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| **OBJECTIVES AND PRINCIPLES OF THE NEW ACT (SECTION 2.1)** | | |
| Principles are generally included in legislation to describe the values of the Act and, together with the objectives, provide guidance to individuals, organisations and the public on how to interpret and apply the Act.  The **Royal Commission** recommended (Rec 42) that the MHWA: includes **new objectives and mental health principles**, with its primary objective to achieve the highest attainable standard of mental health and wellbeing for the people of Victoria by:   * promoting conditions in which people can experience good mental health and wellbeing. * reducing inequities in access to, and the delivery of, mental health and wellbeing services; and * providing a diverse range of comprehensive, safe and high-quality mental health and wellbeing services.   The Royal Commission also recommended (Rec 56) that the Victorian Government promote, protect and ensure the right of people living with mental illness or psychological distress to the enjoyment of the highest attainable standard of mental health and wellbeing without discrimination.  There is more detail in the consultation paper, we have summarised the objectives and principles below.  **The proposed new objectives are:**   1. Achieve the highest attainable standard of mental health and wellbeing for people of Victoria 2. Protect and promote the rights and dignity of people living with mental illness or psychological distress 3. Recognise and promote the role of families, carers and supporters in the care, support and recovery of people living with mental illness or psychological distress   **The proposed new principles are:**  Mental health services and decision-makers under the new Act should:   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. 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. 3. Ensure compulsory treatment and restrictive practices are only used as a last resort. 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 decisions, and respect their views and preferences, including when those decisions involve a degree of risk. 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. 6. Value the lived experience of people living with mental illness or psychological distress, their carers, families and supporters as leaders and active partners. 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 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. 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. 10. Recognise and respond to the range of circumstances that influence mental health and wellbeing including relationships, accommodation, education, financial circumstances and employment status. 11. Provide culturally safe and responsive mental health and wellbeing treatment and care to Aboriginal and Torres Strait Islander peoples that is 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. 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. 13. Recognise and protect the needs, wellbeing and safety of children, young people and other dependants of people receiving mental health and wellbeing services. | | |
| **Question** | **What has been said by consumers** | **Your ideas for answering the questions** |
| **Question 1:**  Do you think the proposals meet the Royal Commission’s recommendations about the objectives and principles of the new Act? (Section 2.1 in the paper) | * The new act must comply with the Convention of the rights of people with a disability (CRPD) * The act must be strong with little room for re interpretation. * The rights of the person using services cannot be overridden by the views of others. * Include an objective in the Act to reduce compulsory treatment rates and duration. * include an objective to reduce seclusion and restraint and eliminate it within 10 years, setting an aspiration for faster elimination. * Include a principle to the Act which specifies that voluntary treatment is always preferred, even where someone meets the criteria for compulsory treatment. * include a principle that seclusion and restraint are harmful practices and that all services will be committed to their elimination. * The principles would be improved by using stronger language, for example use ‘must’ instead of ‘should’. | Your response to Question 1:  If no, why? |
| **Question 2:** How do you think the proposals about objectives and principles could be improved? (Section 2.1 in the paper) | Your response to Question 2: |

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| **NON-LEGAL ADVOCACY (Section 3.1)** | | |
| The Royal Commission found that **non-legal advocacy** is highly valued by consumers, effective in putting supported decision making into practice, and may drive down the use of coercive practices.  The Royal Commission recommends (Rec 56) that the Victorian Government: include a legislative provision in the new Mental Health and Wellbeing Act enabling an opt-out model of access to non-legal advocacy services for consumers who are subject to or at risk of compulsory treatment.    The **new Act** will ensure all consumers receiving, or at risk of receiving, compulsory treatment can connect with **non-legal advocacy services**.  The **new Act** will require mental health and wellbeing service providers to notify **non-legal advocacy services** as soon as practicable, within 24 hours, after the making of an assessment order or a temporary treatment order. Necessary information will also be shared to allow the non-legal advocate to contact the consumer.  The **new Act** will include protections to ensure advocates can connect with consumers such as not restricting communication with advocates and obligations to notify advocates when specific events occur such as the use of seclusion or restraint.  Consumers will have the right to opt out of this service if they choose.  To better recognise **non-legal advocacy**, the Chief Officer for Mental Health and Wellbeing will be supported under the **new Act** to issue operating guidelines for these services. These guidelines will clarify and give effect to the obligations of mental health service providers to engage with **non-legal advocacy** services. | | |
