Analysis of the Implementation of the Victorian Royal Commission

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Primary Documents referred to:

Royal Commission Report into Victoria's Mental Health System:

Justice Action's Analysis of the Royal Commissions Report

Victorian Health Update and Engagement paper - implementation of RC

For responses to Victorian Government implementation : https://engage.vic.gov.au/mhwa **or mhwa@health.vic.gov.au by 1st August 2021**

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Structure, organisation and leadership of the reform process

In February 2019, the Victorian government recognised that the state's mental health system was 'broken' and 'failing to support those who needed it'. In response to the severe systemic failings, the Royal Commission into Victoria's Mental Health System was initiated to provide the people of Victoria with access to effective and humane mental healthcare. Its report confirmed and elucidated those failings and its recommendations make clear that what is needed is root and branch reform; starting with a comprehensive re-evaluation and replacement of the Victorian Mental Health Act. The government has committed to implementing those recommendations in full and replacing the *Mental Health Act* with the *Mental Health and Wellbeing Act* by no later than the middle of 2022.

Justice Action (JA) welcomes this ambitious undertaking and hopes Victoria will soon become an exemplar of the sort of mental health reform acutely required across all Australian jurisdictions. However, there are serious concerns that the current structure of the proposed reform is not fit for purpose, rather a recipe for failure.

The Victorian Department of Health (DoH) has presided over the failings of the mental health system for decades. JA has no doubt that there are many individuals in the DoH who are painfully aware of this and eager to see change. However, large bureaucracies that are conservative by nature, are not noted for their ability to promptly change course. The institutional and cultural inertia of the DoH should be recognised as a major obstacle to the level of reform desperately needed by Victorians living with mental illness and psychological distress. It is unrealistic to expect the Department to take a leading role in the devolution of its own power to community and individual stakeholders called for by the Royal Commission.

Justice Action believes the update and engagement paper confirms its worst fears about the inadequacy of the structure meant to implement the legislative reform called for by the Royal Commission. It does not facilitate the process of change, it undermines it.

The diagram on page 41 of the paper (figure 2 above) confirms the DoH role as both driver and gatekeeper of legislative change. It's expected to produce the policy proposals, 'nudge' public input via the paper, then vet that input through its control over 'incorporation' into policy. It is doubtful any viewpoints the DoH finds uncomfortable will survive this process. The paper's treatment of the Royal Commission recommendations for reform of compulsory assessment and treatment indicates how discomforting they are to the DoH (see below). The process illustrated in figure 2 ensures they will be watered down to a homeopathic extent and will be reflected in the Act as lip service only. They will be no more effective than provisions in the current *Mental Health Act* that call for compulsory treatment to be used exclusively as a last resort.

Figure 1 on page 34 (see above) illustrates the DoH vision for governance and oversight of the Victorian mental health and wellbeing system. As evidenced above, there is a steep hierarchy where parliament presides at the top and services at the bottom, with a fat box representing DoH functions and authorities positioned centrally to dominate the picture. At the bottom of this box, in parentheses, as if in afterthought, is the aspiration for future lived experience leadership to be added to departmental structures, though it is unclear where. Off to one side is the DoH relationship with other mental health entities and further out is the Mental Health and Wellbeing Commission. A double-sided arrow represents the interface between the Commission and other entities while the one-sided arrow from the DoH makes clear what sort of relationship the Department expects to have with them.

This diagram does not reflect the high-level monitoring and accountability functions assigned to the Mental Health and Wellbeing Commission by the Royal Commission in Recommendation 44. Rather, it suggests the Commission and other entities should be subservient to the DoH and sidelined by it, with the Commission's tasks and authority restricted only to other entities. Nor does it reflect the provision of Recommendation 28 that the Commission should support the full and effective participation of those with lived experience in decision making and the development of policy and programs. In fact, beyond

token acknowledgement of lived experience representatives as easily marginalised minority occupants of ‘leadership’ positions, it’s hard to see any role for those with mental illness or psychological distress in policy development in the DoH vision.

Justice Action urges the Victorian government to go back to the drawing board with regards to developing policy proposals that will inform the Mental Health and Wellbeing Act. We recognise the Department of Health as an important stakeholder in this process. Its input is not merely important, but vital to success. But it should not act as the driver and gatekeeper of legislative change.

The natural home for mental health policy development is the Mental Health and Wellbeing Cabinet Subcommittee. The first task of the newly constituted Mental Health and Wellbeing Commission should be oversight of the Subcommittee. Without strong legislative underpinnings to its role, the Commission is doomed to become toothless and irrelevant and the work of the Royal Commission and those who contributed to it will come to nought.

Justice Action understands that we are asking the rider to change horses mid-stream and that doing so may compromise the mid-2022 deadline for replacing the Act. But, as the *Mental Health and Wellbeing Act: Update and Engagement* paper points out, the Royal Commission’s report offers a once-in-a-generation opportunity to align Victoria’s mental health system with the needs of the Victorian people. It is much more important to do this properly than to do it quickly.

Compulsory assessment and treatment

It’s hard to see how the Update and Engagement paper’s proposals could have any outcome other than to *increase* the use of compulsory treatment in Victoria’s mental health system.

Some of the proposed non-legislative measures to increase the use and availability of voluntary, community based treatments, to encourage the participation of those with lived experience in reducing compulsory treatment and to improve workforce training are commendable, necessary and, if properly resourced and implemented, can be expected to

have a real impact on reducing the frequency and duration of compulsory treatment. However, while the engagement paper acknowledges positive non-legislative measures, mentions of these measures only serve to distract respondents from the real issues at hand.

The performance of the Mental Health and Wellbeing Commission will be critical to the success of reducing compulsory treatment, but the only proposed changes to the Act that reflect this are to do with reporting requirements. The Commission is tasked with issuing statutory guidelines on how the principles of the Act are to be applied to making compulsory treatment orders but, there is no mention of how such guidelines are to be enforced.

Justice Action proposes that the *Mental Health and Wellbeing Act* should include an escalating scale of penalties to be applied against individuals and organisations that persistently or egregiously flout guidelines governing the application of involuntary treatment orders. Forced medical treatment is a form of *assault,* only justifiable under extraordinary circumstances, if at all. This needs to be reflected in legislation with penalties proportionate to the seriousness and frequency of offending. They should include provisions for counselling, formal cautions and reprimands, fines, loss of funding and suspension or permanent disqualification of authority to order compulsory treatment. A register of offenders should be maintained to ensure that those who are unfit to exercise such powers are unable to circumvent penalties or 'reset' a record of repeat offending via changes of employment, location, branding or job description.

It is also important that the Act contains no provisions that would hinder or deter those seeking civil redress against organisations or individuals who misuse or abuse its powers.

The system-wide targets to be issued by the Commission will also need legislative backing if they are to be effective, though it should be recognised that failure to meet them may be due to circumstances beyond the control of those responsible for meeting them. While it is to be expected that managerial performance indicators would be the first line incentive used to ensure targets are met, the Commission should be empowered to conduct hearings to identify reasons targets are not met and, if necessary, to recommend changes to leadership or practices or impose penalties in cases where existing procedures have failed to ensure adequate progress in meeting targets. It should also be possible for those who feel they have been

unfairly penalised or scapegoated for failure to meet targets to petition the Commission for redress if the matter is beyond the jurisdiction of the Fair Work Commission.

The criteria for compulsory treatment proposed by the engagement paper is grossly inadequate on all levels.

"Mental illness" should not be a legal criterion for *anything*. While the reliability of mental illness diagnosis has increased substantially over recent decades, it is widely acknowledged that the validity of such diagnoses remains a long term aspiration at best. The frequency with which researchers claim to have discovered reliable objective indicators of mental illness, only for their claims to be later withdrawn or debunked, has prompted some to suggest that valid diagnosis of mental illness is five years away and always will be.

Mental illness diagnoses lack descriptive validity because methods of measuring them are highly subjective and rely on unverifiable assumptions about the internal state of the person being diagnosed. More importantly they lack predictive validity. They provide limited information about the course of the 'illness', the most effective treatment and the likely responses to the treatment. Their validity is also heavily influenced by the age, gender, socioeconomic status, race, culture and the sexual orientation of the subject and thus, is inevitably impacted by the biases and prejudices of diagnosticians and those who set diagnostic guidelines. Such biases foster the disproportionality of diagnoses in members of minority groups who are subject to discrimination. Further, it is important to note that, not so long ago, homosexuality was a 'mental illness.' This puts into question the conceptual legitimacy of 'mental illness' and the authority of psychiatric committees to define it.

