conversations about their rights and available supports.⁵⁶ It is essential that the information is provided in accessible way, with the use of interpreters or other communication aids as needed. We consider that the provisions in the 2014 Mental Health Act provide a sufficient basis for this.

Services should be required to report against these requirements to the Mental Health and Wellbeing Commission.

4.4 Advance statements – a system that inspires greater than 2% take up

The Royal Commission found that fewer than 2 per cent of adult consumers have an advance statement⁵⁷ and 83 per cent of consumers interviewed by VMIAAC said that the views and preferences expressed in their advance statement were not upheld.⁵⁸ IMHA advocates are consistently told by consumers that they do not want to prepare an advance statement as other consumers have told them they are not upheld.

The Royal Commission identified lack of awareness of advance statements⁵⁹ as well as a lack of faith in their effectiveness⁶⁰ as key barriers to the uptake of advance statements and nominated persons.

⁵⁶ Engagement Paper, 17.

⁵⁷ RCMHS Final Report, Volume 4, 399.

⁵⁸ Ibid., 402.

⁵⁹ Ibid., 399-401.

⁶⁰ Ibid., 402-403.

A member of our consumer advisory group, Speaking from Experience, explains it in this way:

To write an advance statement is an act of courage. It takes courage to acknowledge that you may have another breakdown and have the worst experiences of your life repeated again. To use up all that courage for a document that psychiatrists are likely to just ignore anyway – it's just too devastating for many people.

The Royal Commission encouraged the Victorian Government to consider making advance statements binding in all but very limited circumstances when reviewing mental health legislation.⁶¹

We broadly support the proposals regarding advance statements set out in the Engagement Paper, particularly that consumers be automatically provided with written reasons for a decision to override their treatment preferences and that advance statements can include preferences on a broader range of matters. We also support the creation of opt-in advance statement and nominated person registers.

However, the reforms need to go further in order to effectively address the current concerning statistics and practices in relation to advance statements. We recommend that:

- An authorised psychiatrist should only be able to make a substitute decision that overrides the consumer's advance statement if they are satisfied that the preferred treatment specified in the advance statement is 'likely to cause harm or unreasonably impede recovery or will not prevent serious harm or serious distress' and 'not reasonably and practicably available'. Consideration of whether or not the preferred treatment is reasonably and practicably available should not be confined to the treatment provided by that particular mental health service, but rather taking into account services across the mental health system.⁶²
- Written responses should be provided in a timely manner. Where a consumer's preferences are overridden, written reasons are provided prior to overriding their preferences or within 24 hours.
- Non-legal advocacy should be adequately resourced to directly support consumers to create advance statements.⁶³ IMHA currently provides this service but is limited by lack of resources and cannot do this with all consumers.⁶⁴

4.5 Providing reasons for decisions to override a consumer's treatment preferences

While the proposed requirements to document decisions to act against a person's views and preferences represent a significant improvement on current practice, we recommend that a consumer

⁶¹ RCVMS Final Report, Volume 4, 430

⁶² See Engagement Paper, 17. The Engagement Paper currently provides that '[a]n authorised psychiatrist can make a substitute decision that overrides the consumer's advance statement if they are satisfied that the preferred treatment specified in the advance statement is not clinically appropriate or is not a treatment ordinarily provided by the designated mental health service'

⁶³ This was a recommendation 13.3 of the IMHA Evaluation. See: IMHA Evaluation Report, 40.

⁶⁴ IMHA has also co-designed self-advocacy resources, videos and templates for consumers to use in making advance statements. See Independent Mental Health Advocacy, *I want to make an advance statement*. Available here: <<https://www.imha.vic.gov.au/know-your-rights/your-rights-if-you-are-on-compulsory-treatment-order/i-want-to-make-advance-statement>>.

be provided with written reasons for a decision to override their treatment preferences as expressed by them at the time (including through their nominated person or non-legal advocate), just as the proposed changes to advance statements will require written reasons to override treatment preferences as expressed in an advance statement. That is – services should automatically provide consumers with written reasons when making a decision to override their treatment preferences, whether those treatment preferences are expressed contemporaneously or in an advance statement.

Decision-makers should also be required to record what supported decision-making mechanisms have been enacted to support the person to make and participate in the decision about their assessment, treatment and recovery.

4.6 Nominated persons – making this a modern rights-focused role

We support the proposed changes requiring the nominated person to agree to support the person to make their own decisions and to help represent their views and preferences.⁶⁵

IMHA is sometimes contacted by nominated persons wanting to understand the 2014 Mental Health Act and the rights of the person they are supporting. We recommend that consideration is given to how nominated persons are supported to operate within a supported decision-making framework. This support could be provided either through coaching by IMHA non-legal advocates (with appropriate funding), or through access to supported decision-making training (see above).

We encourage consideration of duties and obligations similar to those required by a supportive guardian or administrator under a supportive guardianship order or supportive administration order.⁶⁶

The *Guardianship and Administration Act 2019* (Vic) is one of the pieces of legislation referred to by the Royal Commission as representing the evolution of interpretation of human rights since the 2014 Mental Health Act was enacted.⁶⁷ The Guardianship and Administration Act requires supportive guardians and administrators to, amongst other things:

- avoid acting when there is or may be a conflict of interest and, if acting when there is a conflict of interest, ensure that the interests of the supported person are the primary consideration;
- discuss supported decisions with the supported person in a way that they can understand and that will assist them to make the decision; and
- not coerce, intimidate or in any way unduly influence the supported person into a particular course of action.⁶⁸

Supportive guardians and supportive administrators must also act in accordance with the general principles of the Guardianship and Administration Act including that:

- a person with a disability who requires support to make decisions should be provided with practicable and appropriate support to enable the person, as far as practicable in the circumstances –
 - to make and participate in decisions affecting the person; and
 - to express the person's will and preferences; and

⁶⁵ Engagement Paper, 17.

⁶⁶ *Guardianship and Administration Act 2019* (Vic) s 94.

⁶⁷ RCMHS Final Report, Volume 4, 403.

⁶⁸ *Guardianship and Administration Act 2019* (Vic) s 94.

- to develop the person's decision-making capacity;
- the will and preferences of a person with a disability should direct, as far as practicable, decisions made for that person.

We recommend that these principles, duties, and obligations would be appropriate for nominated persons, who fulfil a similar role to supportive guardians and supportive administrators.

4.7 Improving second psychiatric opinions

While we support the proposal for there to be flexibility in how second opinions can be provided to meet consumer need, views, and preferences, we are concerned to ensure that second opinions are also provided in writing in order to ensure transparency and accountability.

We note that many consumers are seeking a second opinion regarding a specific matter, such as diagnosis. There should be flexibility for a second opinion to be tailored to a consumer's preferences.

The Engagement Paper refers to timely provision of second opinions, however, fails to set a maximum timeframe. To have practical impact for consumers, the legislation should set out timeframes for both provision of and responses to second opinions. Setting a maximum timeframe or requiring second opinions to be provided within a reasonable time would allow for accurate estimation and provision of adequate funding for organisations such as the Second Psychiatric Opinion Service.

RECOMMENDATIONS: EMBEDDING SUPPORTED DECISION-MAKING IN LAW AND PRACTICE

Recommendation 6: Embed supported decision-making in legislation. Name and explain supported decision-making in the new Act. Create a specific principle focused on supported decision-making, require services to support people to make their own decisions and clearly limit the circumstances in which substituted decision-making can occur.

Recommendation 7: Implement supported decision-making in practice. Require anyone exercising powers under the new Act to undertake ongoing mandatory, co-produced training on the new Act, including supported decision-making, recovery, least restrictive treatment and the application of the *Charter of Human Rights and Responsibilities Act 2006* (Vic). Services should report on compliance with the training requirements.

Recommendation 8: Make the statement of rights proactive and consumer-led. The new Act should require updated, co-produced statements of rights be provided to all voluntary and compulsory consumers, both inpatients and people in the community. Supporting consumers to exercise their rights should include proactive linking of consumers to non-legal advocacy and legal assistance.

Recommendation 9: Advance statements and written reasons for over-riding consumer views and preferences. Limit the circumstances in which an authorised psychiatrist can override an advance statement. Require that, where a consumer's views and preferences (whether expressed in an advance statement or by them or their nominated person or non-legal advocate) are over-ridden, written reasons should be provided prior to overriding their preferences within 24 hours. Non-legal advocacy should be available to support people to make advance statements.

Recommendation 10: Nominated persons – make this a modern rights-focused role.

The framework for nominated persons should mirror the principles, duties and obligations which apply to supportive guardians and supportive administrators under the *Guardianship and Administration Act 2019* (Vic).

Recommendation 11: Second psychiatric opinions. The Act should set a maximum timeframe or require second opinions to be provided, and responded to, within a reasonable time.

5. Non-legal advocacy – a consistent, effective state-wide model

As outlined in part 1.1 above, since 2015 IMHA has provided non-legal advocacy for people at risk of or subject to compulsory mental health treatment in Victoria.

The Royal Commission found that non-legal advocacy is highly valued by consumers, providing important support to promote the rights of consumers and the principles of the 2014 Mental Health Act, although not all consumers are aware of how to access it.⁶⁹ On this basis, the Royal Commission recommended that legislative provisions be included in the new Act to enable an opt-out model of access to non-legal advocacy services for consumers who are subject to or at risk of compulsory treatment.⁷⁰

The Engagement Paper proposes the introduction of provisions to support access to non-legal advocacy for consumers, including an obligation on health services to contact the non-legal advocacy service at the time a person is placed on a compulsory order. These are welcome and will assist IMHA advocates to do their work, providing information on rights and the mental health system, coaching for self-advocacy, referrals, and non-legal advocacy to all consumers who want it. These changes will remove the onus on the consumer to find out about and contact IMHA and will ensure greater access to non-legal advocacy services for consumers.

The proposed introduction of operating guidelines to give effect to the obligations of service providers to engage with non-legal advocacy is also welcome.