| **Question** | **What Has Been Said by Consumers** | **Your Ideas for Answering the Questions** |
| Question 3:  Do you think the proposals meet the Royal Commission’s recommendations about non-legal advocacy? (Section 3.1 in the paper) | Guidelines can be ignored by services so as much as possible should be in the act.  The act must include the opt out model of independent advocacy.  The Act must expressly protect the right of access   * to all authorised mental health services * to the mental health system database to see who is on an order under the Act and (only) their contact details.   Where the consumer consents, an independent advocate:   * cannot be prevented by a service from meeting with a consumer. * cannot be prevented from attending a service meeting with a consumer. * can access consumer records | Your response to Question 3  If no, why? |
| Question 4:  How do you think the proposals about non-legal advocacy could be improved? (Section 3.1 in the paper) | Your response to Question 4 |

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| **SUPPORTED DECISION-MAKING (section 3.2)** | | |
| Supported decision making is a human rights concept that promotes freedom of choice for people using public mental health services. Supported decision making means that people are provided with the support they need in order to be able to make their own decisions. In the context of mental health services, this usually means making medical treatment decisions, but it may include other types of decisions too. This is important to us because under the current act, a psychiatrist in a service can make decisions for you if you are under a compulsory treatment order.  If you would like to learn more about supported decision making you can read [this information](https://www.vmiac.org.au/wp-content/uploads/Supported-Decision-Making.pdf) on the VMIAC website.  The current act has provisions for some supports such as **statements of rights, advance statements, nominated persons** and **second psychiatric opinion** and the commission found that uptake of these supports was not as strong as it could be.  **These are the proposed changes:**  As well as compulsory patients being given a **statement of rights**, all patients will now receive them. There will also be a requirement that the person providing the statements must ensure the consumer understand their rights such as having ongoing conversations and making supports available.  **Advance statements** will still be able to be overridden, however people **must** be provided with a written reason. You will also be able to include more in your advance statement and more people will be able to witness it. They will be stored by Safer Care Victoria.  **Nominated persons** will have to agree to **support the person to make their own decisions** and to help represent the views and preferences of the person. More people will be able to witness the appointment of a nominated person.  There will be more flexibility in how **second opinions can be provided**, and an authorised psychiatrist **will be required to document** their reasons for not accepting the opinion of the second psychiatrist and provide a copy of these reasons to the consumer and any other person requested by the consumer.  **Service providers** will be required to **document** discussions about informed consent, the efforts taken to support a consumer’s decisions and decisions that go against a persons views and preferences including how they considered the consumers views and preferences, alternatives reasonably available and the consumers reasons for those views and preferences. | | |
| **Question** | **What has been said by consumers** | **Your ideas for answering the questions** |
| Question 5:  Do you think the proposals meet the Royal Commission’s recommendations about supported decision making? (Section 3.2 in the paper) | * A definition of supported decision making must be provided and be consistent with international disability standards.   Advance statements:   * must be binding, or they are not a part of supported decision making. * must be read even if the person is a voluntary patient. * Services must document and evidence how they have given all due consideration to an advance statement, in the medical file and in writing to the consumer. * Store advance statements or directives on a centralised database managed by the new Mental Health and Wellbeing Commission.   Nominated persons:   * specify that the role of nominated person is separate from that of carer. * all nominated persons sign a statement on accepting this role that they:   + have an obligation to uphold the consumer’s rights, views and preferences.   + agree to promote the consumer’s personal social wellbeing.   + agree to read and understand any advance statement the consumer makes   + agree to provide consumers with support to make their own decisions.   Second opinions:   * Second opinions must be able to be given by other mental health professionals. * The second psychiatric opinion service must be independent of clinical mental health services. * Must be at no cost * Copies of the second psychiatric opinion are to be given to the consumer within a timely period | Your response to Question 5  If no, why? |