The steady creep of DSM and ICD diagnostic criteria for mental illness ensures that enshrining it in the Act will continue to increase its scope to encompass an ever greater proportion of the population. Moreover, the association the Act creates between mental illness and the threat of serious and imminent harm will serve to entrench the stigma of psychiatric diagnosis and deter sufferers from seeking medical assistance. This is despite the fact that those with mental illness diagnoses are no more likely to commit acts of violence than the general population and when they do, their 'illness' is usually not the proximate cause (e.g. in response to increased levels of violence – including state sanctioned violence – *suffered* by those diagnosed with mental illness). Narrowing the test to only 'serious

psychotic illness' would be to no avail, as the term lacks validity and is such a blunt instrument. Criteria such as 'male, aged 18-30, binge drinker, plays contact sports' are far more reliable predictors of violence and self-harm than 'has psychotic illness', but the engagement paper does not propose making 'VFL player' a criterion for compulsory treatment, despite their exposure to serious brain injury. Making mental illness a criterion is both a reflection and reinforcement of the stigma against those deemed mentally ill.

A far more appropriate criterion than "the person has a mental illness" would be "the person suffers serious impairment of capacity to exercise judgement or control over threatening behaviour". This would more effectively target those who may benefit from involuntary measures, circumvent pointless arguments over diagnoses and allow involuntary measures to be applied to those whose incapacity is due to non-psychiatric causes, such as intoxication, dementia or acquired brain injury. If threatening behaviour is not due to impaired capacity, it isn't a medical matter at all, but one of criminality or civil order, regardless of whether diagnostic criteria for mental illness are met.

The engagement paper requires that the Act includes the potential for distress and harm to be considered before ordering involuntary treatment, but no such provisions are suggested in the revised criteria. Why not? This is surely the most logical place to include them. The Act should also clarify that the Mental Health and Wellbeing Tribunal should issue strict guidelines over how such potentials should be weighed and evaluated and provided with the resources necessary to make up to date evidence-based decisions on what those guidelines should be.

It is a sad fact that clinical psychiatric practice often lags many years behind psychiatric research. For example, antidepressants are still routinely prescribed for young people with suicidal ideation despite decades of research demonstrating they *increase* the risk of suicidality. Australian psychiatry has been very slow to acknowledge the seriousness and duration of withdrawal from psychiatric medications and very few resources exist for those wishing to safely discontinue them. Strong evidence now exists that long term maintenance on anti-psychotic medication *impairs* recovery from psychotic illness and leads to brain shrinkage but this is not reflected in prescribing practices or compulsory treatment orders. Perhaps most damning is evidence that the prevalence, duration, seriousness and cost to

society of mental distress does not decrease in line with access to psychiatric treatment; in fact since the 1990s the trend seems to have been in the opposite direction.

The biopsychiatric approach to assessment and treatment of mental illness is a proven failure. Despite lip service to 'biopsychosocial' care, this is yet to be implemented clinically on a large scale. Doubtless part of the reason is lack of resourcing for alternatives to medication and ECT, but the culture and business models of Australian medicine, especially psychiatry, should not be underestimated as a factor. We should not be waiting for practitioners to catch up with research informing best practice clinical care. The Mental Health and Wellbeing Commission should be proactive about keeping up with the evidence base regarding both harms and benefits associated with mental health treatments and using it to inform their guidelines. It must be resourced accordingly.

The proposal to replace 'serious deterioration in mental or physical health' with 'serious distress' has very obvious potential to increase the use of involuntary treatment and frustrate the intent of the Royal Commission's recommendations. It also contravenes recommendations of respect for the 'dignity of risk'.

The death of a beloved pet is likely to cause serious distress to oneself. Should we be permitting the forcible administration of emotionally numbing medication to prevent such distress? Exercising one's right to refuse treatment for cancer is likely to cause serious distress to loved ones. Should we be legislating for involuntary chemotherapy?

While it would be hoped that guidelines issued by the Mental Health and Wellbeing Commission would severely restrict the application of this criterion, that should not be necessary. 'Serious distress' should not be a medical matter unless the sufferer chooses to make it one and if they do it's the sufferer who should receive treatment, not the person they blame for their distress.

Distress is part of the human condition. It should never be a trigger for compulsory treatment.

While the intent of the proposal to add 'imminent' to the criterion of serious harm is noble and laudable, it is far from clear how this is to be practically achieved. It has long been known that the actuarial tools used by mental health professionals to assess dangerousness –

such as HCR-20 – lack the sensitivity and specificity needed to accurately predict the relatively rare incidence of violence to oneself or others. When applied to individuals they result in far more false positives while failing to flag 10-25% of those who do go on to commit such acts. It would be nice to know who will perpetrate serious harm in the short term, but we do not and cannot. So if the potential harms of treatment are to be balanced against the risk of harm of not treating, far greater weight should be put on the risk of treatment to reflect that the risk of not treating is so difficult to predict.

If possible harm is truly imminent – such as when someone is on a ledge threatening to jump or threatening someone with a knife – something more urgent and immediate than a medical response is likely in order.

Justice Action has no practical suggestions as to how this dilemma should be resolved, but believes it needs to be acknowledged. It also should be acknowledged that 'imminent risk' denotes a crisis situation that is unlikely to persist for long, so compulsory treatment orders should reflect this and be of very short duration – certainly less than 28 days.

Of all the unwarranted suggestions in the engagement paper, the most outrageous and pernicious is that the authority to issue temporary treatment orders should be extended to a broader range of professionals such as nurses and social workers. It is difficult to imagine how such a proposal could have been made in good faith.

Allowing more people with less qualification and training to issue such orders will result in more, not fewer, orders being made inappropriately. Even worse is the fact that such workers are often disempowered within the institutions in which they work. Should nurses working in prisons or psychiatric or aged care institutions be given powers such that they will come under pressure from managers and administrators to use them in order to facilitate institutional management. That is, as chemical restraints and threats of punishment. If something goes wrong it will likely be the nurses who will be held responsible, not those who coerced them. This dynamic was evident in the NSW death in custody of David Dungay Junior and the subsequent coronial inquest, even without granting Justice Health nurses legislative authority to make compulsory treatment orders.

If Victorian nurses and social workers are given authority to issue temporary treatment orders, Justice Action has no doubt this will result in an immediate increase in the number of vulnerable people subjected to them and a corresponding increase in deaths in custody.

That the Victorian Department of Health would even consider such a measure is a powerful argument against giving it a key role in the development of policy informing the drafting of the *Mental Health and Wellbeing Act*.

Aim of this paper

Royal Commission Report into Victoria's Mental Health System:

This paper provides critical feedback to the Victorian Department of Health following the Royal Commission recommendations to Victoria's mental health system. Our aim is to ensure that the VRC's directions are reflected in the legislative and systemic changes required to practically and effectively implement reform.

The Victorian Department of Health is developing a new mental health and wellbeing act oriented to consumer rights and their recovery needs with an imperative on urgent reform of the elimination of restrictive and coercive practices that violate the fundamental human rights and dignity of mental health consumers. Justice Action provides feedback and analysis to address four of the key recommendations following the Victorian Royal Commission, as reflected in our 'Analysis of the Royal Commission into Victoria's Mental Health System, 2021'.

1. **Recommendation 53:** Strong oversight of the quality and safety of mental health and wellbeing services
2. **Recommendation 54:** Towards the elimination of seclusion and restraint
3. **Recommendation 55:** Ensuring compulsory treatment is only used as a last resort
4. **Recommendation 56:** Supporting consumers to exercise their rights

Justice Action regards what is happening in Victoria as a blueprint for significant reform toward a compassionate, effective and equitable mental health care system in New South Wales, corresponding to the following:

- A review and recommendations for systemic change urgently needed in New South Wales, where consumer rights are not at the forefront of mental healthcare practices.
- A reform of the cultural and systemic policies must take place in order to maintain a recovery-focused model in mental healthcare.
- The cultural and systemic reform must be led by a diverse group of those with lived experiences to ensure the needs and rights of mental health consumers are being considered and met.

We trust that our analysis is taken into consideration as Victoria moves forward with the new legislation including the establishment of the Mental Health and Wellbeing Commission and subsequent governing bodies. Justice Action aims to focus attention on the cultural change that is needed alongside the new legislation and organisational restructuring: respect for the consumer, dignity of the consumer, and consumer-led decision making building the foundation for a balanced and compassionate mental health and wellbeing system.