The particular features of IMHA's non-legal advocacy model that are critical to its effectiveness are set out below:

- **Independence from mental health services** which provides consumers with assurances that the service they are receiving is there for them, it is not a clinical service but a specialist non-legal advocacy service focused on their rights and amplifying their voice. This also provides confidence to consumers and the community that the service can independently represent consumers' voices.
- **Highly specialist workforce** that is trained and supported by people with expertise in non-legal advocacy, together with an established supervision, reflective practice, and professional development program to ensure that the non-legal advocacy model co-designed with consumers is utilised.

⁶⁹ RCMHS Final Report, Volume 4, 396.

⁷⁰ Ibid., 362.

- **Established relationships of trust** with consumer leaders, consumers, clinicians, and oversight and safeguard bodies, as an effective and consumer led service. IMHA works in partnership to develop consumer resources including with oversight and safeguard bodies and Aboriginal Controlled Health services.
- **Consumer leadership** – IMHA has been co-designed and co-produced with consumer leadership and engagement across the service, including in leadership, recruitment and selection processes and resource development.
- **Strong relationships with health services**, supported by documented operational protocols that support consumers to enact their rights and access services as well as access IMHA seamlessly when they contact another service and require advocacy. This also allows for issues to be escalated for resolution directly with health service management and to build the capacity of services to enact supported decision-making mechanisms through training and education.
- **System lens** – a systemic view of consumer experience and clinical practice across the mental health clinical service system that can communicate with and enhance the effectiveness of other supported decision-making and safeguard mechanisms, such as the Lived Experience Advisory Group, the Second Psychiatric Opinion Service, the Mental Health Complaints Commissioner and the Office of the Chief Psychiatrist.
- **Service quality** – a consistent model of representational advocacy used by all staff, which ensures a high quality service is provided to all consumers. Ongoing quality and improvement measures are built into the service ensuring continuous development, with consumers at the centre.
- **Equitable access** to a high quality and responsive IMHA service visiting all units across Victoria and a state-wide intake phone service for all consumers no matter where they are in Victoria or their background, ensuring reliable service coverage.
- **Responsive to individual needs** – human rights driven, inclusive of diversity, and trauma informed, it provides a service that is responsive to consumer individual needs.
- The development and support of a unique **workforce** of advocates, with tailored orientation, training, supervision, and education that is consistently provided to the advocates throughout their work at IMHA.
- **Strong and established referral pathways** – as part of a state-wide legal assistance provider, IMHA has been able to leverage legal expertise to develop rights information, provide rights talks, and establish legal referral pathways to legal assistance for Mental Health Tribunal hearings, as well as other common legal problems related to housing, discrimination and child protection.

Informed by six years of running IMHA non-legal advocacy across Victoria, the below sections set out the ways in which the proposals for the legislative framework to embed non-legal advocacy could be improved.

5.1 Recognising IMHA's successful model of non-legal advocacy

The proposed changes in the new Act to improve access to non-legal advocacy do not specify that they relate to the IMHA service.

In considering the Engagement Paper, VLA consulted with staff, VMIAC, VLA's consumer advisory group, Speaking from Experience, and other key stakeholders, including mental health service providers. These stakeholders consistently raised concerns that IMHA is not specified in the Royal Commission's recommendations about access to non-legal advocacy and what this might mean for the future of non-legal advocacy because of the work that has been done to establish access to IMHA in all mental health services (including the workforce training and supervision), the effectiveness of the IMHA non-legal advocacy model for consumers, the comfort that services have with the way that IMHA operates, and the system-wide role IMHA is able to play.

While we respect the drafting decision not to specify a particular service provider, there is a risk that attaching obligations generically to 'non-legal advocates' will result in confusion about who the provisions apply to and may create unnecessarily onerous obligations on health services to facilitate access and respond to anyone who describes themselves as an advocate. 'Non-legal advocate' is a broad term and not readily understood. Without further definition in the legislation or via regulation, it could include many services and individuals, rather than those services intended and funded to do such work. The non-legal advocacy described in the Royal Commission's report and the opt-out recommendation appear to relate to the current IMHA non-legal advocacy service and model as it was a key recommendation in the independent and co-produced IMHA evaluation undertaken by RMIT, but without this clarity the positive proven impact of IMHA may be overlooked in the reformed mental health system. Moving away from the state-wide IMHA model of non-legal advocacy as the basis of the opt-out system also creates risks that the effectiveness of the non-legal advocacy service will be diminished.

In order to overcome these risks, VLA suggests that the legislation provides for the prescription of non-legal advocacy providers and that IMHA is prescribed as a provider and that a state-wide non-legal advocacy service is maintained.

5.2 Improving the notification and response requirements

The provision for notification within 24 hours should be extended to include treatment orders, not just assessment or temporary treatment orders. In our practice we see individuals who remain on successive treatment orders for prolonged periods in the community. IMHA data shows that knowledge of non-legal advocacy services is lower in the community, and therefore that those who are most in need of advocacy in the community are least likely to have access to it.⁷¹

Consideration must also be given to how the provision of notification within 24 hours will occur. The provision for 'obligations on service providers to notify a person's advocate in certain circumstances' should be expanded to include when a person's views and preferences have been overridden, when these views and preferences have been expressed via the advocate. The obligation to notify a person's advocate in certain circumstances should be contingent on the person's consent.

In relation to the requirement for service providers to respond to any requests for information by advocates within a maximum of three days, we recommend that this is reduced to 48 hours and that

⁷¹ IMHA Evaluation Report, 25-27.

this applies to the relevant decision-maker. Three days can be a long time for consumers who are detained in inpatient units.

5.3 Making sure advocacy is accessible across services

The provision for ‘advocates to access inpatient services’ should be expanded to include other existing services, including community-based designated mental health services, such as Community Care Units and Prevention and Recovery Centres and hospital-based health services (eg, Emergency Departments and medical wards). Consumers may be in a variety of settings while experiencing or at risk of compulsory treatment, and this would ensure that their setting is not a barrier to accessing non-legal advocacy. In particular, consumers report negative experiences of Emergency Departments,⁷² and access to non-legal advocacy could contribute to alleviation of these experiences. Access should also be facilitated for people at risk of or subject to compulsory treatment in the new mental health and wellbeing centres that the Royal Commission has recommended be established.

RECOMMENDATIONS: IMHA NON-LEGAL ADVOCACY – A CONSISTENT, EFFECTIVE STATE-WIDE MODEL

Recommendation 12: Recognise IMHA’s successful model of non-legal advocacy.

Recognising the strengths of the independently evaluated IMHA non-legal advocacy model, and the risks of failing to clarify the meaning of non-legal advocacy, the new Act should provide for the prescription of non-legal advocacy providers and IMHA should be a prescribed provider.

Recommendation 13: Improve the notification and response requirements. The requirements to notify an advocate within 24 hours should be extended to include treatment orders. In addition, when a person’s views and preferences have been communicated by an advocate and been overridden, this should be communicated to the advocate. Service providers should be required to respond to any requests for information by advocates within 48 hours.

Recommendation 14: Make sure advocacy is accessible across services. The provision for advocates to access inpatient services should be expanded to include other existing services including community-based designated mental health services, Community Care Units, Prevention and Recovery Centres, as well as hospital-based health services (eg Emergency Departments, medical wards) and future mental health and wellbeing centres.

⁷² See for example: Victoria Legal Aid. (2020). *Your Story, Your Say: Consumers’ priority issues and solutions for the Royal Commission into Victoria’s Mental Health System*, 12-13. Available at <<https://www.legalaid.vic.gov.au/about-us/news/your-story-your-say-experiences-of-mental-health-system>>.

6. Radically reducing compulsory treatment

The Royal Commission recognised that in Victoria ‘both the rate and duration of compulsory treatment orders ... are too high, and that it is a systemic failure that compulsorily treating a person has become, in some instances, the default response.’⁷³

Through our work we see that a fundamental change is needed to radically reduce the use and duration of compulsory treatment and we welcome the proposals in the Engagement Paper that aim to do this.

As we outline above, and as the Engagement Paper recognises, the 2014 Mental Health Act was also committed to least restrictive assessment and treatment and a preference for voluntary assessment and treatment, but ‘despite the aspirations behind the Mental Health Act and the introduction of the Mental Health Tribunal to reduce compulsory treatment, this has not been achieved’.⁷⁴ While it is crucial that we get the legislative framework right, the investment in education, properly resourcing mental health services that people choose, and robust accountability are also fundamental to radically reducing Victoria’s over-reliance on compulsory treatment and the harm experienced by people as a result.

Giving a sense of what compulsory treatment as a ‘last resort’ currently looks like in practice, one of the consumer experts in Speaking from Experience said:

‘Last resort’ is relative to the conditions in which ‘last resort’ is decided. This can change depending on tolerance levels of the staff, including security; adequate training in de-escalation; staffing numbers; workload at the time as well as staff management and morale.

The new Act needs to be clearer and stronger both in form and in implementation. If not, we risk another missed opportunity to drive down over-reliance on compulsory treatment and the impact this has for mental health consumers.

As we discuss in more detail in part 9.1, to embed the practical and cultural change required, we recommend the introduction of provisions similar to those in the *Gender Equality Act 2020* (Vic) requiring mental health services to prepare action plans,⁷⁵ which should include strategies, targets and timeframes for reducing compulsory assessment and treatment, and make and report on reasonable and material progress in relation to the relevant indicators.⁷⁶

⁷³ RCMHS Final Report, Volume 4, 364.

⁷⁴ Ibid., 409.

⁷⁵ *Gender Equality Act 2020* (Vic) s 10.

⁷⁶ *Gender Equality Act 2020* (Vic) s 16.

