

Mental Health and Wellbeing Act Submission 2021



Introduction:

The Victorian Mental Illness Awareness Council (VMIAC) is the peak body for mental health consumers in Victoria. Established in 1981 and incorporated in 1986 VMIAC was the first mental health consumer owned and managed organisation in Victoria. VMIAC is recognised by the Victorian Government as the peak organisation for mental health consumers in Victoria and currently provides advocacy, education, consultation, support and information for people who identify as having mental and emotional distress.

Our vision is a world where all mental health consumers stand proud, live a life with choices honoured, rights upheld, and these principles are embedded in all aspects of society.

VMIAC aims to achieve our vision by:

- honouring mental health consumer diversity
- providing advocacy for mental health consumers
- advancing mental health consumer workforce and leadership
- delivering information and training to the community
- enabling mental health consumer driven education and research
- developing strategic partnerships.

VMIAC's work is premised on the following beliefs:

- people's experiences are respected and valued
- people are expert in their own lives
- people have a right to self determination
- people have capacity to make genuine choices,
- people should be safe, respected, valued and informed free from coercion
- people's diversity is embraced.

In 2019 VMIAC asked consumers across the state what our future could look like if the mental health system was replaced with something wonderful. With over 190 people contributing, VMIAC's Declaration identifies an overarching theme of choice. Consumers want more diverse choices when it comes to supports for their mental health and wellbeing. The Declaration also identifies eight topics of focus that covers a broad range of experiences from social change to actions and supports that people want. In 2021, in direct response to the Commission into Victoria's Mental Health System (the Commission) recommendations regarding a new Mental Health and Wellbeing Act (new Act), VMIAC undertook a rapid community consultation, Act on the Act, to inform VMIAC, the government and the community on what changes consumers were asking for. This consultation attracted 180 responses to a survey and 39 participants in six focus groups, in less than 10 days.

These two documents (**enclosed**) have been used along with public position statements, VMIAC's Committee of Management and the extensive knowledge of past and present staff, to inform this submission.

OBJECTIVES AND PRINCIPLES OF THE NEW ACT (Section 2.1)

The Commission recommended (Recommendation 42) that the new Act 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
- providing a diverse range of comprehensive, safe and high-quality mental health and wellbeing services.

The Commission also recommended (Recommendation 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 that 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 uphold 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: are safe and responsive to histories of family violence and trauma; recognise how gender dynamics can affect service use, treatment and recovery; and recognise 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 people that is appropriate to, and consistent with, their cultural and spiritual beliefs and practices and has 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, 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 developmentally and age 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.

VMIAC RESPONSE

VMIAC supports the inclusion of the majority of the stated objectives and principles in the new Act, however, we argue that while addressing the letter of the Commission's recommendations, the objectives and principles do not go to the spirit of the recommendations, nor what consumers have been advocating for, for over 15 years.

Any new legislation must be compliant with the Victorian Charter of Rights and Responsibilities Act 2006 (the Charter) and the international Convention on Rights of Peoples with Disabilities (CRPD). The current proposal is a missed opportunity for Victoria to be at the forefront of international human rights law and will result in consumers continuing to be harmed by a piece of legislation that authorises repeated human rights breaches that harm, traumatise and lead to early deaths of Victorians. If the **Victorian Government are unable to address this significant issue**, they must clearly and publicly state that the **new Act is not compliant with the Charter and the CRPD**.

Objectives

The community consultation undertaken by VMIAC clearly supports a **specific objective in the new Act to reduce compulsory treatment rates and duration**. Legislation can be used equally to drive good behaviour as it can to deter bad behaviour. Rather than use mental health legislation to allow compulsory treatment under prescribed conditions, it must be written in such a way as to deter the use of compulsory treatment. Clarity that an objective of the new Act is to reduce compulsory treatment will support interpretations of the new Act that minimize the use of coercive interventions.