| Question 6:  How do you think the proposals about supported decision making could be improved? (Section 3.2 in the paper) | Your response to Question 6 |

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| **INFORMATION SHARING** (Section 3.3) | | |
| The **Royal Commission made many recommendations** that relate to information sharing. Many are not directly related to the new act but are about how new systems and guidelines should be introduced.  Specific to the new act, the commission recommended that: the Mental Health and Wellbeing Act **specifies the ways in which information about mental health and wellbeing may be collected and used.**  The consultation paper discusses a new information infrastructure that will be developed in a sperate process.  The **proposed changes to the act** include:   * **New principles** that will guide information collection include:   + providing consumers with access to their own information as soon as reasonably practicable after it is requested.   + respect and dignity when recording consumer information.   + respect for consumers’ diverse backgrounds and needs.   + accountability for high-quality information collection and use   + consumer consent and privacy   + supporting transitions between services or care levels, and integrated services   + the important role of families, carers and supporters and their need to access appropriate information and the importance of information sharing to promote and maintain their physical, emotional, cultural and psychological safety.   + the right of Aboriginal and Torres Strait Islander people to self-determination and to have their information shared in a way that is culturally sensitive and considers their familial and community connections.   + transparency between service providers and consumers in relation to information sharing. * Consumers will also be able to provide further instructions about information sharing through an advance statement. * Consumers will be able to ask that a statement be included on their record if they disagree with the information in the record. * New provisions will allow some basic information to be shared across the broader social service system. Consumer will be able to say this shouldn’t be shared | | |
| **Question** | **What has been said by consumers** | **Your ideas for answering the questions** |
| **Question 7:**  Do you think the proposals meet the Royal Commission’s recommendations about information collection, use and sharing? (Section 3.3 in the paper) | * real time access to medical files by consumers * right to make changes and corrections to medical files by consumers * right of consumers to add information to their medical file. * The only time information should be shared without consent is when the person is physically unable to (ie in a coma) and when children are at risk and mandatory reporting is necessary. Under these circumstances what has been shared must be reported to the consumer and entered into the medical record. * the sharing of medical information on the grounds of imminent harm to others should not be permitted, only the necessary information to keep someone safe should be shared. * Have a provision for consumers to identify when a person or service cannot have access to information (excluded persons) | Your response to Question 7  If no, why? |
| **Question 8:**  How do you think the proposals about information collection, use and sharing could be improved? (Section 3.3 in the paper) | Your response to Question 8 |

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| **COMPULSORY TREATMENT (**Section 4.1) | | |
| The **Royal Commission made recommendations** that compulsory treatment is only used as a last resort; moving away from coercive practices; reducing the use of seclusion and restraint with the aim of elimination over a 10-year period; and regulation of chemical restraint.  **The objectives and principles of the new Act will set clear expectations that**:   * compulsory treatment is to be used only as a last resort * treatment, care and support should always be provided with the least possible restrictions on people’s rights.   There will **also be principles relating specifically to the use of compulsory treatment**. These principles will **require decision-makers to consider the impact** of compulsory treatment on the person receiving it, in particular, for people who may have experienced trauma.  The **new Act will require that any distress and harm that compulsory treatment itself may cause be considered in the decision** to issue a compulsory treatment order.  Formal reporting requirements will be established under the new Act to help drive widespread change in the use of compulsory treatment. The **department will publish meaningful service-level and system-wide data on the use and duration of compulsory treatment**.  