6.1 Strengthening principles relating to the use of compulsory treatment

We welcome the introduction of principles relating specifically to the use of compulsory treatment, including the requirement to consider any distress and harm that compulsory treatment itself may cause when making a Treatment Order or Temporary Treatment Order.⁷⁷

As discussed, despite the objective for the 2014 Mental Health Act to provide for treatment in the least restrictive way possible,⁷⁸ mental health services and the Tribunal often default to compulsory treatment. To help overcome this entrenched practice, we recommend the inclusion of clear principles relating to the use of compulsory treatment that specify:

- the intent to ensure the person receives high-quality care should not override the autonomy of people to refuse treatment, when it is not the least restrictive option;
- a person is not to be taken to meet the treatment criteria on the basis that treatment might be considered to be in their best interests; and
- in determining whether there is no less restrictive means reasonably available to enable the person to receive the immediate treatment,⁷⁹ or whether the treatment cannot occur within the community,⁸⁰ the ‘treatment’ being considered is that which is necessary to prevent serious harm or distress;⁸¹ and
- that a person’s access to treatment should be the same regardless of whether they are a voluntary or compulsory consumer, as set out in part 3.2.

6.2 Allowing consumers with decision-making capacity to make their own treatment decisions

As identified by the Royal Commission, ‘[i]nternational human rights frameworks informed the drafting of the Mental Health Act ... but interpretations of the content of such human rights laws have since evolved’.⁸² While more recent laws such as ‘the Guardianship and Administration Act and the Medical Treatment Planning and Decisions Act still permit substituted decision-making in certain circumstances, they also incorporate some principles and practices of supported decision-making that are not evident in current mental health laws’.⁸³ The Royal Commission found that ‘both the Guardianship and Administration Act and Medical Treatment Planning and Decisions Act do not enable substituted decisions to be made for people with decision-making capacity’.⁸⁴

The Royal Commission found that in ‘enabling substituted decisions for people with decision-making capacity, the Mental Health Act is at odds with other legislation’.⁸⁵

⁷⁷ Engagement Paper, 26.

⁷⁸ *Mental Health Act 2014* (Vic) s 10(b).

⁷⁹ *Mental Health Act 2014* (Vic) s 5(d).

⁸⁰ *Mental Health Act 2014* (Vic) s 55(3).

⁸¹ *Mental Health Act 2014* (Vic) s 5(b), as proposed to be amended.

⁸² RCMHS Final Report, Volume 4, 403.

⁸³ *Ibid.*, 40.

⁸⁴ *Ibid.*, 406.

⁸⁵ *Ibid.*

In our view, where a person has decision-making capacity in relation to a treatment decision, they should be able to make this decision – regardless of whether this relates to mental health or other health treatment (for example, chemotherapy or blood transfusions).

As we identified in *Paving the roads to recovery*, there may be exceptional cases where compulsory treatment is justified to prevent serious harm to others notwithstanding that the person has decision-making capacity. The Royal Commission itself anticipated that ‘full alignment with mainstream laws such as the Medical Treatment Planning and Decisions Act may not be possible for people who would be considered “forensic or security patients” under current laws’.⁸⁶

The treatment criteria in section 5 of the 2014 Mental Health Act should be amended to include an additional criterion such that a person can only be made subject to a compulsory treatment order where the person does not have decision-making capacity in relation to the immediate treatment, with an exception where treatment is necessary to prevent serious harm to others. In addition, consequential amendments should be made to section 71 to provide that an authorised psychiatrist may only make a substituted decision for a person where the person does not have decision-making capacity in relation to the treatment, or the treatment is necessary to prevent serious harm to others, and the person is refusing to consent to the treatment. The requirement that the treatment decision be the least restrictive form of treatment should be retained, but strengthened to provide that a person’s wishes should only be overridden where necessary to prevent serious distress or serious harm.⁸⁷ We recommend that to achieve the Royal Commission’s goals of reflecting contemporary human rights practice and thinking and reducing the use of compulsory treatment, the new Mental Health and Wellbeing Act should only permit compulsory mental health treatment when a person lacks decision-making capacity or treatment is necessary to prevent serious harm to others.

If this change is not made now, a critical opportunity to align the Mental Health and Wellbeing Act with contemporary human rights standards and other comparable Victorian legislation will be missed and the risk that the system will continue to default to compulsory treatment will continue for consumers.

6.3 Presumption that the treatment criteria do not apply

To support the Royal Commission’s recommendations to reduce use of compulsory treatment, we propose a further provision be included in the Mental Health and Wellbeing Act that a person determining whether the treatment criteria apply (ie, a Tribunal member, authorised psychiatrist, or other authorised person considering making an order) must start from a presumption that each of the treatment criteria does not apply. This could operate similarly to the presumption in the 2014 Act that a person has capacity to give informed consent.⁸⁸

It would put the onus on the decision-maker to be satisfied that the criteria do apply, which would prompt a level of genuine engagement with the criteria.

⁸⁶ RCMHS Final Report, Volume 4, 413.

⁸⁷ *Paving the roads to recovery*, 20.

⁸⁸ *Mental Health Act 2014* (Vic) s 70(2).

6.4 Amending the criteria and providing statutory guidance to help make compulsory treatment a last resort

We support the proposals that the current criteria for compulsory treatment of ‘preventing serious deterioration in the person’s mental or physical health’ be replaced with ‘preventing the person experiencing serious distress’, and requiring that the harm or distress being prevented must be both serious and imminent. We also support the requirement that other treatment and support options to prevent serious distress or serious harm have been considered and eliminated, although we suggest that ‘trialled or excluded’ would be preferred wording to ‘eliminated’.

It is important that the experience of consumers is at the centre of these provisions — that it is a person’s subjective experience of distress which is considered.

These changes to the criteria, along with ‘giving effect to a person’s will and preferences’, as set out below, should be seen as the minimum necessary legislative change at this time and, if not pursued in the new Act as we recommend, the timetable to align the new Act with other decision-making legislation in Victoria should be brought forward as much as possible to ensure legislative compatibility and to ensure mental health laws are contemporary in their understanding and protection of human rights.

In the meantime, we welcome the proposal that that statutory guidance could be used to improve the understanding and application of the criteria for compulsory treatment. This could be achieved through clarification within the legislation itself or through guidance for decision-makers.

Based on VLA’s role as the major provider of legal advice and representation to people facing compulsory treatment with matters in the Mental Health Tribunal, we consider that guidance on the following matters would assist in application of the legislation that is more consistent with the intention and content of the provisions between decision-makers at various levels, to contribute to compulsory treatment being a true last resort.

Guidance on application of the treatment criteria that, if consistently applied, would immediately reduce the use and duration of compulsory treatment in Victoria

- There is **no onus on a consumer to establish that the treatment criteria do not apply to them**. Some divisions of the Tribunal still effectively apply an onus on consumers to establish that the criteria do not apply to them. Provisions providing for a presumption that the criteria do not apply (see above) and confirming that there is no onus on consumers would help to clarify the application of the criteria and reduce compulsory treatment.
- The **‘treatment’ referred to in 5(d) and 55(3) is the same as the ‘treatment’ found to be necessary to prevent serious distress or harm under 5(b)**. The criteria are often misapplied such that consumers are placed on orders under 5(d) or subjected to detention under Inpatient Treatment Orders in order to enforce treatment that is above and beyond what is necessary to prevent serious deterioration or serious harm.⁸⁹
- **The criteria for making and continuing an order are the same**. There is a wide-spread misapprehension that the threshold for making an order is higher than it is for continuing an

⁸⁹ This may include treatment which is considered ‘clinically optimal’ or in the consumer’s ‘best interests’.

order, leading to decision-makers declining to revoke an order on the misunderstanding that an order could not be made if circumstances relevantly changed in the future.⁹⁰

- The criteria should be considered based on the **circumstances at the time the decision is being made**. In circumstances in which a consumer is voluntarily accepting all treatment, orders should not be sought or made ‘just in case’ things may change at some unspecified point in the future.
- **Past non-compliance** should not in and of itself lead to a finding that a consumer will be non-compliant in the future. In our experience consumers who have not complied with their treatment plans in the past are often considered ‘non-compliant’ and not given further opportunities to receive treatment voluntarily in the future, even where their circumstances, views, and preferences have changed.
- **An authorised psychiatrist may only make a Temporary Treatment Order** in relation to a consumer following the recent revocation of an order by the Tribunal where there has been a **relevant change in circumstances** since the Tribunal’s decision.⁹¹
- The perceived ‘**best interests**’ of a consumer are not relevant to the making of an order. Tribunal members still often state that they have made an order because they believe it is in the consumer’s best interests (rather than because the treatment criteria are met).
- The **need for future treatment, or an admission to an inpatient unit**, cannot be taken in and of itself as amounting to serious distress or harm. Services and the Tribunal often make orders on the basis that they are necessary to prevent a further admission to hospital.⁹²
- **Detention or mere containment** that does not alleviate the symptoms of mental illness does not meet the definition of ‘treatment’ for the purposes of the treatment criteria.⁹³

6.5 Giving effect to a person’s will and preferences

To reflect the recent reforms in relevant legislation identified by the Royal Commission, in circumstances where a person does not have decision-making capacity (or, in the alternative, if the Mental Health and Wellbeing Act continues to provide for the compulsory treatment of people who have decision-making capacity, in all circumstances), decisions should align more closely with the Guardianship and Administration Act and *Medical Treatment Planning and Decisions Act 2016* (Vic).

The new standard set by the Guardianship and Administration Act protects consumers’ rights to self-determination by requiring a substitute decision-maker to ‘give all practical and appropriate effect to a person’s will and preferences’, and may only override the person’s will and preferences if doing so is ‘necessary to prevent serious harm’.⁹⁴ The new Act should provide that a decision-maker must give all practical and appropriate effect to a person’s will and preferences, and must demonstrate how they have done this.⁹⁵ If the authorised psychiatrist or Tribunal is not able to determine a person’s will and preferences, the authorised psychiatrist should give effect to what the authorised psychiatrist

⁹⁰ Considered in *WCH v MHT* [2016] VCAT 199 [102].

⁹¹ *XX v WW* [2014] VSC 564.

⁹² As noted by the Tribunal in *JMN* [2015] VMHT 29, “[a]n admission to hospital would not of itself be a hurt, injury or damage”.

⁹³ See e.g.: *EDY* [2015] VMHT 37.