Further to this **VMIAC recommends the inclusion of an objective that specifically identifies the elimination of seclusion and restraint**. The new Act should be clear that the use of seclusion and restraint breaches the CRPD and will be made unlawful in Victoria. This objective would be further supported by the provision of mechanisms in the regulations, or accompanying Department of Health (Department) guidelines, that provide incentive and rewards for services that achieve this goal early and in a sustained way.

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: are safe and responsive to histories of family violence and trauma; recognise how gender dynamics can affect service use, treatment and recovery; and recognise how gender intersects with other types of discrimination and disadvantage.
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NON-LEGAL ADVOCACY (Section 3.1)

- The 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 Commission recommends (Recommendation 56) that the Victorian Government include a legislative provision in the new 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, for example, not restricting communication with advocates and setting obligations for services 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.

VMIA RESPONSE

VMIA is very pleased to see proposed changes to the independent advocacy service from an opt in service to an opt out service, however, **VMIA remains very concerned that the spirit of the Commission's recommendations regarding the opt out service has been undermined by the lack of specifics regarding the potential statutory nature and management of the service.** The evaluation of Victorian Legal Aid's (VLA) Independent Mental Health Advocacy (IMHA) service and submissions made to the Commission regarding this and VMIA's own advocacy services, strongly support the ongoing provision of the IMHA service within VLA as a statewide advocacy service.

VMIA recommends that it must be clearly stated within the new Act that, where an organisation directly provides mental health services or has partnerships with mental health services for mental health service delivery, it cannot be responsible for independent mental health advocacy services. If this were to happen, there would be a clear conflict of interest, undermining the benefits of independent advocacy. We also note that removing IMHA from its current position risks reducing the ability of the organisation to evaluate systemic trends and undertake systemic advocacy, utilise the relationship with VLA, and it undermines the trust built between IMHA and consumers.

In keeping with the recommendations of the Commission and proposed principle 6 of the new Act 'Value the lived experience of people living with mental illness or psychological distress, their carers, families and supporters as leaders and active partners', the inclusion of a requirement for lived experience partnerships in the management of the service is strongly recommended.

VMIA is encouraged by, and fully supportive of, the proposed strengthening of the independent mental health advocacy service to include requirements for mental health services to actively support the advocacy service to undertake their work. Recommendations are welcomed regarding the right of access to advocacy services, information with consent, services needing to respond to requests in three days and strengthening consumers' rights to communicate with advocates.

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 Mental Health Act 2014 (Vic) (current Act), a psychiatrist in a service can make decisions for you if you are under a compulsory treatment order.

The current Act has provisions for some supports such as statements of rights, advance statements, nominated persons and a second psychiatric opinion service; 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 statement must ensure the consumer understands their rights, such as having ongoing conversations and making supports available.
- Advance statements will still be able to be overridden, however, a written reason must be provided. Consumers will also be able to include more in their 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 person's views and preferences including how the consumer's views and preferences were considered, alternatives reasonably available and the consumer's reasons for those views and preferences.

VMIA RESPONSE

VMIA strongly supports the strengthening of supported decision-making instruments within the new Act. The current Act has failed in this regard. There is a lack of transparency, lack of confidence, lack of knowledge and a lack of process when it comes to the delivery of supported decision-making to mental health consumers across the state.

VMIA recommends that a definition of supported decision-making is included in the new Act, specifically excluding shared and substitute decision-making approaches. This definition must be consistent with the Charter, the CRPD and international disability standards. In regard to the provision of a statement of rights, it must also be a requirement that the measures taken are recorded in the person's medical record.