Executive summary

The Victorian Royal Commission (VRC) into Mental Health investigated issues within the mental health care system in Victoria, and provided critical recommendations to address its failings. Victoria's Department of Health has responded with their Update and Engagement paper, foreshadowing the legislative and systemic changes being implemented following the Royal Commission. Justice Action analysed the recommendations from the VRC, and the resulting Update and Engagement paper, and prepared the following response and feedback.

The Australian public are embracing the shift to a safe and compassionate mental health and wellbeing system. Victoria is urged to set the standards for a new human rights approach and multidisciplinary paradigm in mental health care. The Victorian Government has an obligation to eliminate abusive and inhumane practices, including the use of restrictive and compulsory treatments. Practices using coercive treatment, unnecessary involuntary admissions and forced medication violate power, dignity, and choice. In response, consumers are deterred from seeking treatment or support and driven further into alienation, isolation, despair and hopelessness, impacting on their lives and subsequently the wider community.

Among the systemic failings to be addressed, the utmost priority for Justice Action are those concerning the cultural shift toward unconditional respect for mental health consumers and their fundamental right to lead their own care. The key principles for change as outlined in our analysis focuses on the establishment of the new governing bodies where the critical engagement of commissioners with lived experience cannot be marginalised, as well as the consumers' active involvement and oversight in decision-making processes of policies and programs. Justice Action addresses the shift from the biomedical model to a more balanced and multidisciplinary system, including a recovery-oriented approach to mental health care, and the initiative of healthcare providers' accountability to the management of harm or trauma imposed from the use of restrictive practices on mental health consumers.

Our position is that, so far the Victorian Government has not sufficiently addressed the recommendations regarding consumer-led care and forced medication (recommendations 53-56), to ensure consumers will not be subject to unnecessary trauma and harm via the use of seclusion, restraint and compulsory treatment in mental health care settings. Justice Action

provides a critical evaluation of the four recommendations following the VRC and appeals to the Victorian Department of Health to take appropriate measures with urgent and direct action.

Strong oversight of the quality and safety of mental health and wellbeing services

Recommendation 53 highlights the importance of a governing body accountable for overseeing, monitoring, inquiring, and reporting on system-wide quality and safety standards. The VRC reports on the demoralising practice of consumer rights and preferences downplayed or entirely disregarded in favour of the most 'risk-averse' treatment option[1]. The VRC prioritises the elimination of seclusion, restraint and compulsory treatment, and the reduction of gender-based violence and suicides in healthcare settings.

The critical difference in the new mental health system as directed by the VRC requires that the hierarchy of treatment plan decision-making not be dominated by psychiatrists, and embrace a multidisciplinary, recovery-orientated, consumer-led approach. To overhaul a failing system, the VRC stipulates that the Commission and its subsidiary boards include leadership of relevant professionals (such as nurses, social workers), and particularly those with lived experience of the mental health care system.

The major principle for reform is accomplished with the formal representation of persons with lived experience for the oversight, monitoring and review of the implementation of services, programs, and strategy of the new mental health care system. On review of the proposed administration of the Mental Health and Wellbeing Commission and its reporting bodies, the Department of Health proposes the minimum requirement of one representative of persons with 'lived experience' of mental health recovery to be appointed to the Commission Leadership team. The Department of Health must recognise that the imperative to foster a multidisciplinary system requires a strong representation of commissioners with expertise and experience across multiple relevant disciplines and backgrounds.

[1] *Royal Commission into Victoria's Mental Health System,* (Final Report, February 2021) Volume 4, 306.

Justice Action finds that the operational outline, as it stands, requires a stronger commitment to the inclusion of 'lived experience' representatives so that Victorian mental health care consumers are more adequately represented. To circumvent the potential marginalisation of the representative and the tokenistic nature of their position, it is necessary that there be more than one representative. The proposal focuses on the establishment of new bodies with the traditional and outdated administration of 'people in power' (predominantly psychiatrists) making decisions under a different title. The Department of Health must meet the urgent appeal of a 'safe and compassionate mental health system' and reconcile that cultural and systemic change with the imperative to better serve Victoria's mental health consumers requires a more significant representation of commissioners, carers, supporters and multidisciplinary professionals with lived experience to oversee and ensure the provisions of safe, quality care.

Towards the elimination of seclusion and restraint

Recommendation 54 aims to eliminate the use of seclusion and restraint in mental healthcare settings within the next 10 years.[2] The violent, counterproductive and damaging implications from the use of seclusion and restraints in the mental health system on the protection of human rights is echoed on a global scale. The World Health Organisation's published report, *'Guidance on community mental health services: promoting person-centred and rights-based approaches'*[3] advocates the elimination of compulsory and restrictive treatment practices, prioritising consumer rights with increased staffing, better training of staff, facilities designed to foster recovery rather than crisis management, and promotes the use of early intervention over reactive crisis response care models.[4]

The VRC emphasises the 'profound, dehumansing and often long-term effects'[5] from the trauma and re-traumatisation of consumers subject to restrictive practices in the mental health system. The VRC urges that healthcare providers consider the harm caused to their patient before engaging in abusive practices of seclusion and restraint. The Department of Health

[2] *Royal Commission into Victoria's Mental Health System,* (Final Report, February 2021) Volume 5, 90.
[3] *Guidance on community mental health services: promoting person-centred and rights-based approaches* (June, 2021) Volume 1.
[4] *Royal Commission Into Victoria's Mental Health System - Analysis,* (2021) Volume 1, 7.
[5] *Royal Commission Into Victoria's Mental Health System - Analysis,* (2021) Volume 4, 298

proposes systemic changes for a 10-year plan to address the reduction and eventual elimination of seclusion and restraint practices. The proposal states that the new legislation will direct healthcare providers to consider potential distress or harm before issuing a compulsory treatment order. The active legislation states that compulsory and restrictive treatment is only to be used as a last resort, when 'there is no less restrictive means reasonably available.'[6] The current Act promotes trauma-led care as the standard practice for mental healthcare practitioners.[7]

The Department of Health has not acknowledged the need for explicit legislative change for the immediate reduction of the abusive practices of seclusion and restraint applied in the current mental health system. It's imperative that a cultural shift toward the immediate reduction of violent and inappropriate administering of restrictive practices must ensure healthcare providers are held accountable to the management of any resulting harm or trauma imposed on mental health consumers.

Ensuring compulsory treatment is only used as a last resort

Recommendation 55 urges the reduction of the rate and duration of compulsory treatment orders (CTOs) in the Victorian mental health system.[8] On review of the response to reduce CTOs Justice Action finds that the Victorian Department of Health's proposal of statutory guidelines and formal reporting procedures[9] is inadequate to properly safeguard consumers against clinical practices that fail to respect their rights, will and preferences with powers of compulsory treatment. In addition to professional and standardised monitoring procedures for workers in the mental health system the Department of Health must implement the regular and uniform collection of CTO data for public reporting. Active investigating and accounting for incidents of preventable engagement of CTOs will work to identify and reduce the

[6] *Mental Health Act* (2014) No. 26, Part 4 - Compulsory patients
[7] Victoria State Government: *health.vic* (2017) *<https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/safety/trauma-informed-care/trauma-understanding-and-treating>*
[8] *Royal Commission into Victoria's Mental Health System, Final Report, Volume 4: The fundamentals for enduring reform,* Parl Paper No. 202, Session 2018–21 (document 5 of 6), 364.
[9] *Mental Health and Wellbeing Act: update and engagement paper*, (Final Report, June 2021) Volume 1, 24-26.

system-wide problems of coercive, involuntary practices in Victoria's mental health system. A system of accountability must include a governing body to ensure that action is taken for internal performance monitoring and reporting of the rates and duration of CTOs. Justice Action makes an urgent appeal that the Victorian Department of Health take immediate action to reduce excessive and abusive practices of CTOs, holding accountability and transparency at the forefront to drive mental health reform.