⁹⁴ *Guardianship and Administration Act 2019* (Vic) s 9(1).

⁹⁵ This could be achieved through amending sections 71, 93 and 96 of the *Mental Health Act*.

believes a person's will and preferences are likely to be, based on all the information available, as far as practicable in the circumstances. If the authorised psychiatrist or Tribunal is not able to determine a person's likely will and preferences, they should choose the least restrictive treatment. A person's will and preferences should only be overridden where necessary to prevent serious distress or harm, with the least restrictive means adopted to achieve this aim.

6.6 The risks of a broader range of professionals authorised to make temporary treatment orders

It is unclear how authorising a broader range of professionals to make temporary treatment orders would support a shift to a more holistic system or reduce compulsory treatment.

Members of Speaking from Experience expressed concerns about this proposal, including the risk to therapeutic relationships and disengagement from professionals with relationships of trust. One member framed his concerns as: 'It doesn't make sense to me if the reforms are designed to reduce reliance on compulsory treatment. If you add more parking inspectors, you'll get more fines'.

Another consumer expert said:

I'm most concerned about a broader range of clinicians being able to make treatment orders. If my case manager was given this power and used it, I would never return to see her again. Having been on temporary treatment orders many times, I'm constantly worried about when this will happen again. If clinicians other than a psychiatrist were given this power, this anxiety would be non stop and I would stop seeking help altogether.

In our view this change should not be introduced at this time and should only be considered in the future if:

- a proper consultation process is undertaken with consumers who have experience of compulsory treatment;
- there is evidence that it has reduced rates of compulsory treatment in jurisdictions where it is in place;
- any professionals who are enabled to make Temporary Treatment Orders also have the power to revoke and vary Temporary Treatment Orders and Treatment Orders;
- it is designed to facilitate supported decision-making; and
- requirements are put in place for anyone with power to put a person on a compulsory treatment order to undertake training on the legal framework, including their obligations under the Charter of Human Rights.

6.7 The role of the Mental Health Tribunal in reducing compulsory treatment and embedding the new Act

The Mental Health Tribunal plays a critical role in determining whether the criteria for the compulsory treatment orders sought by health services apply to a person to make, revoke or vary orders. The Royal Commission noted that aspirations behind the 2014 Mental Health Act and the introduction of the Mental Health Tribunal to reduce compulsory treatment had not been achieved.⁹⁶

We understand that the Royal Commission has not recommended changes to the Tribunal at this stage, noting that in the short term, large-scale reform could risk undermining systemic reforms to prevent the use of compulsory treatment and reduce its use and duration.⁹⁷ Although we appreciate that an independent review of the Tribunal's role will be undertaken in 5–7 years, informed by our work assisting people with matters in the Mental Health Tribunal, we are of the view that it is not possible to pursue the commitment to reducing the use and duration of compulsory treatment in Victoria without considering the role of the Mental Health Tribunal.

We make the following comments and recommendations to support the Tribunals' role reducing compulsory treatment and embedding the new Act.

Transparency, timeframes and powers

Despite the Tribunal's critical function in Victoria's mental health system, there is limited oversight and transparency of Tribunal processes and decisions. Appeals are rare,⁹⁸ hearings are not recorded and consumers commonly do not have legal representation.

We recommend the following changes will help improve accountability of decision-making, uphold the rights of consumers, and reduce rates and duration of compulsory treatment:

- Improve transparency of Tribunal hearings and decision-making by requiring all Tribunal hearings to be **recorded**. All proceedings in the Victorian Civil and Administrative Tribunal are recorded and this is common practice in mental health tribunals in other states, such as New South Wales.
- Make rights to appeal Temporary Treatment Orders accessible and meaningful for consumers by requiring applications for **revocation of Temporary Treatment Orders** to be heard and determined within seven days.
- Empower the Mental Health Tribunal to make **prospective community treatment orders**. Where a consumer is clinically ready for community-based treatment, but accommodation or other supports are not yet in place, the Tribunal generally makes an inpatient treatment order. To prevent this, we recommend including provision in the new Act for the Mental Health Tribunal to make an order that the authorised psychiatrist vary the order to a Community Treatment Order within a period specified by the Tribunal.⁹⁹

⁹⁶ RCMHS Final Report, Volume 4, 409.

⁹⁷ Engagement Paper, 27.

⁹⁸ Of 6,757 hearings regarding treatment orders in 2019 – 2020, 807 were initiated by a patient's application for revocation of that order. During that period 31 applications were made to VCAT for a review of a Tribunal decision, only 13 of which proceeded to full hearing and determination. From: MHT Annual Report 2019–2020, 21, 24, 31.

⁹⁹ Under the previous *Mental Health Act 1986* (Vic), the Mental Health Review Board had the power to order the authorised psychiatrist to make a community treatment order within a reasonable period specified by the Board, but this power was not extended to the Tribunal under the 2014 Mental Health Act.

- Actively **address administrative reversal of Tribunal decisions** by introducing a mechanism to identify cases where new treatment order is made or a Community Treatment Order is varied back to an Inpatient Treatment Order within 24 hours of a Tribunal decision and bring them urgently before the Tribunal for examination, without the consumer having to take responsibility for this.¹⁰⁰

Better understanding pre-hearing conferences

The Engagement Paper proposes that the new Act will allow the Mental Health Tribunal, where a consumer does not object, to require that a conference be held ahead of the Tribunal considering a treatment order extension. In the absence of more information about what is proposed, we are concerned that the introduction of pre-hearing conferences will create another obligation for consumers, without resulting in a reduction of compulsory treatment. In our view, this change should not be introduced unless:

- a proper consultation process is undertaken with consumers who have experience of compulsory treatment and Tribunal hearings to inform the design of this process, including when it should be available;
- it is designed to facilitate supported decision-making;
- it can occur at the request of consumers and they get to choose who is present;
- consumers are not obliged to participate and if they do not, it does not proceed; and
- consideration is given to how to address issues of power imbalance in the interaction to ensure that consumers are not coerced into agreeing to arrangements that they do not actually want to be put in place that then remove the requirement for Tribunal oversight.

RECOMMENDATIONS: RADICALLY REDUCING COMPULSORY TREATMENT

Recommendation 15: Stronger principles relating to the use of compulsory treatment. In addition to the proposed principle requiring consideration of any distress and harm that compulsory treatment may cause, specific compulsory treatment principles should provide guidance regarding consumer autonomy to refuse treatment, discouragement of 'best interests' decision-making and a focus on the least restrictive treatment necessary to prevent serious harm or distress.

Recommendation 16: Allow consumers with decision-making capacity to make their own treatment decisions. Only permit compulsory mental health treatment when a person lacks decision-making capacity, or treatment is necessary to prevent serious harm to

¹⁰⁰ Under the current legislation, once the Tribunal has refused or revoked a compulsory treatment order or varied an inpatient order to a community order, a person cannot be made subject to a new order that is inconsistent with the Tribunal's decision unless there has been a change of circumstances since the Tribunal's decision. See *XX v WW* [2014] VSC 564, which considered the analogous provisions of the Mental Health Act 1986, "Absent some change in circumstances, a [registered medical practitioner] cannot lawfully make a recommendation for an ITO simply because he/she disagrees with the decision of the Board. The power cannot be exercised capriciously or so as to render the Board's powers nugatory." However, our advocates and lawyers have seen a number of cases where the Tribunal makes a decision to refuse an application for a compulsory treatment order or to make the a community treatment order community based rather than inpatient treatment order, as requested by the health service and then the health service effectively reverses the Tribunal's decision, by varying the Tribunal's community-based treatment order to an inpatient treatment order or by making the person subject to a new Assessment Order and Temporary Treatment Order.

others. There should also be a starting presumption that each of the treatment criteria does not apply.

Recommendation 17: Amend the criteria and provide statutory guidance to help make compulsory treatment a last resort.

- a) Replace the current **criteria** for compulsory treatment with ‘preventing the person experiencing serious distress’ (in the subjective experience of the consumer), and requiring that the harm or distress being prevented is both serious and imminent.
- b) Provide **statutory guidance** on appropriate understanding and application of the Mental Health and Wellbeing Act to avoid current common misunderstandings by decision-makers, which contribute to an over-reliance on compulsory treatment.

Recommendation 18: Give effect to a person’s will and preferences. Provide that a decision-maker must give all practical and appropriate effect to a person’s will and preferences, and may only override them if necessary to prevent serious harm or serious distress. Where it is necessary to override a person’s will and preferences to prevent serious harm or distress, the least restrictive means should be adopted to achieve this purpose.

Recommendation 19: The risks of a broader range of professionals authorised to make temporary treatment orders. Do not empower a broader range of professionals to make temporary treatment orders without proper consultation with consumers with lived experience of compulsory treatment.

Recommendation 20: The role of the Mental Health Tribunal in reducing compulsory treatment and embedding the new Act.

- a) **Transparency, timeframes and powers.** Improve the role and impact of the Tribunal through requiring all Tribunal hearings to be recorded, requiring applications by consumers for revocation of Temporary Treatment Orders to be heard and determined within seven days, empowering the Tribunal to make ‘prospective community treatment orders’; and introducing a mechanism to address administrative reversal of Tribunal decisions.
- b) **Pre-hearing conferences.** Pre-hearing conferences should not be introduced without proper consultation with consumers with lived experience of compulsory treatment and Tribunal hearings.

7. Information collection, use and sharing – a consent driven model

The Royal Commission recommends simplifying the collection, use, and sharing of information whilst also acknowledging the importance of consumer dignity, consent, and the right to privacy.¹⁰¹

We reiterate the need for information collection, use, and sharing to be centred on consumer consent.

¹⁰¹ State of Victoria, Royal Commission into Victoria’s Mental Health System, *Final Report, Summary and recommendations*, Parl Paper No. 202, Session 2018–21 (document 1 of 6).