The **new Act will require** that other treatment and non-treatment supports, which could be reasonably provided to a person to reduce the risk of distress or harm, be considered during assessment prior to making an order. Such supports may include, for example, talking therapies, peer support, specialist trauma services, respite services or referral to services to address specific needs such as for housing.  The criteria for compulsory treatment will change. The changes being proposed are:   * replacing reference to ‘preventing serious deterioration in the person’s mental or physical health’ with ‘preventing the person experiencing serious distress’ * requiring that the harm being prevented (to the person or another person) must be both serious and imminent * requiring that all other treatment and support options to prevent the distress or harm have been considered and eliminated.   Statutory guidance will be issued to provide clarity about the harms to be prevented and how decision-makers can be satisfied that compulsory treatment is being used as the last resort.  **Mental Health Tribunal**  allow the Mental Health Tribunal to require that a conference be held ahead of the Tribunal considering a treatment order extension. Consumers will be able to request that a conference be held. A conference will not be required if the consumer objects.  The new Act may allow the Mental Health Tribunal **to make, or not make**, a treatment order when the criteria for compulsory treatment are met,  To support a shift to a more holistic system, there may need to be **changes to the process and people** involved in authorising temporary treatment orders. This could include permitting a **broader range of professionals** to authorise temporary treatment orders, such as nurse practitioners and social workers.  In developing the new Act, consideration will be given to how the new Act or regulations can include measures to provide confidence to decision-makers who make treatment and care decisions that are consistent with the principles, the broader vision for Victoria’s mental health and wellbeing system and allow for dignity of risk. | | |
| **Question** | **What has been said by consumers** | **Your ideas for answering the questions** |
| **Question 9:**  Do you think the proposals meet the Royal Commission’s recommendations about reducing the use and negative impacts of compulsory assessment and treatment? (Section 4.1 in the paper) | Mental Health Tribunal:   * is not required to make an order, even if the treatment criteria are met (for example, if the consumer wants to try a treatment approach that is different to the psychiatrist’s recommendation) * can approve a specific, limited treatment plan rather than an open order which allows any treatment   Define ‘serious’ so that it means imminent risk of   * death * physical injury to others and/or * injury to self which maims or is life-threatening   Define ‘last resort’ so that it there is a requirement of services to demonstrate that a variety of different treatments and supports have been offered, including social supports such as housing, protection from violence or abuse and health stresses.  Have a requirement that the intended benefits of treatment must be weighed against the potential harms.  Remove community treatment orders (CTO) from the Act.  If CTOs stay in the Act then their use needs to be more tightly controlled, monitored and reported, including by significantly shortening the duration, tightening the criteria for CTOs and expressly exclude rationale for CTOs that are based on non compliance.  Expand who can make compulsory treatment orders to include mental health professionals and independent decision makers.  Have a requirement that professionals outside the service be included if requested by consumers, ie private psychiatrist or psychologists.  Require the involvement of more than 1 mental health professional.  Require that that compulsory treatment must change or stop if it negatively impacts physical health or personal recovery.  Include a new safety condition for compulsory treatment which prohibits the use of high risk treatments (e.g., very high medication doses or electroconvulsive therapy) and/or off-label medication use, within compulsory treatment, unless the person gives free and informed consent without duress | Your response to Question 9  If no, why? |

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| **REDUCING SECLUSION AND RESTRAINT** (Section 4.2) | | |
| The **Royal Commission recommends** that the Victorian Government:   * Ensure the Mental Health and Wellbeing Act: * Specifies measures to reduce rates and negative impacts of compulsory assessment and treatment, seclusion and restraint. * Regulate the use of chemical restraint through legislative provisions in the new Mental Health and Wellbeing Act. * Facilitate the Mental Health and Wellbeing Commission to monitor, as a matter of priority, the use of seclusion and restraint.   **The new Act will regulate** the use of seclusion and restraint.  **The new Act will:**   * **Acknowledge the harm caused by restrictive interventions** and the shared responsibility for their elimination * Require clinicians to **balance consideration of the harm** likely to be caused by a restrictive intervention with the harm sought to be prevented by it when contemplating its use * **Require clinicians to document the alternative treatments and supports** that were tried or considered and the reasons why they were found unsuitable.   The **objectives and principles of the new Act will also require that service providers** consider factors that may impact on the person’s experience such as the person’s age, disability, culture, neurodiversity, language, religion, race, gender, gender identity, sexual orientation and trauma history, in considering alternative strategies and the use of restrictive interventions.  **The new Act will include a definition** of chemical restraint that restricts its use to only as a last resort. It is proposed that the way chemical restraint is regulated, including through clinical guidelines, **considers both the clinical intent and the impact of chemical restraint** on the consumer. | | |