A method of prevention to the eventual abolishment of involuntary or coercive interventions challenges the Victorian Department of Health to improve access to voluntary mental health support. A recommendation of the VRC states 'when commissioning mental health and wellbeing services, set expectations that they will provide non-coercive options for people'.[10] The Department of Health seeks to 'meet the VRCs vision of a more balanced mental health and wellbeing system'[11] with the establishment of a Mental Health Improvement unit to oversee the implementation of the new community-based systems. In review of the proposal, Justice Action finds that Victoria's Department of Health fails to consider the opportunity of mental health consumers' active involvement in decision-making processes of policies and programmes. Hence, the current proposal fails to outline how consumers are entitled to participate in all decisions that affect them, and how consumers are to benefit from special safeguards if involuntary assessment, treatment or rehabilitation is imposed. To promote social justice and equity in mental health, consumer's rights and leadership must be strengthened, thereby, Justice Action makes the critical recommendation of mental health consumers' contribution and participation in all areas of the development and delivery of social and mental health policies and services.

The Royal Commission reports that 'despite aspirations behind the Mental Health Act and the introduction of the Mental Health Tribunal to reduce compulsory treatment, this has not been achieved'.[12] The current mental health system heavily adopts the biomedical model leading to stringent or restricted practices in decision-making, and with psychiatrist's at the top of the hierarchy. The biomedical model in mental health carries potential biases in the treatment and care of mental health consumers due to, limited patient input; low status given to 'lived experience' with a preference to rely on the hierarchy of medicalised methods centred on

[10] *Ibid*.
[11] *Mental Health and Wellbeing Act: update and engagement paper*, (Final Report, June 2021) Volume 1, p. 25.
[12] *Ibid., p. 409.*

'diagnosis, medication and symptom reduction'[13]; lack of patient-centred consulting; and 'power imbalances that work to suppress the patient's voice'.[14] Coercive psychiatric measures restrict human rights and the VRC has expressed an urgent need to develop alternatives to the current clinical paradigm.

In consideration of CTOs, the VRC has recommended a holistic method of treatment, care and decision-making.[15] The Department of Health proposes the 'use of regulation to enable further changes 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'.[16] The response from the Department of Health promotes flexibility of authorised persons that are more appropriate to the consumer's care, needs and wishes. The new Mental Health and Wellbeing Act must also stipulate how the current system will move away from the biomedical framework to achieve an immediate reduction and eventual elimination of CTOs. The VRC has recommended that in addition to ensuring CTOs are only used as a last resort, 'it is essential that treatment, care and support are also provided to people earlier in the community to reduce the need and likelihood of a person experiencing compulsory treatment'.[17] Justice Action recommends a multidisciplinary framework to address the 'missing middle' with priority given to alternative treatment methods i.e. recovery-orientated and trauma-informed support services. Services that offer an alternative method aim at reducing coercive and restrictive practices such as forced medication, restraint and seclusion. Specific to forced medications, alternative systems must provide care for individuals seeking to avoid or reduce reliance on medications, including supported withdrawal from medications.

The evidence of the effectiveness of CTOs has been contested by the VRC and the urgency of this reform has not been overstated. Compulsory treatments cause long-term physical harm, psychological trauma, severe breaches of human rights, and increased community stigma and

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[13] *Guidance on community mental health services: promoting person-centred and rights-based approaches,* (June 2021), Volume 1.
[14] Trisha Greenhalgh et al, 'Six "Biases" Against Patients and Carers in Evidence-Based Medicine' *(2015) 13(1) BMC Medicine* 200, 200
[15] State of Victoria, *Royal Commission into Victoria's Mental Health System, Final Report, Volume 1: A new approach to mental health and wellbeing in Victoria,* Parl Paper No. 202, Session 2018–21 (document 2 of 6), 306.
[16] *Mental Health and Wellbeing Act: update and engagement paper*, (Final Report, June 2021) Volume 1, 27
[17] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) Volume 4, 91.

discrimination. Urgent action is required to safeguard the equal protection of human rights and ethical standards of people that are subject to compulsory treatment.

Supporting consumers to exercise their rights

Recommendation 56 outlines the severe implications of using mechanisms of clinical power in order to sanction compulsory admission and treatment of forced medication, seclusion, and physical or chemical restraints as cruel and inhumane practices causing serious harm and re-traumatisation of mental health sufferers, and the impact on fundamental human rights. The VRC advocates for urgent reform in providing alternatives from coercive interventions to promote the basic rights and liberties of consumers in the mental health system. The VRC recommends that the Victorian Government aim to 'promote, protect and ensure the rights of people living with mental illness or psychological distress to the enjoyment of the highest attainable standard of mental health and wellbeing without discrimination'[18].

The Department of Health has proposed less-restrictive practices and administration of advance statements and greater access to health workers and non-legal advocacy. In addition, education and training programs will be developed to aid safeguards and supported decision making.[19] The proposal fails to effectively address the intended legislative reform shift from the pre-existing clinical paradigm to a consumer-led and person-centred approach. To ensure mental health consumers receive the same basic rights and standards of care as other members of the community, Justice Action recommends that consumer rights and safety in the mental health system be upheld with focus on 'recovery' rather than the current clinical practices that centre on treatment and reduction of the symptoms of mental illness.

The principles of a recovery-centred approach ensure that individuals with mental illnesses are provided with the support and means to make their own decisions and are treated with dignity and respect. Rather than consumers being subject to trauma and impotence in the mental health system, a consumer-led decision-making approach fosters self-determination and self-management and eliminates any form of discrimination. Whilst this approach substantially protects and benefits the relevant individuals, it also plays into major societal

[18] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) Volume 4, 362
[19] *Mental Health and Wellbeing Act: update and engagement paper*, (Final Report, June 2021) Volume 1, 16

implications. In particular, it emphasises on the destigmatisation and demedicalisation of many forms of suffering that are currently treated as symptoms of mental illnesses and subsequently, prioritises resilience and adaptation over short term 'symptom' reduction.

With the complexity and difficulties to navigate legal systems, consumers' in crisis encounter considerable barriers to access legal advice and representation. The VRC recommends that to improve consumer rights 'increase access to legal representation for consumers who appear before the Mental Health Tribunal (MHT), particularly when consecutive compulsory treatment orders in the community are being sought'.[20] The Department of Health has not addressed the demand of increased legal representatives as an additional approach and strategy to reduce the rates of CTOs. In addition to legal representatives, the MHT has advocated for mental health consumers to receive access to alternate forms of rights-based advocacy when appearing before the tribunal to 'maximise the potential for beneficial outcomes and to promote supported decision making.'[21] The MHT advises that access to rights-based advocacy promotes a holistic method to mental health care and supports the consumer to determine goals for their treatment and recovery.

The critical role of peer work services integrated in early intervention and at all levels of treatment (i.e., in and out of hospitalisation) and recovery periods provide an alternate form of resource to reduce coercive practices and promote the rights of consumers. Peer workers are highly valued by mental health consumers on compassionate grounds, and to strengthen supported decision-making processes. Greater access to peer workers, especially in hospital settings is essential for a new compassionate mental health care system.

To adhere to the advice of the VRC on the protection of consumer rights, the expansion of funding and a change of legislation is imperative for vulnerable consumers to access resources, such as legal and alternate forms of support critical to the care, safety and recovery of mental health consumers. The Victorian Department of Health is urged to take appropriate action to protect the rights and safety of vulnerable consumers with a human rights focused, recovery-oriented and compassionate mental health care system.

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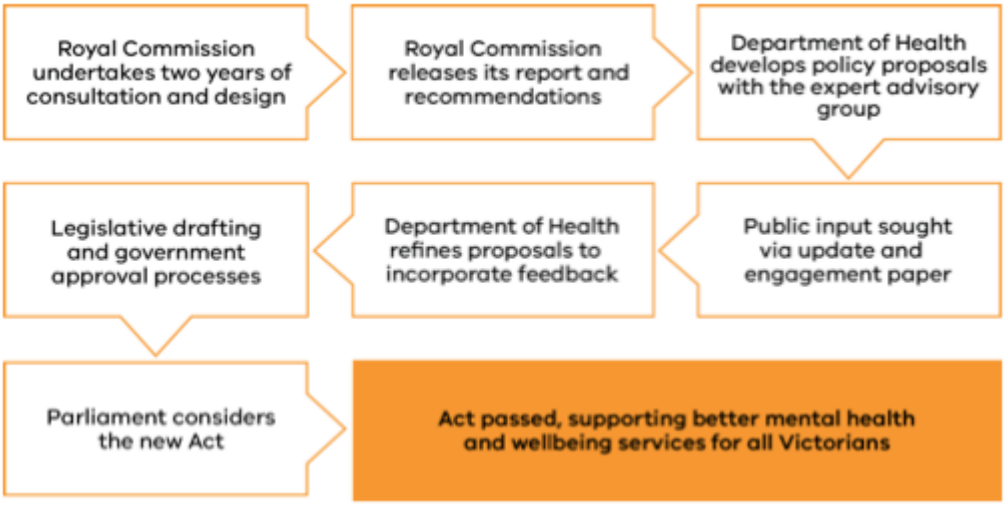
[20] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) Volume 4, 362

[21] Mental Health Tribunal: Royal Commission into Victoria's Mental Health System (2020) *<https://www.mht.vic.gov.au/sites/default/files/documents/202009/MHT%20Second%20Royal%20Commission%20submission.pdf>*

Evidence of findings:

Dept of H vets proposal offered & refines it p 42

Figure 2: Process for developing the new Mental Health and Wellbeing Act



Strong oversight of the quality and safety of mental health and wellbeing services

Recommendation 53 - the evidence and findings supporting this recommendation are noted and indexed below.