7.1 Improved consumer access to information

VLA is encouraged that the proposals aspire to enhance consumer access to their own information, as recommended by the Royal Commission, by enabling the Commission to issue guidelines to mental health and wellbeing providers on consumer access to information.¹⁰² One person told Victoria Legal Aid that the lack of access to their clinical notes made it challenging to exercise their rights:

*It's not easy to exercise your rights when you don't have any of the information you need. In there I tried to access my own clinical notes, to understand what they were saying about me. Instead they said that I would have to go through this rigorous freedom of information process, to access the notes that they were writing about me! I just gave up. For someone doing worse than me, this would be impossible.*¹⁰³

We support the proposals to allow consumers to ask that a statement be included on their record if they disagree with any information recorded.¹⁰⁴

VLA recommends that the new Act provides for:

- real time access to medical files by consumers (without needing to make formal Freedom of Information requests);
- the right to note disagreements with information on medical files by consumers; and
- the right of the consumer to add information to their medical file.

We also recommend that processes should be put in place to support consumers to have a greater say in their treatment and recovery, including greater input into clinical notes, improved support to access clinical files, and co-producing treatment and discharge plans (which some mental health services have discussed trialling with IMHA).

7.2 A consent-driven model for information sharing

The proposals in the Engagement Paper outline new principles to guide the collection and use of information.¹⁰⁵ VLA is encouraged by these principles, but believes these principles are not strong enough in meeting the Royal Commission's recommendations to introduce a consent-driven approach to information sharing.

A separate process is proposed for developing standards and professional guidelines to support the new Act and VLA, including members from Speaking from Experience, would welcome the opportunity to be involved in this, as well as the discussions regarding the new information-sharing system, the proposed online user-friendly consumer portal that can be accessed in real time.

VLA supports a more streamlined and seamless experience for the sharing of information with families, carers, supporters, and broader social services. While increased information sharing will

¹⁰² Although the Engagement Paper refers to the Health Complaints Commission, we assume this is intended to refer to the Mental Health and Wellbeing Commission.

¹⁰³ State of Victoria, Royal Commission into Victoria's Mental Health System, *Final Report, Volume 5: Transforming the system—innovation and implementation*, Parl Paper No. 202, Session 2018–21 (document 6 of 6), 77. (**RCVMHS Final Report, Volume 5**).

¹⁰⁴ Engagement Paper, 21.

¹⁰⁵ See, e.g., Engagement Paper, 20.

most likely improve the continuity of treatment, provision of care and support, and consumer experiences, the extent to which different types of information are collected and shared needs to be carefully considered when implementing the recommended reforms. This is to ensure that consumer choice, privacy and safety are upheld.¹⁰⁶

The starting point is that information-sharing should be driven by consumer consent. It needs to be clear in the principles that when recording information, consumers' views are placed at the centre.

We often see information shared about consumers without their knowledge or consent with people they do not want to be involved at that particular point in time.

VLA believes that the sharing of basic information across broader social services, such as with Ambulance Victoria and housing services, without the consent of a consumer does not meet the Royal Commission's recommendations around a consent-driven approach to sharing of information. VLA believes a consumer's consent should be obtained before any information is shared, except for the limited exceptions we have detailed below. One member of Speaking from Experience explained it in this way:

No information should be shared between services without consent. Unless it's a life or death situation, but even then it should just be relevant information.

If my diagnosis of borderline personality disorder is shared it could put me at risk of not receiving adequate treatment. I have often been denied treatment or been mistreated due to this diagnosis that has been passed on to other services. I have found that when services are not given this information, I am treated better.

It should not be the case that the default is sharing basic information, rather than obtaining consent. Most consumers will not be reading the legislation to know they have the right to opt out of consenting to basic information being shared.

Another member of Speaking from Experience spoke about the impact of information about their mental health diagnosis being shared when it was not relevant with health professionals who then became distracted by this, rather than effectively treating the physical health problem for which they were seeking medical attention.

There need to be clear and simple consent policies and mechanisms that give as much control as possible to consumers in terms of who sees what information, and in which circumstances.¹⁰⁷

The capacity for consumers to provide instructions about information sharing through an advance statement is positive and in line with the recommendations, however, this cannot be the only mechanism for consumers to express their choices regarding information sharing, particularly given the low rate of take up and the fact that these statements may continue to be non-binding.

¹⁰⁶ Royal Commission into Victoria's Mental Health System, Witness Statement of Kym Peake, 2020, para. 315

¹⁰⁷ RCVMHS Final Report, Volume 5, 73.

VLA acknowledges there are sometimes conflicting views between consumers, families, and carers on how information should be collected, used, and shared. In such instances, VLA recommends that the views of consumers should take priority.

Consumers should also be allowed to nominate excluded persons with whom mental health services cannot share information. The sharing of information with family members can pose a serious safety issue to those at risk of or experiencing family violence, sexual assault, discrimination, stigma, or abuse, so VLA encourages measures that would enable consumers to prevent identified people from accessing information about them or their treatment.¹⁰⁸ Clear processes and protections should be put in place to prevent disclosure of 'excluded persons', noting the risk this could present. VLA recommends that the new Act provide that information can only be shared without consumer consent where necessary:

- because the consumer is unable to consent due to physical incapacity (for example, in a coma);
- to prevent imminent risk of serious harm;
- due to mandatory information sharing requirements in other legislation; or
- to facilitate access to non-legal advocacy or legal assistance for matters related to their compulsory treatment.

In such circumstances:

- only the information that is necessary to prevent the serious harm or that is legally required should be shared; and
- what is shared:
 - must be reported to the consumer unless this creates a serious and imminent risk of harm; and
 - must be recorded.

VLA believes the above changes will ensure the proposals better meet the Royal Commission's recommendations into information collection, use, and sharing.

7.3 Mechanisms to facilitate access to legal representation

The Royal Commission found that legal representation at the Mental Health Tribunal is highly valued by consumers, providing important support to promote the rights of consumers and the principles of the 2014 Mental Health Act, although not all consumers are aware how to get it.¹⁰⁹ The Royal Commission recommended increased access to legal assistance for Mental Health Tribunal hearings.¹¹⁰ The Royal Commission identified funding limitations as a major reason for Victoria's low representation rate.¹¹¹ Increased funding is fundamental to see any meaningful increase in access to legal representation.

¹⁰⁸ Daya, Indigo and Edan, Vrinda, *Act on the act: A rapid consultation with consumers to inform drafting of the new Victorian Mental Health and Wellbeing Act (2021)* (**Act on the act**) 61, 62, 64.

¹⁰⁹ RCVMHs Final Report, Volume 4, 396.

¹¹⁰ RCVMHs Final Report, recommendation 56(3).

¹¹¹ RCVMHs Final Report, Volume 4, 397.

There are also, however, practical, process-focused changes that could be put in place immediately to contribute to increases in representation, until funding is allocated to implement this recommendation. While the 2014 Mental Health Act provides for a right to legal representation at the Tribunal, there are no processes in place at a system level to facilitate access to legal assistance. In addition, there are no consistent processes that services must follow to facilitate it. Provision of hearing lists, sharing of consumer information and access to consumers are largely at the discretion of services and vary greatly across the state. Arrangements for VLA's service are determined by agreement with each service.

Many mental health services do not allow lawyers to meet with consumers to explain and offer access to VLA's service. Rather, they provide the consumer with the option of access to legal aid and if the person declines, their details are not shared with VLA. Allowing VLA to explain the service directly to the consumer often provides a better basis for them to understand the lawyer's role and consent to their involvement. It also makes clear to the consumer, who may be overwhelmed with information or dealing with crisis or distress, that the lawyer is separate and independent from the clinical service, which can be an important factor in their decision.

Similarly, there are no standards or practice directions that govern lawyers' access to information relevant to the Tribunal hearing, as there are in some other states. In our experience, concerns about confidentiality commonly override concerns about ensuring procedural fairness for consumers at their hearing by lawyers having a proper opportunity to consider all the evidence relevant to the person's matter.

These varied practices create difficulties for legal assistance service planning and result in inconsistent access for consumers.

There are no arrangements for the Tribunal to provide VLA with hearing lists or for a person who wants legal representation to be referred directly from the Tribunal to VLA as would be common in other areas of VLA's practice. The Tribunal's view is that confidentiality provisions prevent direct sharing of hearing lists as occurs in other states.

In designing information sharing provisions in the new Act, and related processes, we recommend the following changes to facilitate increased access to legal assistance for consumers:

- Requiring designated mental health services and the Tribunal to provide:
 - Consumer contact details to legal service providers for the purpose of facilitating legal assistance before the Tribunal without requiring consumer consent. This is a proposed exception to confidentiality to include the sharing of basic information (name, hearing details and contact information) with prescribed legal service providers to facilitate providing legal assistance services to consumers subject to compulsory treatment in order to increase consumer access to legal representation;¹¹²
 - Any documents the consumer is entitled to in relation to their hearing to a consumer's legal representative, electronically or otherwise, with consumer consent;
- Implementing a centralised system for referral of consumers with Tribunal hearings to obtain legal assistance for their hearing;

¹¹² This would be used by the legal assistance provider only to contact the consumer to offer legal assistance. Once this contact is made, the consumer can then decide whether they want legal assistance for their Tribunal hearing and, if so, can provide their consent to the sharing of further information, such as the Tribunal report and other documents to be provided to the Tribunal.

- A clear consistent protocol for the provision of this information that all services and the Tribunal are required to follow; and
- Requiring the Tribunal to allow legal representatives to appear by telephone or video in any matter on request.

This approach supports access to legal assistance so that consumers are able to exercise their rights whilst protecting consumer privacy as much as possible, particularly given the limited use of the information and the confidentiality obligations to which legal professionals are subject. Such arrangements would also help mental health services to understand when information should and should not be shared, allow lawyers to allocate more time to direct consumer assistance rather than chasing up hearing lists and documents, and improve service access and procedural fairness at Tribunal hearings.

RECOMMENDATIONS: INFORMATION COLLECTION, USE AND SHARING – A CONSENT DRIVEN MODEL

Recommendation 21: Improved consumer access to information. Provide for real time access to medical files by consumers (without needing to make formal Freedom of Information requests) and include rights for consumers to note disagreement with information on medical files and add information to medical files.