| **Question** | **What has been said by consumers** | **Your ideas for answering the questions** |
| **Question 11:**  Do you think the proposals meet the Royal Commission’s recommendations about reducing the use and negative impacts of seclusion and restraint, and regulation of chemical restraint? (Section 4.2 in the paper) | * 10 years is too long, stop it now. * include minimum targets to reduce seclusion and restraint set by the RCVMHS, linked to key performance indicators. * include a new section to define, regulate and reduce chemical restraint. * include a definition for chemical restraint, that says that the impact of the medication on the person receiving it (either impact on their decision-making capacity and/or restraining the functioning of body, mind and/or emotion), rather than purely on the intention of the person using the intervention. | Your response to Question 11  If no, why? |
| **Question 12:**  How do you think the proposals about seclusion and restraint could be improved? (Section 4.2 in the paper) | Your response to Question 12 |

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| **GOVERNANCE AND OVERSIGHT** (Section 5.1) | | |
| The **Royal Commission recommended** that the Victorian Government:   1. Establish an independent statutory authority, the **Mental Health and Wellbeing Commission**    1. hold government to account for the performance and quality and safety of the mental health and wellbeing system;    2. support people living with mental illness or psychological distress, families, carers and supporters to lead and partner in the improvement of the system;    3. monitors the Victorian Government’s progress in implementing the Royal Commission’s recommendations; and    4. address stigma related to mental health.   The **Royal Commission recommended that the Victorian Government**:   * + 1. enable the Mental Health and Wellbeing Commission to use its full suite of complaints and oversight functions to monitor, inquire into and report on system-wide quality and safety.     2. facilitate the Mental Health and Wellbeing Commission to monitor, as matters of priority, the:   1. use of seclusion and restraint;   2. use of compulsory treatment;   3. incidence of gender-based violence in mental health facilities; and   4. incidence of suicides in healthcare settings.      1. enable the Mental Health and Wellbeing Commission to:   5. work with the Department of Health and relevant regulators to build a comprehensive understanding of quality and safety issues in mental health and wellbeing services;   6. ensure on an ongoing basis that complaints-handling and investigation approaches:      + - meet the needs of consumers, families, carers, and supporters and        - support services to resolve concerns.   7. advise government on issues of concern and areas for improvement; and   8. record, report and publish service-level complaints and other relevant data and information.   The **new Act will establish**:   * Mental Health and Wellbeing Commission which will   + have responsibility for system-wide oversight of the quality and safety of mental health service delivery and advise government on areas of concern and improvement.   + inquire into system-wide quality and safety challenges or concerns and have the power to initiate investigations.   + receive complaints about noncompliance with the principles of the new act and investigate complaints about mental health and wellbeing service delivery.   + play a key role in monitoring achievement of some of the Royal Commission’s key goals, such as reducing the use of compulsory treatment and coercive practices.   + be led by a small group of Commissioners including at least one Commissioner with lived experience of mental illness or psychological distress and one Commissioner with lived experience as a family member or carer.   + have oversight and complaint handling functions that will be extended to all providers funded by the Victorian Government to deliver mental health and wellbeing treatment, care and support.   The **Royal Commission recommends** that the Victorian Government:   1. establish in legislation the role of **Chief Officer for Mental Health and Wellbeing** to lead the Mental Health and Wellbeing Division in the Department of Health, and set out in that legislation that this Chief Officer is:   a. delegated the functions and powers conferred on the Secretary of the Department of Health under the new Mental Health and Wellbeing Act;  b. appointed by and reports to the Secretary; and  c. at the level of a Deputy Secretary.   1. empower the Chief Officer to take responsibility for the implementation of the Royal Commission’s recommendations, unless otherwise stated in these recommendations.   