Advance statements must be binding. This is also consistent with other Victorian legislation, such as the Medical Treatment Planning and Decisions Act 2016, and continuing to allow services to overturn advance statements risks breaching various rights under the Charter, including equal protection from the law. **VMIA strongly recommends that this is attended to in the new Act.** If advance statements are not binding, they cannot be considered a supported decision-making tool and the new Act will not meet Victoria's obligations against the CRPD. **VMIA recommends that the only means of overturning an advance statement should be an independent legal process.**

VMAC recommends that advance statements are required to be read even when the consumer is voluntary. The current requirement that they only come into force when the person is made compulsory is not consistent with good care. In addition, there is strong evidence from consumer reporting that in reality a voluntary admission is, more often than not, coerced and there is a real lack of choice. Under these circumstances it is vital that advance statements have the full weight of the law. Addressing this gap contributes to the principle VMAC has recommended, to clarify the rights of voluntary consumers.

Services must document and evidence how they have given all due consideration to an advance statement and how they have taken action to comply with the advance statement, the new Act and the Charter. It is inconsistent with the Charter and the CRPD for services to be excused from adhering to an advance statement because a requested treatment is not 'usually' provided by that service. **Services must undertake actions** that demonstrate genuine attempts to provide that treatment or to transfer the consumer to a service that does provide that particular treatment.

VMAC does not support the recommendation that advance statements are stored at Safer Care Victoria. **Consumers did not support this in consultations**, stating the lack of confidence in the Department as reason. Advance statements must be stored on a centralised database managed by the new Mental Health and Wellbeing Commission.

VMAC is encouraged by the proposed changes to the nominated persons scheme, in particular the requirement that nominated persons will be required to agree to support the person to make their own decisions and to help represent the views and preferences of the person. VMAC recommends that this is strengthened to require this agreement in writing and witnessed. This **agreement should be clear and specific and include** 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 support any advance statement the consumer makes
- agree to provide the consumer with support to make their own decisions.

VMAC is disappointed in the lack of detail regarding changes to the second psychiatric opinion service. Again, this is a service that has failed to bring about the changes and supports that consumers had sought with its inclusion in the current Act. Delays are not the only problem that consumers have identified. The service is not seen as independent due to the relationship with a health service and that most of the psychiatrists used by the service are employed by mental health services.

Therefore, **VMAC strongly argues that the second psychiatric opinion service allows for:**

- second opinions to be given by other mental health professionals
- the second psychiatric opinion service to be independent of clinical mental health services
- copies of the second psychiatric opinion to be given to the consumer within 24 hours and to others, as requested by the consumer, within 48 hours of that request
- where an authorised psychiatrist wishes to overrule an independent second psychiatric opinion, that the consumer agrees with, the authorised psychiatrist must apply for permission from the Chief Psychiatrist.

The new Act should make clear that the funded second psychiatric opinion service is not the only way to receive a second opinion and that a second opinion, sought directly from a professional outside the service, carries equal weight.

Information Sharing (Section 3.3)

The 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. The Commission recommended that the new 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 separate process and the proposed changes to the new Act are set out below.

- New principles that will guide information collection which include:
 - o providing consumers with access to their own information as soon as reasonably practicable after it is requested
 - o respect and dignity when recording consumer information
 - o respect for consumers' diverse backgrounds and needs
 - o accountability for high-quality information collection and use
 - o consumer consent and privacy
 - o supporting transitions between services or care levels, and integrated services
 - o 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 consumer physical, emotional, cultural and psychological safety.
 - o 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
 - o 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 medical 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. Consumers will be able to say where this should not be shared.

VMIAC RESPONSE

VMIAC is encouraged by the proposed principles to guide information collection, however, the lack of detail regarding how some of the principles will work in practice is concerning. Once again, we see words being used that allow considerable flexibility in regard to interpretation and outcomes. Phrases such as 'reasonably practicable' gives services too much room for interpretation and could mean anything from several days to several months. Strict time periods must be applied in all circumstances. In addition, until advance statements are legally binding, 'allowing' for information sharing instructions in them will lead to little if any change in these practices.

VMIAC strongly argues that access to current medical records for consumers who have requested information and are current clients of the service, **must be immediate**. **VMIAC also recommends** that access to information of consumers that are no longer active with that service be provided within **seven days**.