Recommendation 22: A consent-driven model for information sharing. Information-sharing should be driven by consumer consent. There should be limited and specified circumstances in which information can be shared without consent and, in those circumstances, only the information necessary to prevent serious harm or that is legally required should be shared. Consumers should be able to confidentially nominate excluded persons with whom mental health services cannot share information.

Recommendation 23: The architecture to increase legal representation for consumers who appear before the Tribunal. Create a legislative exemption and related processes that require designated mental health services and the Tribunal to provide basic consumer information (name, hearing details and contact information) to prescribed legal service providers without consent for the purpose of facilitating access to legal assistance before the Tribunal. Other documents the consumer is entitled to in relation to their hearing should be provided to the consumer's legal representative with consent.

8. Eliminating the use and negative impacts of seclusion and restraint

We welcome the focus on reducing the rates of seclusion and restraint, and the acknowledgement that they are not therapeutic interventions.¹¹³

One of members of Speaking from Experience, who has been subjected to seclusion and restraint on multiple occasions said:

I worry that staff will continue to use these measures because they have 10 years to keep doing it. I think it should be significantly reduced ASAP and if we must, allow the 10 years for culture change. Before 10 years is ideal. Efforts should be put into teaching clinicians patience, trauma informed care and de-escalation techniques.

8.1 The harm of restrictive interventions

We support the proposal to require clinicians to balance consideration of the harm likely to be caused by the restrictive intervention with the harm intended to be prevented by it when contemplating its

¹¹³ Engagement Paper, 29.

use.¹¹⁴ We recommend this provision clarifies that the restrictive intervention may *only* be used when the risk of harm being prevented outweighs the harm caused by its use. Further, in considering alternative treatments, clinicians must be guided by a person's views and preferences.

As set out above in relation to reducing compulsory treatment and below in part 9.1, we recommend the inclusion of provisions equivalent to those in the *Gender Equality Act 2020* (Vic), requiring services to develop a plan setting out targets, measures and timeframes for progress towards the elimination of restrictive interventions, to be submitted to the Mental Health and Wellbeing Commission, and to make reasonable and material progress against that plan, which is publicly reported on.

This work should be done with consumers and clinicians to address the reasons for use of restrictive interventions and how to eliminate these.

8.2 Regulation of chemical restraint

We support efforts to regulate chemical restraint.

We are concerned that a definition of chemical restraint being 'medication given primarily to control a person's behaviour, not to treat a mental illness or physical condition' will not encompass the circumstances we frequently see in which an overly sedating medication is given for a dual purpose – both to control a person's behaviour and to treat a mental health issue. The proposed definition is too narrow and would prevent the necessary oversight and regulation of this kind of treatment. If a medication is used for both purposes, in circumstances where another medication would achieve a similar purpose in treating the mental health issue but would not have the same effect in controlling the person's behaviour, it should be considered 'chemical restraint' and subject to the same oversight, regulation and monitoring.

The definition of 'restrictive intervention'¹¹⁵ should be amended to include chemical restraint.

We also recommend consideration of provisions that incorporate elements of the South Australian definition of 'restrictive practice' which encompasses seclusion and 'the use of physical, mechanical or chemical means to restrain the patient'.¹¹⁶

RECOMMENDATIONS: ELIMINATING OF THE USE AND NEGATIVE IMPACTS OF SECLUSION AND RESTRAINT

Recommendation 24: Ensure progress towards elimination. Include provisions equivalent to those in the *Gender Equality Act 2020* (Vic), requiring services to develop a plan setting out targets, measures and timeframes for progress towards the elimination of restrictive interventions, to be submitted to the Mental Health and Wellbeing Commission, and to make reasonable and material progress against that plan, which is publicly reported on.

Recommendation 25: Regulate restrictive interventions and chemical restraint. Only permit restrictive interventions to be used when the harm being prevented outweighs the harm caused by its use. Be clear that in considering alternative treatments, clinicians must

¹¹⁴ Ibid., 30.

¹¹⁵ *Mental Health Act 2014* (Vic) s 3.

¹¹⁶ *Mental Health Act 2009* (SA) s 3.

be guided by a consumer's views and preferences and broaden the definition of chemical restraint to include medications given with the dual purpose of controlling a person's behaviour and to treat a mental health issue.

9. Governance and oversight – critical for embedding change

VLA welcomes the recognition by the Royal Commission of the need for strong system leadership and accountability, including the leadership of people with lived experience.

Through our work, we see that there is very limited visibility of, or consequences for, non-compliance with the 2014 Mental Health Act.

In the absence of accountability, strong legislation is meaningless and does not translate to any practical difference for people using Victoria's mental health system. As set out by VMIAC, the goal of these reforms should be 'having an Act that stands up for the rights of the people it serves. An Act that has authority and accountability measures if it is breached'.¹¹⁷

One consumer advisor from Speaking from Experience summarised it in this way:

People have been complaining about the same issues for 30+ years, yet each complaint is treated as something new and so nothing changes.

... no one is properly held to account so services develop a mindset where they feel totally immune and shielded from oversight. This attitude contributes to a culture that enables these issues to continue occurring.

While recognising the role for an effective, accessible complaints system as part of an accountability framework, individual complaints put the burden on individuals and are an ad hoc form of audit and oversight. It is important that the Mental Health and Wellbeing Commission is also able to receive and consider system-wide information about the failure to comply with the new Act, including failure to comply with the principles.

This part sets out our recommendations for establishing a robust framework of accountability to drive cultural change.

9.1 A regulatory model geared to drive cultural change

In the current system, all mental health services are subject to the same legislation and practice guidelines from the Chief Psychiatrist. Despite this and an existing legislated complaints mechanism, VLA's lawyers and IMHA advocates see wide variation of consumer experience between different services and different parts of the same service. Concerns can be followed up directly with these services but is difficult to follow up at a systemic level due to the current system of 'devolved governance'. As a result, opportunities for sharing best practice and addressing poor practice are lost.

¹¹⁷ Act on the act, 4.

For the system change contemplated by the Royal Commission to be achieved, it is essential that all services are subject to performance requirements against which they are audited and required to report.

The new Act and associated system governance should provide for the various oversight agencies to obtain information from sources such as IMHA and to cross reference information from other sources, such as legislative compliance, KPI performance, complaints data, and consumer experience to drive system improvement. It is also essential that service level performance data is published on a regular basis through a variety of means to ensure that it is accessible to those providing services to consumers and to consumers themselves.

We recommend that the leading work of organisations and government to formulate the *Gender Equality Act 2020* (Vic) and the mechanisms it contains to bring about wide-scale cultural change are embraced and adapted for this similarly significant legal and cultural reform.

Learning from an existing model for embedding cultural change

The *Gender Equality Act 2020* (Vic) has been described as ‘a once in a generation opportunity to influence policy, culture and attitudes across Victoria’.¹¹⁸ The Act aims to promote gender equality by:

- Requiring the Victorian public sector, local councils and universities to **take positive action** towards achieving workplace gender equality.
- Requiring these organisations to **consider and promote** gender equality in their **policies, programs and services**.
- Establishing the **Public Sector Gender Equality Commissioner** to provide **education, support implementation and enforce compliance**.¹¹⁹

An adapted model designed to embed change in the mental health system should include requirements for mental health services to:¹²⁰

- Undertake an **audit** of existing policies, programs and services and their compliance with the Mental Health and Wellbeing Act.
- Develop a **plan to implement the Mental Health and Wellbeing Act**. This plan would:
 - Be required to articulate how the mental health service has considered the **principles** in the Mental Health and Wellbeing Act in developing the plan.
 - Help mental health services **plan, implement and measure change**.
 - Be **published** and **submitted to** the Mental Health and Wellbeing Commission.

¹¹⁸ Commission for Gender Equality in the Public Sector, *History of the Gender Equality Act 2020*. Available at <<https://www.genderequalitycommission.vic.gov.au/history-gender-equality-act-2020>>

¹¹⁹ Ibid.

¹²⁰ See, e.g., Commission for Gender Equality in the Public Sector, *Gender Equality Action Plan 2021–2025: Guidance for Defined Entities (Gender Equality Action Plan Guidance)*. This document contains guidance for developing Gender Equality Action Plans under the *Gender Equality Act 2020* (Vic). The guidance is issued under section 47 of the Act. This means defined entities **must have regard to this guidance** when complying with their obligations under the Act.

- Be **developed with consumers** (including consumers that experience intersectional discrimination based on Aboriginality, age, disability, ethnicity, gender identity, race, religion, sexual orientation), staff, and legal and advocacy services.¹²¹
- Include strategies, targets, timelines and measures for:
 - Reducing the use and duration of compulsory treatment
 - Embedding supported decision-making
 - Ensuring access to non-legal advocacy
 - Eliminating the use of seclusion and restraint
 - Implementing effective complaints and accountability mechanisms
 - Providing services that recognise the needs and experiences of diverse consumers, including Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse communities, LGBTIQ+ people, older people, women, and people diagnosed with dual disability.
- **Publicly report** on the **progress** toward implementing the Mental Health and Wellbeing Act, which is also submitted to the Mental Health and Wellbeing Commission.
- Ensure **adequate resources** are allocated to developing and implementing their plans.¹²²
- Develop **policies, programs and services** that promote compliance with the Mental Health and Wellbeing Act.
- **Assess compliance** with the Mental Health and Wellbeing Act, including requirements to provide rights information, use supported decision-making, facilitate access to advocacy by providing contact information and responding to requests for information, providing access to health records and providing Tribunal material to consumers within required statutory timeframes.

The framework should also include appropriate powers for the Mental Health and Wellbeing Commissioner to meaningfully address non-compliance with the Mental Health and Wellbeing Act.¹²³

9.2 Mental Health and Wellbeing Commission – creating meaningful oversight

VLA welcomes the creation of a new Mental Health and Wellbeing Commission that will be required to report to parliament on performance, safety, and quality, including in relation to compulsory treatment.