The **new act will establish the role of the Chief Officer for Mental Health and Wellbeing**. The proposed role of the Chief Officer will include:   * + developing mental health and wellbeing strategy, policy and guidelines   + planning, developing and commissioning mental health and wellbeing services that respond to Victoria’s diverse communities   + monitoring the performance, quality and safety of mental health and wellbeing service providers   + developing and supporting the mental health and wellbeing workforce   + supporting the new Regional Mental Health and Wellbeing Boards to perform their functions   + setting and revising targets for reducing compulsory treatment/seclusion and restraint   + implementing the Royal Commission’s recommendations.   **The Royal Commission recommends** that the Victorian Government:   * from the end of 2023 and by no later than the end of 2026, enable each Regional Mental Health and Wellbeing Board also to commission mental health and wellbeing services and hold individual providers to account to improve the outcomes and experiences of people who use their services. * in parallel with the establishment process, ensure that Regional Mental Health and Wellbeing Boards:   + are accountable for the delivery of agreed outcomes through new accountability arrangements; and   + are skills-based and include at least one person with lived experience of mental illness or psychological distress and one person with lived experience as a family member or carer.   **The new act** will establish Regional Mental Health and Wellbeing Boards (with temporary boards being set up to advise on the development of the boards). These new boards will:   * + support mental health and wellbeing services to be planned and organised in a way that responds to community needs and improves outcomes   + provide for greater integration across services beyond the mental health and wellbeing system, including both Victorian Government and Commonwealth Government funded services   + be skills-based, inclusive of people with lived experience of mental illness or psychological distress as consumers and family members or carers.   **The Royal Commission recommends** that the Victorian Government:  with the assistance of the interim regional bodies, establish a multiagency panel in each region to coordinate as required the delivery of multiple mental health and wellbeing services for people living with mental illness or psychological distress, including children and young people, who may require ongoing intensive treatment, care and support.  **The new act** will establish Statewide and Regional Multiagency Panels, which will   * + bring together different service providers to support collaboration and accountability in providing integrated treatment, care and support to this group of consumers   + have diverse membership, which varies across regions and between meetings based on local needs and services and the needs of individual consumers   + provide strategic advice to Regional Mental Health and Wellbeing Boards and the department regarding broader policy or service delivery matters related to people who require ongoing intensive treatment, care and support from multiple agencies.   The **Royal commission identified a gap** in the role of the chief psychiatrist and the new act will the **expand the role of oversight by the Chief Psychiatrist to include correctional settings** this means that Mental health services provided in correctional settings will be subject to the Chief Psychiatrist’s standards, oversight, monitoring and reporting. | | |
| **Question** | **What has been said by consumers** | **Your ideas for answering the questions** |
| **Question 13:**  Do you think the proposals meet the Royal Commission’s recommendations about governance and oversight? (Section 5.1 in the paper) | The new Act provides for the Mental Health and Wellbeing Commission to have the following powers:   * Formally review services and make recommendations * Undertake sanctions in the event a service or practitioner does not comply with the Act or recommendations from the Commission, that include but are not limited to:   i) Refer to police for possible criminal investigation  ii) Deregistration of services  iii) Recommend deregistration of professional person  iv) Application of fines  v) Other sanctions as appropriate (e.g., reduced funding)   * The Act requires a minimum of annual public reporting by the Commission that specifies the performance of services and includes but is not limited to:   a) Non-compliance with Victorian Charter of Human Rights and Responsibilities (2006)  b) Analysis of reductions in seclusion and restraint  c) Analysis of reductions in compulsory treatment  d) Analysis of grounds for compulsory treatment  e) Any investigations, including recommendations and outcomes  f) Sector-wide and individual service compliance with the principles and objectives of the Act.   * The Act provides for the necessary powers for the Commission to intervene when the Commission becomes aware of an imminent breach of the Act. * The Act requires that at least 50% of the Commissioners are consumers | Your response to Question 13  If no, why? |
| **Question 14:**  How do you think the proposals about governance and oversight could be improved? (Section 5.1 in the paper) | Your response to Question 14 |