If the above is not possible prior to the implementation of the new medical record management system recommended by the Commission, **VMIAC recommends that alternatives** to Freedom of Information requests for medical records are included in the new Act. **This new process must be timely and must not allow for redaction of information** other than when serious and imminent harm would be caused by releasing the information.

VMIAC often hears from consumers about the errors and misinformation that is contained in their medical records, and the long-term effect this has on their care, treatment and access to services. VMIAC supports the position that consumers can request a statement, highlighting errors or inaccuracies, be included in their record, noting that this is a right that already exists and is not dependant on the new Act. To ensure that this is a right, that is useful in a consumer's experience of care, VMIAC **recommends that consumers have an additional right to make corrections to medical records**. VMIAC understands that this will entail a formal process and recommends that this process is independent of the mental health system.

VMIAC has some concerns regarding the wording of principles concerning the sharing of information with families, carers and supporters. VMIAC has heard many times from consumers that inappropriate information has been shared (both **with** the service and **from** the service) and the damage that this has done to relationships and supports. VMIAC is also aware that the wording of this section, in the current Act, can lead to inconsistency within a service and across the state. Once again **VMIAC urges that the language used in this section of the new Act is clear** with minimal risk of misinterpretations.

To provide clarity, **VMIAC recommends that the only time that medical information is shared without consent** is when the person is physically unable to (i.e. in a coma), when children are at risk and mandatory reporting consistent with other legislation is necessary. Under these circumstances, what has been shared and with whom, must be reported to the consumer and entered into the medical record.

In the event that provision is allowed for sharing of information, on the grounds of imminent harm to others, only the **necessary information to keep someone safe should be shared**. In this circumstance medical information, including mental health service use, is not necessary information and should not be shared. If information is shared under these circumstances, what has been shared and with whom must be reported to the consumer and entered into the medical record.

VMIAC recommends that the new Act contains a provision for **excluded persons**. The provision of an excluded person's provision into the new Act extends beyond the issue of sharing of information, either with or without consent. An excluded person's provision would enable the consumer to clearly identify who can also give information to the service. This is particularly important when addressing situations that involve domestic and family violence. VMIAC has worked with many consumers over many years that have had a negative impact from incorrect information being sought from, and provided by, people the consumer would identify as a perpetrator of domestic violence and coercive control.

Compulsory Treatment (Section 4.1)

The Commission made recommendations that:

- compulsory treatment is only used as a last resort
- services move away from coercive practices
- the use of seclusion and restraint is reduced, with the aim of elimination over a 10-year period
- chemical restraint is regulated.

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.

The Mental Health Tribunal will be allowed to require that a conference be held ahead of any 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.

VMIAAC RESPONSE

VMIAAC's position on the provision of compulsory treatment is clear.

'There is no place for compulsory mental health treatment unless it is specifically requested by a person'.

Compulsory mental health treatment is an inappropriate and ineffective response to mental and emotional distress. It violates our human rights and discriminates against us by treating us differently based on a diagnosis of mental illness.

Consumers should have the right to make informed decisions about their own bodies and not be forced to take medication which might cause undesirable side effects such as movement symptoms, metabolic and cardiovascular conditions, hormonal or sexual changes, cognitive impairment, or other side effects which distress the person. VMIAC Policy Position Paper #1: Compulsory treatment

VMIAC therefore recommends the removal of all provision for compulsory treatment in the new Act, except where specifically requested by the consumer. If the current regime is to be continued, it must be made clear that the new Act is not compliant with the Charter or the CRPD.

In addition to this public declaration, the new Act must include stronger safeguards to ensure that compulsory treatment is only used as a last resort. It is a priority to address the proposed principle ‘treatment, care and support should always be provided with the least possible restrictions on people’s rights’, and human rights education is required. VMIAC recommends that it is a requirement under the new Act that **all persons associated with decision-making regarding compulsory treatment undertake an accreditation process**. This process must be co-designed and co-delivered, inclusive of approval of people under the program, by consumers and human rights specialists.