JA Analysis of Royal Commission Into Victoria's Mental Health System 2021

Recommendation 53 highlights the importance of establishing the Mental Health and Wellbeing Commission to provide 'strong oversight of the quality and safety of mental health and wellbeing services'. The body would have a 'full suite of oversight functions to monitor, inquire and report on system-wide quality and safety,[22]. Monitoring and actively reviewing as a matter of priority the use of seclusion and restraint, compulsory treatment and incidences of gender based violence and suicides in healthcare settings.[23]

To further this goal, the Commission recommended the establishment of other bodies and roles to support the *Mental Health and Wellbeing Commission* (Recommendation 44). These include installing new functions/roles of a Chief Officer for *Mental Health and Wellbeing* (Recommendation 45(1)), and *Regional Mental Health and Wellbeing Boards* (Recommendation 4(2)). Also, within the '*Mental Health and Wellbeing Commission*' the Commission recommended that a *Safer Care Commissions* unit is established to:
'*improve quality and safety that embeds contemporary and multidisciplinary approaches in services.*'[24] [The purpose of this unit would be to] *'focus on reducing the use of seclusion, restraint and compulsory treatment ...particularly in inpatient settings.*'[25]

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[22] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) Volume 1, 89.
[23] *Ibid*.
[24] *Royal Commission into Victoria's Mental Health System (Final Report Summary Plain Languages, February 2021) 34*.
[25] *Ibid*.

Update and Engagement paper, section 5 - Governance and Oversight, pp. 33

(Dept. of Health U&E Sections referenced in 'blue')

'Transforming Victoria's mental health and wellbeing system requires strong system leadership and accountability, including the leadership of people with lived experience.'[26]

The new Act will establish the following new roles or entities:

- Mental Health and Wellbeing Commission
- Chief Officer for Mental Health and Wellbeing
- Regional Mental Health and Wellbeing Boards
- Statewide and Regional Multi Agency Panels

Consumer Oversight

"Lack of consumer representation at governance level is problematic. If the consumer perspective is not present at the top level, then it will keep getting lost everywhere else and a critical mass needed to change culture will not occur." Cath Roper

"Throughout my career, I have noticed myself, and other consumer/survivor workers, open up fresh perspectives on old issues for the mental health sector. When we read documents,hear about issues or reflect on opportunities, our lens is often different to the status quo. Having been in services, and having a lived experience of distress and recovery, means that we are constantly finding ways to shift mental health services to better meet the will and preferences of the people using services." Indigo Daya[27]

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[26] *State of Victoria, Royal Commission into Victoria's Mental Health System, Final Report, Volume 4: The fundamentals for enduring reform*, *Parl Paper No. 202, Session 2018–21 (document 5 of 6), 77.*

[27] RCVMHS - Fact Sheet - Mental Health and Wellbeing Commission (2021) *<https://finalreport.rcvmhs.vic.gov.au/wp-content/uploads/2021/01/Fact-Sheet-%E2%80%93-Mental-Health-and-Wellbeing-Commission.pdf*

What is changing in the new Act about governance and oversight?, pp. 36

Chief Psychiatrist:

It is proposed that the Chief Psychiatrist continues to focus on clinical leadership and oversight of specific mental health and wellbeing practices and report to the new Chief Officer for Mental Health and Wellbeing.

Justice Action's response:

This proposition reinforces the hierarchy ideology present in the current system which fails to address the gaps in clinical mental health care practices. The Chief Psychiatrist remains at the top providing direction for mental health consumer's care, therefore maintaining the biomedical approach and limiting capacity to provide consumer-led care. The jurisdiction of the Chief Psychiatrist will now also be extended to correctional settings, which contributes to the hierarchical nature of the system. However, giving greater powers to the Chief Officer for Mental Health and Wellbeing may offer the benefit of streamlining and standardising the approach to mental health and wellbeing care practices among those in and out of correctional settings, as should be the case.

Proposed new entities Mental Health and Wellbeing Commission, pp. 36

The Mental Health and Wellbeing Commission will:

- have responsibility for system-wide oversight of the quality and safety of mental health service delivery
- monitor and report on system-wide quality
- respond to complaints about mental health and wellbeing service delivery
- inquire into system-wide quality and safety challenges or concerns
- advise government on areas of concern and areas for improvement
- 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.

Justice Action's response:

Consumer response should be integrated at every level of the mental health system. The reform changes require collective contribution from governments, community members, advocates, and people with lived experience of mental illness. Does the proposal sufficiently adopt a multidisciplinary approach? Is it sufficient to have one representative from the direct and secondhand lived experience groups? Will other relevant professions be included on the commission? (e.g. social worker / occupational health / support worker / mental health nurse / etc). How will the commission be funded? The inclusion of only one lived experience representative appears tokenistic and will not be sufficient to cater to the wider needs of consumers as the individual experience varies greatly among the population.

Additionally, how will the lived experience leader be selected? How can we be sure the individual is not cherry-picked by the relevant authorities from a subset of 'suitable' candidates who have benefited under the current system and therefore will not be an advocate for the systemic and cultural changes that are needed?

In terms of funding, our understanding is that the extra funding allocated in the 2021-2022 budget to Mental Health and Wellbeing is to go to *Safer Care Victoria* and the new *Mental Health and Wellbeing Commission* to set up and manage themselves. They would also have powers to withdraw, direct and redirect funding in favour of the new consumer-led / multidisciplinary treatment model. Justice Action deems this to be a crucial area where people with lived experience must have influence, so that use of funds directly addresses the needs and wants of mental health care consumers.

VMIAC surveyed 142 Victoria-based mental health consumers and found that their needs are currently not being met. In fact, the direction of funding to shape mental health care settings as clinical, restrictive, and sterile environments rather than comforting and recovery-centric causes detriment and traumatisation to consumers. The impact of these conditions is exacerbated by the fact that often when a consumer is under the care of a mental health facility, they are already in a state of crisis and distress. The suggestions that came from the respondents to the VMIAC survey show a major misalignment between the current makeup of mental health care settings and what they should be in order to best foster recovery and meet consumer needs. Delegating funding decision-making power to consumers with lived experience will assist with addressing these issues and reforming the mental health care

system in line with the recovery-focused, consumer-centric service Victoria is working to implement.[28]

As recommended by the Royal Commission, it is proposed that the current powers of the Mental Health Complaints Commissioner transfer to the new Mental Health and Wellbeing Commission, including:

- investigating complaints, making recommendations to service providers, accepting an undertaking from a provider to take remedial action, or issuing a compliance notice if the provider has not complied with this undertaking or has acted in contravention of the new Act
- working with services to understand the importance of consumer complaints and to build the capacity to respond to complaints in a way that achieves positive outcomes
- using the insights into the quality and safety of mental health and wellbeing service delivery captured through complaints to initiate and inform reviews and inquiries.

Justice Action's response:

There is no indication that the Commission will be obliged to follow up to ensure the recommended changes resulting from reviews of service delivery and trends in service failures are implemented and maintained.

The Mental Health and Wellbeing Commission will be required to report to parliament on:

- the performance and quality and safety of the mental health and wellbeing system, including performance against targets to eliminate the use of seclusion and restraint
- performance of its functions, including those relating to complaints, investigations and inquiries.

Justice Action's response:

How frequently is the Commission required to report to parliament? Will the effectiveness and impact of their investigations and recommendations be part of the report to ensure they are adequately performing their duties? Where seclusion and restraint treatment is utilised,

[28] VMIAC: Consumer-led transformational change (2020) <h*ttps://www.vmiac.org.au/wp-content/uploads/VMIAC-Consumer-led-transformational-change-final.pdf*>

who is accountable for providing the justification and supporting evidence for the use of this treatment?