We support the introduction of the ability for consumers to make complaints about health services not complying with the principles of the Act.

¹²¹ See Gender Equality Action Plan Guidance, 9 and Appendix C.

¹²² *Gender Equality Act 2020* (Vic) s 10(3).

¹²³ The Gender Equality Commissioner has a range of enforcement options available under the Act. They include: working directly with an organisation to achieve an informal resolution (section 22(3)); issuing a compliance notice (section 22(1)); recommending that the Minister takes action against the organisation (section 26(b)); naming the organisation and their failure to comply on the Commission's website (section 26(c)); as a last resort, making an application to the Victorian Civil and Administrative Tribunal for an order directing the organisation to comply (section 26(d)).

We note that the effectiveness of the current complaints system has been impacted by a lack of mandatory minimum standards for complaint management and reporting by health services, as well as lengthy response times by the Mental Health Complaints Commissioner.

Consumer advisers from Speaking from Experience have spoken about not feeling safe making complaints about the service that is detaining or treating them. They spoke about the discrimination they have experienced when making complaints about service providers, including not being given credibility because of a mental health diagnosis and the stigma attached to that. Even when they had complained, it was observed that the process takes an extremely long time and does not lead to change. It was observed that too often complaints are just handled within individual services and there is no central recording of complaints or transparency or accountability about what happens in response.

System reform will be dependent on the preparedness of the new Mental Health and Wellbeing Commission to use its new powers and an end to the passive approach that has been taken to regulation under the current legislation.

Under the new Act, the Mental Health and Wellbeing Commission should:

- Be given the power and resources necessary to set standards for complaint handling, monitor these functions by health services, and manage complaints made to it directly in a timely way. This should include the publication of complaint data and learnings from services and the Commission.
- Be given roles and powers similar to those designed to lead cultural change under the *Gender Equality Act 2020* (Vic), including providing education, supporting implementation and enforcing compliance with the Mental Health and Wellbeing Act.¹²⁴
- Report on service level data to allow comparison and benchmarking, which is published in a way that makes it readily accessible to the general public. The current annual reporting is too infrequent to support meaningful quality improvement processes, and we recommend some key data is reported quarterly.

Coordinate sharing of information between oversight bodies to ensure underperforming services are quickly identified and supported to improve practice. As discussed through this submission, VLA's lawyers and IMHA advocates are present in all mental health services across Victoria. Our work with consumers across Victoria gives us insights into the different approaches taken by the different services and the variation in consumer experience across the system. We would welcome the introduction of processes for VLA and IMHA to be able to provide input into the Mental Health and Wellbeing Commission about compliance by services with the new Act.

9.3 The risks and potential of new governance structures and oversight bodies

The creation of a number of new entities underlines the significance of governance in system reform. However, there is a risk of confusion or dilution of responsibility through the introduction of so many new entities.

¹²⁴ The Gender Equality Commissioner has a range of enforcement options available under the Act. They include: working directly with an organisation to achieve an informal resolution (section 22(3)); issuing a compliance notice (section 22(1)); recommending that the Minister takes action against the organisation (section 26(b)); naming the organisation and their failure to comply on the Commission's website (section 26(c)); as a last resort, making an application to the Victorian Civil and Administrative Tribunal for an order directing the organisation to comply (section 26(d)).

Our experience is that one of the failures of the current system is the inconsistency of approach, policies, and practices in different services which means that the quality of care and the experience of consumers varies greatly depending on where you live rather than on individual or local community needs.

System improvement in a more decentralised system of regionally based service delivery oversight will depend on the creation of minimum standards, clearly defined measures of success, public reporting, and information sharing between safeguard and oversight bodies, as well as a preparedness for regulatory bodies to use their powers to hold providers to account and ensure that standards are met. There will also need to be clear role definition that is understood internally in each entity, between entities and throughout the system, including to consumers and those who support them.

The measures of service and system success must include consumer outcomes and experience and be arrived at through a process of consumer co-design or co-production if they are to succeed in achieving their intention.

All new entities need to have consumer leadership embedded in their design, establishment, operation, safety and quality improvements, and evaluation.

The proposed creation of lived experience roles in governance and across all areas of operation is welcome. We caution, however, against the proposal of single consumer leadership positions in oversight and governance structures. Best practice is for two or more consumer leadership positions, as well as mechanisms that allow continuous input from a diverse range of consumers and their supporters into the work of these bodies, to improve the experience of consumer leaders and maximise the strength and impact of consumer leadership.

In relation to the proposed state-wide and regional multiagency panels, we reiterate that it is essential that these bodies be designed and established in consultation with consumers, and that safeguards for consumer rights are put in place to address power imbalances and provide maximum consumer choice, amplifying the consumer's voice and avoiding the risk of coercion.

9.4 Oversight of mental health services in correctional settings

In recognition of the principle of equivalence for people with mental health issues in correctional settings, we support the expansion of the jurisdiction of the Chief Psychiatrist and the Mental Health and Wellbeing Commission into correctional settings.

We acknowledge that Forensicare consumers reported that 'the quality of mental health care in prison was far below that in Thomas Embling Hospital'¹²⁵ and identified concerns about a lack of accountability for rights breaches.¹²⁶

Service standards for mental health services should apply to the delivery of services in correctional settings. Consideration should also be given to what this means for these consumers' access to mechanisms being put in place for consumers of the mental health system such as the right to non-legal advocacy. If necessary to ensure equivalence, the jurisdiction of the Chief Mental Health and Wellbeing Officer should also encompass service delivery in correctional settings.

¹²⁵ Forensicare Consumers' submission, 4.

¹²⁶ Ibid., 13.

9.5 Reviewing the new Act's effectiveness and increasing its potential

The Royal Commission made clear in its report that the aspirations of the 2014 Mental Health Act to create a rights and recovery driven mental health system were never realised.¹²⁷ This is in large part due to implementation failure and it is critical that this does not happen again.

The new Act is a critical foundation of the future system the Royal Commission is seeking to create. For this reason, a five to seven year timeframe to review the effectiveness of the new legislation is too long.¹²⁸ We also consider that a three year timeframe is the maximum that consumers should wait to see the abolition of mental health legislation that allows a person with capacity to be treated without their consent and for the effectiveness of critical system elements such as the Office of the Chief Psychiatrist and Mental Health Tribunal to be fully assessed.

An evaluation framework needs to be put in place alongside the new Act identifying the measures that will allow the effectiveness of the new legislation to be assessed at that time and for any necessary changes to be made to avoid the implementation failure and lost potential of the 2014 Mental Health Act being repeated.

We recommend that a review is undertaken once the new Act has been in place for three years. This does not need to be a full review of the legislation. Rather, it would be meaningful to undertake an independent evaluation of the extent to which the critical legislative changes have been effective in achieving the aims of the Royal Commission: that voluntary treatment is preferred and compulsory treatment is a true last resort; for services to operate on the basis of supported decision-making; for supported decision-making mechanisms to be taken up by consumers; for the system not to create harm so that consumers' experience is positive; that consumers understand and exercise their rights.

This would provide recommendations to address barriers hindering the aims and support the system to continue towards achieving reform. In the wake of a Royal Commission, consumers are entitled to expect true system reform to be achieved at what will be more than 10 years since the promise of the 2014 Mental Health Act.

RECOMMENDATIONS: GOVERNANCE AND OVERSIGHT – CRITICAL FOR EMBEDDING CHANGE

Recommendation 26: A regulatory model geared to drive cultural change. Adapt a robust model of accountability based on the *Gender Equality Act 2020* (Vic) to embed cultural change and drive compliance with the Mental Health and Wellbeing Act. See recommendation 1.

Recommendation 27: Mental Health and Wellbeing Commission – creating meaningful oversight. Empower the Mental Health and Wellbeing Commission to take a proactive approach to regulation and quality improvement, including setting standards for complaint handling, managing complaints in a timely way, publishing service level data to allow comparison and benchmarking, enforcing compliance with the Mental Health and

¹²⁷ RCVMH Final Report, Volume 4, 23.

¹²⁸ Ibid., 277-276, 428-430, 434.

Wellbeing Act, and coordinating sharing of system-wide information (for example from services such as VLA and IMHA) about compliance with the new Act.

Recommendation 28: The risks and potential of new governance structures and oversight bodies. Ensure clear role definition of new entities and clearly defined measures of service and system success, which are publicly reported against. Consumer leadership must be embedded in the design, establishment and operation of all new entities.

Recommendation 29: Oversight of mental health services in correctional settings. Service standards, and oversight by the Chief Psychiatrist and Mental Health and Wellbeing Commission, should apply to delivery of services in correctional settings to ensure equivalent standards of care to mainstream mental health services.

Recommendation 30: Review the new Act's effectiveness and increase its potential. An initial review of the Mental Health and Wellbeing Act should occur three years after enactment (earlier than the proposed five to seven years). An evaluation framework should be co-designed with consumers for the new Act to make sure its impact and effectiveness can be meaningfully measured. Crucial reforms, if not enacted now, including to align the new Mental Health and Wellbeing Act with existing Victorian law on substitute decision-making must also be actively pursued in this three year timeframe.

Annexure 1: Thirty recommendations for a Mental Health and Wellbeing Act that embeds consumer leadership, rights and accountability

Informed by the leadership of, and our work with, consumers subject to or at risk of compulsory treatment, we make the following recommendations to be implemented as part of development of the Mental Health and Wellbeing Act.