An additional safeguard is the expansion of the people approved to make an order. Clear advice from consumers is that is inappropriate for such an important decision to be made by only one person. Consumers have also shared stories of when a compulsory treatment order has been made against the advice of private psychiatrists, and how this has exacerbated their distress. While many clinicians will argue that it is a team decision, and in many instances this may be the case, over the years we have also heard from clinicians of their disagreement with specific incidents of compulsory treatment and how challenging it is to be heard in the very hierarchical structure of medicine. Therefore, **VMIAC recommends that** a minimum of two clinicians, at least one who is not a psychiatrist, is needed to make a compulsory treatment order.

VMIAC supports the proposal that the Mental Health Tribunal is not required to make an order even if the criteria for an order is met. Further supporting this would be clarification of the treatment order through well defined specific orders. The freedom that services have with orders under current regulations and clinical guidelines is unacceptable. **Compulsory treatment orders must be specific to medication and provide a maximum dose that does not exceed the Therapeutic Goods Administration approved dose. If an amendment of an order is sought (either increase dose or change of medication), an application to the Mental Health Tribunal would be required.** It is unacceptable, to VMIAC and consumers, that poorly evidenced practices are permitted under compulsory treatment orders. Off-label use of psychopharmaceuticals should not be permitted under compulsion, nor should the use of electroconvulsive therapy.

VMIAC commends the proposed change that requires ‘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’. However, as previously stated, the use of words such as ‘reasonable’ allows for too much interpretation and will result in services not offering or working towards the offering of these types of supports. This word should be removed, and the requirement to work with a person in identifying and accessing these supports be clearer.

Further to this, the proposed change that requires ‘all other treatment and support options to prevent the distress or harm have been considered and eliminated’, is not clear. **This proposed change must be amended** to state that ‘all other treatment and support options to prevent the distress or harm have been considered and **eliminated by the consumer**’.

VMIAC notes the proposal to replace reference to 'preventing serious deterioration in the person's mental or physical health' with 'preventing the person experiencing serious distress'. While this phrasing is acknowledged as a potentially positive change, it will amount to nothing if the new Act does not also contain clear definitions of 'serious'. What is serious to one person is not serious to another, and in the case of mental health services this is often clouded by what the perceived risk to the service is rather than the risk to the person or others in the community.

Therefore, **VMIAC recommends that a definition of 'serious' is included in the new Act** that states that 'serious' means the imminent risk of death or physical injury to others and/or injury to self which **maims or is life-threatening**.

VMIAC also recommends that a definition of 'last resort' be included. The words 'last resort' are often used by people without clear requirements of what actually constitutes last resort. In the consultation Act on the Act, consumers were clear that last resort meant the **there is a requirement of services to demonstrate** that a variety of different treatments and supports have been offered, including but not limited to talking therapies, peer support, social supports such as housing, protection from violence or abuse and addressing physical health stresses, and **that the consumer has made a choice either to not use them or has found them to be unhelpful**.

VMIAC commends the proposed change that will require that 'any distress and harm that compulsory treatment itself may cause be considered in the decision to issue a compulsory treatment order'. VMIAC cautions that the focus of this must be on the **consumer's views, not the clinician's views**.

Finally in relation to compulsory treatment orders **VMIAC recommends that there be a requirement that if a compulsory treatment order negatively impacts on a person's physical health or personal recovery it must be immediately stopped**, within medical safety guidelines. That suggestion acknowledges that with some medications it is not safe to immediately stop but tapering is required.

VMIAC is concerned about the lack of detail regarding the intention and function of the 'conference' that has been identified as a potential tool for the Mental Health Tribunal. The paper acknowledges that the Mental Health Tribunal will have a separate review and it would appear to be better to leave this particular change to that review rather than implement a new process, that requires significant consideration and co-design, to ensure that it does not become another tool of coercion.