Chief Officer

Chief Officer for Mental Health and Wellbeing, pp. 37

Establishing the role of Chief Officer for Mental Health and Wellbeing in the new Act is intended to elevate the status of mental health and wellbeing within the department and strengthen leadership of the mental health and wellbeing system.

Justice Action's response:
How does this differ from the current Chief Psychiatrist role? Who will make funding decisions in order to implement their strategies / plans to address systemic failings and gaps? As below, the Department of Health remains the primary fund manager.

Regional Mental Health and Wellbeing Boards, pp. 37

The Royal Commission recommended that Victoria's mental health and wellbeing system be designed around eight regions, with a Regional Mental Health and Wellbeing Board established to oversee the delivery of high quality and safe services in each region.
Implementing the functions of the Regional Mental Health and Wellbeing Boards will be staged over several years, consistent with the recommendations of the Royal Commission. This will allow for partnerships to be developed between the department, new entities and service providers, as well as their respective communities.

The department will remain the primary funder and manager of Victoria's mental health and wellbeing system and will take on the role of strategic commissioner. The department will set clear expectations in relation to how Regional Mental Health and Wellbeing Boards undertake their functions.

Statewide and Regional Multiagency Panels, pp. 38

Regional Multiagency Panels will be established in each region. The panels will be one component of support available to the group of consumers who need and benefit from ongoing intensive treatment, care and support. Regional Multiagency Panels will be established under the new Act to help ensure the reform endures, and is funded, as a continuing function in Victoria's redesigned mental health and wellbeing system.

Justice Action's response:

How is this different from the current Mental Health Review Tribunal? What sort of issues would they resolve?

As suggested by the Royal Commission, a statewide panel will be legislated and chaired by the Chief Officer for Mental Health and Wellbeing, comprising the chairs of each Regional Multiagency Panel, to resolve complex issues requiring a system-level response.

Adult Mental Health and Wellbeing Services

Collaborative Centre for Mental Health and Wellbeing, pp. 38

The Collaborative Centre for Mental Health and Wellbeing was a recommendation of the Royal Commission's interim report. Led by a skills-based board, the Collaborative Centre will bring together people with lived experience and a broad range of multidisciplinary experts and researchers to deliver adult mental health and wellbeing services to a local population and to develop, translate and share best practice across the system.

To ensure the Collaborative Centre can begin operations as soon as possible, it is intended that it be established in standalone legislation ahead of the new Mental Health and Wellbeing Act.

Justice Action's response:

This sounds more like it will be a consultative body rather than a collaboration with the other agencies as outlined above. What is the rationale (besides expedience) for separating the Collaborative Centre from the new legislation? Will the centre be worked into the new

legislation later to ensure their services are streamlined and standardised along with the rest of this new mental health and wellbeing hierarchy?

The new oversight and accountability model as outlined in the Update and Engagement paper demonstrates that little is being done to address the core issue that the current mental health care system and culture does not take into account the dignity and rights of the consumer. The new system seems to continue with the same biomedical model of care, with the focus and power on psychiatric and medical approaches rather than a consumer-led multidisciplinary approach incorporating counselling, culturally-specific needs and non-chemical treatment options.

The appointment of just one representative from the direct lived experience and one representative from the secondhand (family / carer) lived experience group to the Mental Health and Wellbeing Commission is tokenistic at best and does not offer adequate representation of the mental health care consumer community. This in itself is evidence that the dignity and rights of consumers are not being taken seriously in Victoria. The appointment of several individuals with a variety of lived experiences and cultural needs to leadership roles within the above-mentioned governing bodies is essential to driving the cultural and systemic changes that are so desperately needed in the mental health and wellbeing sphere.

An aspect of the new structure which has not been clearly addressed in the Update and Engagement paper is how an organisation or consumer may make a challenge to the service. Where is the autonomy for an organisation to challenge the quality or safety of a service, is there any recourse for organisations or consumers to hold providers accountable for their service quality and safety? Under the current Mental Health Act, the Mental Health Tribunal and Chief Psychiatrist are the authorities responsible for investigating complaints, appeals and conducting treatment reviews. Will this continue to be the process? We believe that as with all other issues impacting the rendering of safe, high quality mental health care services, the input and influence of persons with lived experience is crucial to appropriately managing reviews, complaints and challenges to the system.

Towards the elimination of seclusion and restraint

Recommendation 54 - the evidence and findings supporting this recommendation are noted and indexed below.

JA Analysis of Royal Commission Into Victoria's Mental Health System 2021

Recommendation 54 focuses on immediately reducing the use and duration of seclusion and restraint in mental health and wellbeing service delivery, with the aim of eliminating restrictive and compulsory practices within the next 10 years.[29] The Commission identified this recommendation as *'necessary to uphold the rights of consumers and to respond to service failure.'*[30] By respecting consumer's rights and consumer-led reform, the Commission expects that, '*over time, early intervention, less compulsory treatment, well designed facilities, increased staffing levels and better training and support will remove the need for practices of last resort and establish alternative approaches as routine practice.'*[31] This approach also *'responds to broader concerns that consumers have about human rights issues in clinical mental health environments, leading many to suggest community-based care as a less restrictive option.'*[32]

The recommendation outlines 3 other key steps the Victorian Government should take in order to eliminate seclusion and restraint. First is the recommendation that the Victorian Government should regulate the use of chemical restraint through legislation provisions in the new *Mental Health Wellbeing Act.* Secondly, the Victorian Government should ensure the *Chief Officer for Mental Health and Wellbeing* develops and leads a strategy to reduce the

[29] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) Volume 5, 90.
[30] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) Volume 4, 299- 301.
[31] *Ibid*.
[32] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) Volume 1, 315.

use of seclusion and restraint.[33] Third, https://www2.health.vic.gov.au/about/publications/policiesandguidelines/victorias-10-year-mental-health-plan

The recommendations are designed to transform Victoria's mental health and wellbeing system so that treatment, care and support are recovery-oriented. This aims to support consumers to build and maintain a self-defined and self-determined meaningful life, regardless of whether symptoms of mental illness are present which is *'consistent with a human rights based approach to non-coercive options provided through community based service offerings.'*[34]

Update and Engagement paper, section 4 - Treatment, Care and Support

(Dept. of Health U&E Sections referenced in 'blue')

Compulsory Treatment

What is changing in the new Act about compulsory assessment and treatment?, pp. 25

To meet the Royal Commission's vision of a more balanced mental health and wellbeing system, the redesigned system will move from a crisis-driven model to a system built around community-based services. Not all changes will be driven through legislation. Other system reforms also aim to enhance voluntary methods of treatment, care and support to meet people's needs and preferences. For example, introducing a more diverse mix of treatment, care and support will provide greater access to therapeutic interventions and recovery-centred responses.

The redesigned service system will be further supported by practice change and workforce initiatives. The new Act will support related reforms through using modern, human

[33] *Ibid* 90.
[34] *Ibid* 315.

rights–focused principles and establishing stronger system oversight over publicly funded mental health and wellbeing services.

Justice Action's response:
Noting that not all changes will be driven through legislation, the strength and purpose of Safer Care Victoria is described as legislated powers. In order to facilitate a multidisciplinary recovery-focused approach to care, will the funding be provided to make this happen? As discussed above and in section 5.1 of the Update and Engagement paper (pp.36), the power over final treatment plan decision-making needs to be decentralised from where it currently sits with the psychiatrists, however the psychiatrist is maintaining final say in treatment plans.

The re-designed system targets publicly funded services. What about the private, revenue-driven services? Will the legislation be adequate to mitigate opportunities for private services to breach the above principles of consumer-led, recovery-driven care?

Proposals about compulsory assessment and treatment in the new Act, pp. 25

As outlined in section 2 of this paper, 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.

Justice Action's response:
Per the active legislation below, this should already be how compulsory treatment is being utilised:

Part 4—Compulsory patients Mental Health Act 2014 No. 26 of 2014 35

The criteria for a person to be made subject to an Assessment Order are—
(d) there is no less restrictive means reasonably available to enable the person to be assessed.

On review of the existing legislation against the Update and Engagement paper, what is changing? Will there be an addendum specifying accountability for any harm caused, and/or means of recourse for those who are inappropriately ordered to comply with compulsory treatment? Will the existing legal protection of staff be removed to ensure harmful treatment is not administered without consequence to the provider?