Objectives and principles that drive reform

1. **Mechanisms that will give the principles and objectives meaning.** To ensure the principles and objectives have a real impact for consumers, we recommend a similar framework to the *Gender Equality Act 2020* (Vic), carefully designed to lead and embed cultural change, is included in the Mental Health and Wellbeing Act. This should include an obligation on mental health services to prepare action plans that comply with the principles, strategies that include measurements, targets and timelines, public reporting, and both educative and enforcement roles for the Mental Health and Wellbeing Commission.
2. **Recognise and reduce the harm of compulsory treatment.** To reduce the risk that compulsory treatment is relied on to prioritise access to treatment in an under-resourced system:
 - a. Include an additional point in the objective to ‘achieve the highest attainable standard of mental health and wellbeing for the people of Victoria’, which recognises the harm to mental health and wellbeing that can be inherent in compulsory treatment.
 - b. Include a principle that a person’s access to treatment (whether that be the range of treatments, intensity of supports, and/or timeliness of interventions) should be the same regardless of whether they are a voluntary or compulsory patient.
3. **Promote a consumer focus.** Consistent with the principle of protecting and promoting the rights, dignity and autonomy of consumers:
 - a. **A clear understanding of personal recovery.** Clarify that ‘recovery’ refers to personal recovery, as determined by a consumer themselves, rather than clinical recovery.
 - b. **Centre consumers in considering the role of families, carers and supporters.** Include provisions that support an approach consistent with the definition of carers in the *Carers Recognition Act 2012* (Vic) and the will and preferences of consumers about the involvement of family and carers in treatment processes. Accompany this with training for mental health practitioners to understand the role of carers, family, and supporters, approaches to working with consumers and carers and the dynamics of family violence.
4. **Clarity about which decision-makers and consumers the Act applies to.** Clearly articulate in the Act that ‘decision-makers’ includes the Department of Health, the new Mental Health and Wellbeing Commission, the new Regional Mental Health and Wellbeing Boards, the Mental Health Tribunal and wellbeing service providers funded by the Victorian Government, including those providing mental health and wellbeing services in prisons. Clarify that the Act and the principles apply to voluntary and compulsory consumers.

5. **Strengthen specific principles.** Strengthen and clarify specific principles as described in the table in part 3.5. Our recommendations are aimed at improving consistency with the *Convention on the Rights of Persons with Disabilities* and the *Guardianship and Administration Act 2019* (Vic), strengthening consumer autonomy, including a standalone principle on supported decision-making and better recognising cultural wellbeing, systemic discrimination and the need for trauma-informed practice.

Embedding supported decision-making in law and practice

6. **Embed supported decision-making in legislation.** Name and explain supported decision-making in the new Act. Create a specific principle focused on supported decision-making, require services to support people to make their own decisions and clearly limit the circumstances in which substituted decision-making can occur.
7. **Implement supported decision-making in practice.** Require anyone exercising powers under the new Act to undertake ongoing mandatory, co-produced training on the new Act, including supported decision-making, recovery, least restrictive treatment and the application of the *Charter of Human Rights and Responsibilities Act 2006* (Vic). Services should report on compliance with the training requirements.
8. **Make the statement of rights proactive and consumer-led.** The new Act should require updated, co-produced statements of rights be provided to all voluntary and compulsory consumers, both inpatients and people in the community. Supporting consumers to exercise their rights should include proactive linking of consumers to non-legal advocacy and legal assistance.
9. **Advance statements and written reasons for over-riding consumer views and preferences.** Limit the circumstances in which an authorised psychiatrist can override an advance statement. Require that, where a consumer's views and preferences (whether expressed in an advance statement or by them or their nominated person or non-legal advocate) are over-ridden, written reasons should be provided prior to overriding their preferences within 24 hours. Non-legal advocacy should be available to support people to make advance statements.
10. **Nominated persons – make this a modern rights-focused role.** The framework for nominated persons should mirror the principles, duties and obligations which apply to supportive guardians and supportive administrators under the *Guardianship and Administration Act 2019* (Vic).
11. **Second psychiatric opinions.** The Act should set a maximum timeframe or require second opinions to be provided, and responded to, within a reasonable time.

IMHA non-legal advocacy: A consistent, effective state-wide model

12. **Recognise IMHA's successful model of non-legal advocacy.** Recognising the strengths of the independently evaluated IMHA non-legal advocacy model, and the risks of failing to clarify the meaning of non-legal advocacy, the new Act should provide for the prescription of non-legal advocacy providers and IMHA should be a prescribed provider.
13. **Improve the notification and response requirements.** The requirements to notify an advocate within 24 hours should be extended to include treatment orders. In addition, when a person's views and preferences have been communicated by an advocate and been

overridden, this should be communicated to the advocate. Service providers should be required to respond to any requests for information by advocates within 48 hours.

14. **Make sure advocacy is accessible across services.** The provision for advocates to access inpatient services should be expanded to include other existing services including community-based designated mental health services, Community Care Units, Prevention and Recovery Centres, as well as hospital-based health services (eg Emergency Departments, medical wards) and future mental health and wellbeing centres.

Radically reducing compulsory treatment

15. **Stronger principles relating to the use of compulsory treatment.** In addition to the proposed principle requiring consideration of any distress and harm that compulsory treatment may cause, specific compulsory treatment principles should provide guidance regarding consumer autonomy to refuse treatment, discouragement of 'best interests' decision-making and a focus on the least restrictive treatment necessary to prevent serious harm or distress.
16. **Allow consumers with decision-making capacity to make their own treatment decisions.** Only permit compulsory mental health treatment when a person lacks decision-making capacity, or treatment is necessary to prevent serious harm to others. There should also be a starting presumption that each of the treatment criteria does not apply.
17. **Amend the criteria and provide statutory guidance to help make compulsory treatment a last resort.**
 - a. Replace the current **criteria** for compulsory treatment with 'preventing the person experiencing serious distress' (in the subjective experience of the consumer), and requiring that the harm or distress being prevented is both serious and imminent.
 - b. Provide **statutory guidance** on appropriate understanding and application of the Mental Health and Wellbeing Act to avoid current common misunderstandings by decision-makers, which contribute to an over-reliance on compulsory treatment.
18. **Give effect to a person's will and preferences.** Provide that a decision-maker must give all practical and appropriate effect to a person's will and preferences, and may only override them if necessary to prevent serious harm or serious distress. Where it is necessary to override a person's will and preferences to prevent serious harm or distress, the least restrictive means should be adopted to achieve this purpose.
19. **The risks of a broader range of professionals authorised to make temporary treatment orders.** Do not empower a broader range of professionals to make temporary treatment orders without proper consultation with consumers with lived experience of compulsory treatment.
20. **The role of the Mental Health Tribunal in reducing compulsory treatment and embedding the new Act.**
 - a. **Transparency, timeframes and powers.** Improve the role and impact of the Tribunal through requiring all Tribunal hearings to be recorded, requiring applications by consumers for revocation of Temporary Treatment Orders to be heard and determined within seven days, empowering the Tribunal to make 'prospective community

treatment orders'; and introducing a mechanism to address administrative reversal of Tribunal decisions.

- b. **Pre-hearing conferences.** Pre-hearing conferences should not be introduced without proper consultation with consumers with lived experience of compulsory treatment and Tribunal hearings.

Information collection, use and sharing – a consent driven model

- 21. **Improved consumer access to information.** Provide for real time access to medical files by consumers (without needing to make formal Freedom of Information requests) and include rights for consumers to note disagreement with information on medical files and add information to medical files.
- 22. **A consent-driven model for information sharing.** Information-sharing should be driven by consumer consent. There should be limited and specified circumstances in which information can be shared without consent and, in those circumstances, only the information necessary to prevent serious harm or that is legally required should be shared. Consumers should be able to confidentially nominate excluded persons with whom mental health services cannot share information.
- 23. **The architecture to increase legal representation for consumers who appear before the Tribunal.** Create a legislative exemption and related processes that require designated mental health services and the Tribunal to provide basic consumer information (name, hearing details and contact information) to prescribed legal service providers without consent for the purpose of facilitating access to legal assistance before the Tribunal. Other documents the consumer is entitled to in relation to their hearing should be provided to the consumer's legal representative with consent.

Eliminating of the use and negative impacts of seclusion and restraint

- 24. **Ensure progress towards elimination.** Include provisions equivalent to those in the *Gender Equality Act 2020* (Vic), requiring services to develop a plan setting out targets, measures and timeframes for progress towards the elimination of restrictive interventions, to be submitted to the Mental Health and Wellbeing Commission, and to make reasonable and material progress against that plan, which is publicly reported on.
- 25. **Regulate restrictive interventions and chemical restraint.** Only permit restrictive interventions to be used when the harm being prevented outweighs the harm caused by its use. Be clear that in considering alternative treatments, clinicians must be guided by a consumer's views and preferences and broaden the definition of chemical restraint to include medications given with the dual purpose of controlling a person's behaviour and to treat a mental health issue.

Governance and oversight – critical for embedding change

- 26. **A regulatory model geared to drive cultural change.** Adapt a robust model of accountability based on the *Gender Equality Act 2020* (Vic) to embed cultural change and drive compliance with the Mental Health and Wellbeing Act. See recommendation 1.
- 27. **Mental Health and Wellbeing Commission – creating meaningful oversight.** Empower the Mental Health and Wellbeing Commission to take a proactive approach to regulation and quality improvement, including setting standards for complaint handling, managing complaints

in a timely way, publishing service level data to allow comparison and benchmarking, enforcing compliance with the Mental Health and Wellbeing Act, and coordinating sharing of system-wide information (for example from services such as VLA and IMHA) about compliance with the new Act.

28. **The risks and potential of new governance structures and oversight bodies.** Ensure clear role definition of new entities and clearly defined measures of service and system success, which are publicly reported against. Consumer leadership must be embedded in the design, establishment and operation of all new entities.
29. **Oversight of mental health services in correctional settings.** Service standards, and oversight by the Chief Psychiatrist and Mental Health and Wellbeing Commission, should apply to delivery of services in correctional settings to ensure equivalent standards of care to mainstream mental health services.
30. **Review the new Act's effectiveness and increase its potential.** An initial review of the Mental Health and Wellbeing Act should occur three years after enactment (earlier than the proposed five to seven years). An evaluation framework should be co-designed with consumers for the new Act to make sure its impact and effectiveness can be meaningfully measured. Crucial reforms, if not enacted now, including to align the new Mental Health and Wellbeing Act with existing Victorian law on substitute decision-making must also be actively pursued in this three year timeframe.

Annexure 2: Snapshot of VLA clients