Community Treatment

While the consultation paper outlines some significant changes to compulsory treatment it is not clear about any specific changes to community treatment orders. **VMIAC is concerned about the lack of attention to this significant issue.** Victoria has a long record of having amongst the highest use of community treatment orders which severely limits people's rights and are unproven in preventing hospital admissions or supporting recovery. **VMIAC recommends that the use of community treatment orders need to be more tightly controlled, monitored and reported**, including by significantly shortening the duration and narrowing the criteria. VMIAC also recommends that justification for community treatment orders expressly excludes medication non-compliance as a valid reason.

SUPPORTED DECISION MAKING (Section 3.2)

The **Commission recommends** that the Victorian Government ensure the new Act:

- specifies measures to reduce rates and negative impacts of compulsory assessment and treatment, seclusion and restraint
- regulates the use of chemical restraint through legislative provisions in the new Act
- facilitates 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.

VMAC RESPONSE

VMAC commends the government on declaring these steps to reduce and eventually eliminate the use of seclusion and restraint. For many decades consumers have identified the abuse of these practices and the damage and trauma consumers have endured. VMAC however calls for the government to be brave and not wait 10 years. Victoria already has been working on reducing seclusion for over a decade and have for several years been focusing on a goal of elimination.

Further to this, the United Nations Special Rapporteur on torture and other cruel inhuman or degrading treatment or punishment has been clear that the use of seclusion and restraint is a breach of people's rights, particularly in relation to the right to be free from torture, cruel, inhuman and degrading treatment, but also other rights such as the right to liberty and bodily integrity.

VMAC calls for the government to end seclusion and restraint immediately. Failing this the end date for seclusion should be no longer than the review date of the new Act, which VMAC advocates must be no longer than two years.

VMAC is pleased to see a declaration that the new Act will include a definition of chemical restraint. For many years VMAC, amongst other advocates, have raised the important issue of chemical restraint and its use in a compulsory treatment environment. Chemical restraint must be defined by the impact on consumers and not on the intent of the clinician, prescribing or administering the medication. With a stated principle of the new Act being the 'least possible restriction of rights with the aim of promoting recovery and full participation in community life', the definition for chemical restraint must take impact into consideration. Impact on the consumer would need to address two factors. Firstly, that of impact on ability to participate in community life which would need to account for impact on functioning of body, mind and/or

emotion. Secondly, the impact on decision-making capacity must also be considered. The aim of treatment and care must be to improve both of these factors therefore, if the medication being used without express informed consent of the person **negatively affects either of these, it must be defined as chemical restraint.**

In addition to the definition of chemical restraint, **provision must be made to regulate the use of chemical restraint in the same way as for compulsory treatment, that is as a last resort.** Alternatives, such as peer support, talking therapies and calming techniques such as sensory modulation, must be offered prior to the use of chemical restraint. Furthermore, **the use of chemical restraint must be publicly reported** and include what occurred prior to the use of chemical restraint, what was offered as an alternative, how long the impact on the person lasted and what strategies have been discussed with the person to avoid the use of chemical restraint in the future.

GOVERNANCE AND OVERSIGHT (Section 5.1)

The **Commission recommended** that the Victorian Government establish an independent statutory authority, the **Mental Health and Wellbeing Commission (MHWC)**, to:

- hold government to account for the performance and quality and safety of the mental health and wellbeing system
- support people living with mental illness or psychological distress, families, carers and supporters to lead and partner in the improvement of the system
- monitor the Victorian Government's progress in implementing the Commission's recommendations
- address stigma related to mental health.

The **Commission recommended** that the Victorian Government:

- enable the MHWC to use its full suite of complaints and oversight functions to monitor, inquire into and report on system-wide quality and safety
- facilitate the MHWC to monitor, as matters of priority:
 - o the use of seclusion and restraint
 - o the use of compulsory treatment
 - o the incidence of gender-based violence in mental health facilities
 - o the incidence of suicides in healthcare settings
- enable the MHWC to:
 - o work with the Department and relevant regulators to build a comprehensive understanding of quality and safety issues in mental health and wellbeing services
 - o ensure, on an ongoing basis, that complaints-handling and investigation approaches both meet the needs of consumers, families, carers, and supporters and support services to resolve concerns
 - o advise government on issues of concern and areas for improvement
 - o record, report and publish service-level complaints and other relevant data and information.