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. In addition, any compulsory treatment order will need to be made with the intent to ensure the person receives high-quality care, and with the aim of supporting recovery and moving towards non-coercive approaches to treatment and support.

Justice Action's response:
Service providers should already be operating within the principles of trauma-informed care. How will this be embedded into the legislation and defined? There is no mention of assessing the consumer for capacity to make their own decisions about their treatment, or management of objections from the consumer. How is dignity of risk being addressed?

Part 4—Compulsory patients Mental Health Act 2014 No. 26 of 2014 57
(2) For the purposes of making an Order under subsection (1)(a), the Tribunal must, to the extent that is reasonable in the circumstances, have regard to all of the following—

A. the person's views and preferences about treatment of his or her mental illness and the reasons for those views and preferences, including any recovery outcomes that the person would like to achieve;

B. the views and preferences of the person expressed in his or her advance statement;
C. the views of the person's nominated person;
D. the views of a guardian of the person;
E. the views of the person's carer, if the Tribunal is satisfied that making the Order will directly affect the carer and the care relationship;
F. the views of a parent of the person, if the person is under the age of 16 years;
G. the views of the Secretary, if the person is the subject of a family reunification order or a care by Secretary order.

Cultural Change

Promoting cultural change to support the dignity of risk, pp. 27

The mental health workforce carries a significant burden of community expectations about how risk is managed, which can lead to more risk-averse decision making. Much of the change needed to address this issue will require a systemic cultural shift and broad public education to reduce stigma and misconceptions about mental illness.

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.

Justice Action's response:
It is not clear in the proposal that providing confidence to consumers regarding their dignity of risk and fundamental right to lead their own treatment (where capacity allows) is paramount to decision-makers? The proposal is still conducive to provider-led rather than consumer-led care models.

Ensuring Compulsory Treatment is only used as a last resort

Recommendation 55 - the evidence and findings supporting this recommendation are noted and indexed below.

JA Analysis of Royal Commission Into Victoria's Mental Health System 2021

Compulsory treatment is the treatment of a person for mental illness subject to an order under the Mental Health Act 2014. This can include the compulsory administration of medication, hospital stays, electroconvulsive treatment or neurosurgery for mental illness. To ensure compulsory treatment is used as a last resort, the Commission recommends that the Victorian Government 'set targets to reduce the use and duration of compulsory treatment on a year-by-year basis'.[35]

The Commission also recommends that the Victorian Government, 'when commissioning mental health and wellbeing services, set expectations that they will provide non-coercive options for people [36] expanding non-coercive alternatives and improving consumer-centred service.' This will also ensure that diverse, well-resourced community-based mental health and wellbeing services are readily available. The Mental Health Improvement Unit within Safer Care Victoria is also recommended to work with mental health and wellbeing services to increase consumer empowerment, involvement and autonomy.[37]

Compulsory treatment can also have long-term negative effects that range from physical harm, being physically restrained during admission, psychological trauma, severe breaches of human rights, and increased community stigma and discrimination.[38] Given compulsory treatment's impact on human rights, the negative experience of compulsory treatment experienced by many consumers, and the contested evidence on its effectiveness when used

[35] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) Volume 4, 91.
[36] *Ibid*.
[37] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) Volume 5, 91.
[38] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) Volume 4, 91.

in community settings, the urgency of this reform has not been overstated by the Commission. It is essential that as well as ensuring CTOs are only used as a last resort, treatment, care, and support are also provided to people earlier in the community to reduce the need and likelihood of a person experiencing compulsory treatment.[39]

Update and Engagement paper, section 4 - Treatment, Care and Support, pp. 24-27

(Dept. of Health U&E Sections referenced in 'blue')

Compulsory Treatment

What is changing in the new Act about compulsory assessment and treatment?, pp. 25

Despite the aspirations behind the *Mental Health Act* and the introduction of the Mental Health Tribunal to reduce compulsory treatment, the rate and duration of CTOs in the Victorian mental health system is too high.[40]

Justice Action's response:
To promote social justice and equity in mental health, consumer rights and leadership must be strengthened, ie., with the recruitment of mental health consumers with lived experience in the contribution and participation for the development of social and mental health policy and services. Mental health consumers should have the opportunity to be actively involved in decision-making processes about policies and programmes.

How will mental health consumers be entitled to participate in all decisions that affect them, and to benefit from special safeguards if involuntary assessment, treatment or rehabilitation is imposed?

To meet the Royal Commission's vision of a more balanced mental health and wellbeing system, the redesigned system will move from a crisis-driven model to a system built around

[39] *Ibid*.
[40] *State of Victoria, Royal Commission into Victoria's Mental Health System, Final Report, Volume 4: The fundamentals for enduring reform,* Parl Paper No. 202, Session 2018–21 (document 5 of 6), p. 409.

community-based services. Not all changes will be driven through legislation. Other system reforms also aim to enhance voluntary methods of treatment, care and support to meet people's needs and preferences. For example, introducing a more diverse mix of treatment, care and support will provide greater access to therapeutic interventions and recovery-centred responses.

Justice Action's response:

The previous legislation adopted stringent rules in decision-making with psychiatry at the top of the hierarchy. A multidisciplinary framework that is appropriate to the mental health consumer's care, needs and wishes is required. How will the current system move away from the biomedical framework to achieve this? The biomedical model carries potential biases in the treatment and care of persons with mental health conditions due to limited patient input, low status given to 'lived experience', lack of patient-centred consulting, and power imbalances that work to suppress the patient's voice.

Alternative Treatment Approach - Recovery-Orientated Support Services:

Recovery-Orientated services offer an alternative method aimed at reducing coercive and restrictive practices such as forced medication, restraint and seclusion. Alternative systems are required to provide care for individuals seeking to avoid or reduce reliance on medications, including supported withdrawal from medications.

The redesigned service system will be further supported by practice change and workforce initiatives. This will be led by the new Mental Health Improvement Unit, working with mental health and wellbeing services to:

- increase consumer leadership and participation in all activities to reduce compulsory treatment
- support the design and implementation of local programs, informed by data, to reduce compulsory treatment
- make available workforce training on non-coercive options for treatment that is underpinned by human rights, safety and supported decision-making principles.

The new Act will support related reforms through using modern, human rights–focused principles and establishing stronger system oversight over publicly funded mental health and wellbeing services.

Justice Action's response:

The Victorian Government has agreed to a 10-year timeframe to eliminate restrictive practices without a formal framework, strict guideline or information on services and interventions to support the proposal. Explicit legislation is critical to safeguard consumers, and from profit driven private entities that carry the potential to risk greater breaches.

Mental Health Act, 2014 (Vic): Part 4 - Compulsory Treatment

- 'The Act promotes voluntary treatment in preference to compulsory treatment wherever possible.
- The Act seeks to minimise the use and duration of compulsory treatment to ensure that the treatment is provided in the least restrictive and least intrusive manner possible.
- The Act achieves this by introducing specific criteria for compulsory treatment, creating Treatment orders that operate for a fixed duration and requiring timely oversight by an independent Mental Health Tribunal.
- The Mental Health Act 2014 (Act) seeks to minimise the use and duration of compulsory treatment by specifying strict criteria for making a person subject to an Assessment order, a Temporary treatment order or Treatment order.'[41]

Proposals about Compulsory Assessment and Treatment in the new Act: Strengthening principles and accountability, pp. 25

The objectives and principles of the new Act will set clear expectations that:

- compulsory treatment is to be used only as a last resort

[41] Victoria State Government. health.vic (2017) *<https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/mental-health-act-2014-handbook/compulsory-treatment>*

- treatment, care and support should always be provided with the least possible restrictions on people's rights.

Justice Action's response:
The Mental Health Act, 2014 stipulates that voluntary treatment should be sanctioned when considering a CTO. However, the Royal Commission found this is not the case with excessive rates of CTO's prescribed by Victoria's Healthcare system.

How will accountability be addressed as a means of recourse for those who experience harm? Mental healthcare workers feel there is a difficult expectation to administer CTOs in order to avoid blame for any harm that occurs to a patient.[42] How will the existing legal protection of staff be balanced to ensure that such harm is not caused?

The greatest measure to ensure the immediate reduction of CTOs will be the regular and uniform collection of CTO data for public reporting.

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.

Mental Health Act, Victoria (2014):

Mental health services should adopt trauma-informed care practices to aid the recovery of people in care, reduce the potential for re-traumatisation, and promote a more collaborative and empowering care environment.