The **new Act will establish the MHWC**, 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 non-compliance 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 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 Victorian Government funded providers, to deliver mental health and wellbeing treatment, care and support.

The **Commission recommended** that the Victorian Government:

- establish in legislation the role of the Chief Officer for Mental Health and Wellbeing to lead the Mental Health and Wellbeing Division in the Department, and set out in that legislation that the Chief Officer is:
 - o delegated the functions and powers conferred on the Secretary of the Department under the new Act
 - o appointed by and reports to the Secretary
 - o at the level of a Deputy Secretary
- empower the Chief Officer to take responsibility for the implementation of the Commission's recommendations, unless otherwise stated in the Commission's 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 Commission's recommendations.

The **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 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:
 - o are accountable for the delivery of agreed outcomes through new accountability arrangements
 - o 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, family members or carers.

The Commission recommends that the Victorian Government, with the assistance of interim Regional Bodies, establish a Multi-Agency Panel in each region to co-ordinate (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 Multi-Agency 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 **Commission identified a gap** in the role of the Chief Psychiatrist and the new Act will **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.

VMAC RESPONSE

VMAC acknowledges the significant reforms that have been recommended by the Commission and reflected in the proposed changes for the new Act. VMAC acknowledges the good intentions of these changes, however, there remains some important issues that the new Act will need to address in order to fulfill this vision for an improved and rights focused mental health service system.

VMAC is concerned about the recommendation that 'at least' one Commissioner with lived experience as a consumer will be interpreted as the need for only a single Commissioner. It is well documented and understood by consumer leaders and experienced workers that this is not consistent with safe and meaningful consumer leadership. It also does not align with the Commission's recommendations regarding co-production. For co-production to be anything more than tokenistic, power and voice must be addressed. For power and voice to be addressed those with traditionally the least power, in this case the consumer, must make up the majority of the commission. VMAC understands that this will be unpalatable for many in the mental health system, however we urge the government to be brave and ensure that, **as a minimum, 50% of Commissioners have lived experience of psychological and emotional distress and that at least half of these are experienced consumer leaders**.

VMAC's consultations and advocacy work has heard many, many examples of the failure of oversight processes to date. This has also been confirmed in the Commission's Final Report. Consumers in Victoria deserve and demand equity of protections afforded to other Victorians. **Therefore, VMAC recommends that** the new Act states that the MHWC functions **include a responsibility to promote, support and ensure compliance** with the new Act. Furthermore, a key function of the MHWC **must be to protect the rights of consumers**.

For this to occur **VMAC also recommends** that the MHWC **mandates training for all mental health workforces that includes, as a minimum competency related to human rights**, co-production and delivery with consumer leaders and experts.

In addition, the **MHWC must have the following powers and authority to:**

1. Formally review services and make recommendations.
2. Intervene when there is evidence that a service is about to breach the new Act, including the necessary power to ensure that the imminent breach does not occur and the ability to issue penalties for actions not compliant with the new Act that have led to the imminent breach.
3. Undertake sanctions in the event that a service or practitioner does not comply with the new Act or recommendations from the Commission, that include but are not limited to:
 - o referral to police for possible criminal investigation
 - o de-registration of services
 - o recommendation of de-registration of professional persons to the relevant accreditation body
 - o other sanctions as appropriate (e.g. reduced funding).

Further to this, the new Act must require that the **MHWC issue annual public reporting that specifies the performance of services and includes but is not limited to:**

- non-compliance with the Charter and the new Act
- analysis of reductions in seclusion and restraint
- analysis of reductions in compulsory treatment
- analysis of grounds for compulsory treatment
- analysis of complaints received by services and services responses to complaints
- any investigations, including recommendations and outcomes
- sector-wide and individual service compliance with the principles and objectives of the new Act.

This approach may be facilitated, in part, by designated mental health services submitting co-designed self-audits, action plans and progress reports in relation to the principles of the new Act, the reduction of compulsory treatment and the elimination of restrictive practices. Mental health services already have these reporting obligations with respect to gender inequality under the Gender Equality Act 2020 (Vic).

In relation to the MHWC's uptake of the complaints function that currently sits with the Mental Health Complaints Commissioner, the timeline for this must be specific and be implemented as quickly as possible. It is well established, and reported on by the Commission, that the Mental Health Complaints Commissioner has failed to make the changes to services that was envisioned in its conception. Clear regulations need to be established so that the new MHWC does not fail in the same ways. VMIAC's previous recommendation regarding the constitution of the MHWC will assist in ensuring that this does not happen.

VMIAC has some concerns regarding the expansion of who can make complaints to the MHWC, specifically as it pertains to family and carers. While VMIAC firmly supports the right of families and carers to make complaints on their own behalf, about the ways in which services have responded to themselves and their needs, VMIAC does not support the notion that others can make complaints on behalf of consumers, without the consumer's consent. We note that even where carers may make complaints with the consent of the consumer, there may be conflicting interests and limited informed consent for consumers. **Therefore, VMIAC recommends that the grounds on which people make complaints to the MHWC are clearly articulated.** This does not preclude the supports of families and carers to consumers during the process as that is consistent with principles of supported decision-making and under circumstances where this is the consumer's preference it should be supported by the MHWC's processes. **VMIAC also recommends that when a complaint is made by a family member or carer the MHWC should not make findings or recommendations that limit the rights of consumers.**

VMIAC acknowledges the wider scope of the new MHWC and **recommends that it is clear in the new Act that the broader scope is inclusive of the Regional Mental Health and Wellbeing Boards.** It will be important to consumers that concerns or problems that arise with the Boards have a strong oversight and are a focus during the establishment of the Boards.

VMIAC acknowledges the proposed development of the Regional Mental Health and Wellbeing Boards and that they will co-ordinate services within eight regions across the state. However, **VMIAC is critical of the lack of information** about how the Boards will be formed and their governance and operation. Specifically, it is unclear in the engagement paper what the boundaries of the regions will be and how they will function in relation to other health and community service operational boundaries.

The Commission was critical of the current catchment organisation of mental health services, quoting non-alignment with other services as a significant issue for both access to and continuity of care. VMIAC and other advocates have also stated the inherent discrimination present in the strict adherence to catchments in the mental health system when catchments for other health services are more flexible and responsive to need. **VMIAC therefore recommends that the new Act abolishes mental health catchments, supports choice for consumers and ensures flexibility of services.**

VMIAC also highlights the lack of a commitment to consumer leadership in the operation and governance of the Boards and we urge the Victorian Government to remain consistent with the principles of co-production and ensure that leadership of the Boards is inclusive of, and gives authority to, consumer expertise.

CONCLUDING COMMENTS

VMIAC is pleased to see these changes to the current legal framework for mental health services in Victoria. However, VMIAC reiterates our, and our members', disappointment in the conservative approach that has been taken, and the failure of the proposed changes to align the Victorian legislation with the CRPD and the Charter. VMIAC encourages the Victorian Government to reconsider a number of decisions, delay changes inconsistent with other Victorian legislation and ensure obligations under international law are adequately met.

If these changes are not able to be supported within the current process VMIAC urges the Victorian Government to commit to a review of the new Act in a maximum of two years.



VMIAC works across Victoria and acknowledges the many Aboriginal nations that have lived and cared for this sacred land for thousands of years, and which continues today. We pay respect to Traditional Custodians and Elders – past, present, and emerging – and thank them for their wisdom and generosity of spirit. We acknowledge that this land was never ceded. We support the Uluru statement from the heart.