Justice Action's response:
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. In addition, any compulsory treatment order will need to be made with the intent to ensure the person receives high-quality care, and with the aim of supporting recovery and moving towards non-coercive approaches to treatment and support.

[42] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) Volume 4, 391.

Accountability and transparency of healthcare workers and institutes is essential to drive reform. Public reporting is recommended by the VRC for the Mental Health and Wellbeing Commission to 'publish reports on the performance and quality and safety of the mental health and wellbeing system'.[43]

Accountability

Accountability, pp. 26

The Mental Health and Wellbeing Commission will:

- Issue statutory guidelines on how to apply the principles when making compulsory assessment and treatment orders
- Be able to investigate and monitor the use of compulsory treatment.

The Chief Officer for Mental Health and Wellbeing will set system-wide targets, including for reducing the use and duration of compulsory treatment.

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.

Justice Action's response:

The Department of Health must implement professional and standardised monitoring procedures for workers in the mental health system with active investigating and accounting for incidents of preventable engagement of CTO's, and to identify the system-wide problems of the excessive use of coercive, involuntary practices in Victoria's mental healthcare. A system of accountability must include a governing body to ensure that appropriate changes are implemented and its effectiveness reviewed, including internal performance monitoring and reporting.

[43] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) Summary and Recommendation, 80

Criteria for compulsory treatment, pp. 26

Under the current *Mental Health Act,* the following criteria must be met to make a compulsory temporary treatment order or a treatment order:

- the person has mental illness
- Because the person has mental illness, they need immediate treatment to prevent:
    - serious deterioration in the person's mental health or physical health, or
    - serious harm to the person or another person
- The immediate treatment will be provided if an order is made
- There is no less restrictive way to enable the person to receive that immediate treatment.

What will change under the new Act?

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.

Justice Action's response:
This is already the case in NSW where the rate of CTOs continues to increase. How effective is the new Act in reducing CTOs with outdated psychiatric practices and continuation of the current clinical paradigm? The same issues of consumer distress will be substantiated by this limited change in the CTO criteria.

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.

Justice Action's response:
Under the *Mental Health Act 2014*, CTOs have been found to violate consumer rights to seek treatment that meet the consumer's needs. To eliminate the abusive practice of CTOs, policies need to be more defined and healthcare workers held to higher standards of accountability.

Authorisation of CTOs

Authorisation of compulsory treatment, pp. 27

Under the current Mental Health Act, authorised psychiatrists make temporary treatment orders that have a maximum duration of 28 days. If a person remains on a temporary treatment order for 28 days, the Mental Health Tribunal must conduct a hearing to determine whether to make a treatment order for the person. The Mental Health Tribunal also hears and determines applications for extensions to treatment orders.

What will change under the new Act?

The Royal Commission outlined a vision for a more holistic system, rather than a system that often focuses on a 'biomedical model' of treatment and decision making.

Justice Action's response:
Introduction of a multidisciplinary framework that is appropriate to the mental health consumer's care, needs and wishes is necessary. How will the current system move away from the biomedical framework to achieve this?

Mental Health Tribunal

Mental Health Tribunal, pp.27

The new Act will allow the Mental Health Tribunal to require that a conference be held ahead of the Tribunal considering a treatment order extension. The purpose of the conference is to

facilitate more diverse input, shared decision making and enhanced understanding in relation to compulsory treatment by involving, where appropriate, the consumer, their family or carers and advocates, and the treating team.

Justice Action's response:
The administration and facilitation must not be legally allied to health facilities, hospitals, etc. Will the family, carers and advocates receive a qualified position or is it more of a formality/mediator role? What level of authority is issued to the supports to advocate for consumer preferences?

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, and may reduce the maximum duration for community treatment orders to six months.

Justice Action's response:
Will the plan to reduce treatment orders take into account CTO extensions?

Rather than making further significant changes to the Mental Health Tribunal's role now, an independent review of its role will be undertaken in line with the Royal Commission's recommendation. Noting the Royal Commission's view that, in the short term, large-scale reform could risk undermining systemic reforms to prevent the use of compulsory treatment and reduce its use and duration.

Justice Action's response:
As outlined in the Victorian mental act (2014) the role of the tribunal is to protect the rights and dignity of people with mental illness. The VRC explicitly states that the tribunal has not been effective in its role to safeguard and protect consumers, as evident from the excessive and unreasonable applications of treatment orders in Victoria. The Department of Health has failed to define the specific changes to the role of the Mental Health Tribunal. The current administration consists of a lawyer, a psychiatrist and a community member. How will the system be reshaped to the eventual elimination of restrictive practices and CTOs if the governing body issuing CTOs remain in place?

Regulation Changes

Use of regulation to enable further changes, pp. 27

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.

The new Act and regulations will allow for greater flexibility about who may be authorised to make a temporary treatment order, with permitted persons to be prescribed in regulations. Further consultation will be undertaken in developing regulations to consider the benefits and workforce and operational issues that might arise through alternative approaches.

Justice Action's response:
The new act promotes flexibility of authorised persons such as a nurse or social worker. The critical response must also stipulate how the current system will move away from the biomedical framework to achieve an immediate reduction and eventual elimination of CTOs.

What is needed is a multidisciplinary framework to address the 'missing middle' with priority given to alternative treatment methods i.e. recovery-orientated and trauma-informed support services. Services that offer an alternative method aim at reducing coercive and restrictive practices such as forced medication, restraint and seclusion.

Supporting consumers to exercise their rights

Recommendation 56 - the evidence and findings supporting this recommendation are noted and indexed below.

JA Analysis of Royal Commission Into Victoria's Mental Health System 2021

Recommendation 56 ensures the promotion and protection of consumer rights through the least restrictive options and increased access to legal representation as part of the mental health system reform. It includes 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. In the future, mental health laws are to be aligned with decision-making principles and practices, and to be consumer centred rather than focusing on the clinical paradigm.

This remains a problem in how CTOs, even as a last resort, are to be resolved whilst upholding consumer rights and responsibilities. *Dr. Coventry suggested that extended rehabilitation models of care must be altered to better address the potential differences in requirements of people with mental illness and highly complex support needs. Models of care also need to be supported by investment into specialised training and supervision for the workforce. Moreover, a great need to enable the provision of evidence‐based treatment for complex needs and intensive psychosocial rehabilitation is a fundamental necessity.* Without a streamed approach, consumers with specific needs requiring specialist input are cared for alongside others with differing needs.[44]

[44] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) Volume 1, 619

Update and Engagement Paper - Section 3 - Non-legal advocacy, supported decision making and information sharing, pp 13-22

(Dept. of Health U&E Sections referenced in 'blue')

Protection of Rights

Promote, protect and ensure the right of people living with mental illness or psychological distress (pp. 12-13)

People living with mental illness or psychological distress will:

- be provided with a statement of rights when made subject to any compulsory order or when admitted to an inpatient unit on a voluntary basis
- be able to have nominated person paperwork and advance statements witnessed by a broader range of people
- be able to include preferences about a broad range of matters in advance statements and be provided with written reasons for any decision to override treatment preferences as expressed in an advance statement
- be able to receive more timely second psychiatric opinions through changes to increase flexibility in how opinions can be provided
- be provided with written reasons for any decision not to accept a recommendation made by a second psychiatrist
- be offered advocacy support if a compulsory assessment or treatment order is made
- have a right to communicate with an advocate that cannot be restricted
- be able to ask that a statement be included on their record if they disagree with the information in the record.

Justice Action's response:

Showing minimal changes to the 'protection of rights' compared to the *Mental Health Act, 2014 (Vic)*. The explicit changes include flexibility with the witness party in relation to advanced statements, and greater access to advocates including access to secured patients.

Access to independent advisory groups such as IMHA have a critical role to provide safety, care, and supported decision making.[45] Currently the service is mainly ineffective as legal and non legal advocates do not have the resources to provide efficient consultations with consumers.

There is a critical need for major funding of independent organisations such as IMHA to cope with service demand. Ensuring consumers are connected to non-legal advocacy is imperative in order to understand and maintain consumer rights in acute settings i.e. when subject to compulsory treatment.

Statement of Rights

Obligation to Inform consumers via Statement of Rights, pp. 16

The new Act will require a statement of rights to be given to consumers who are voluntarily admitted as inpatients. The person providing the statement must ensure the consumer understands their rights, which would be given effect via ongoing conversations about their rights and available support.

The content and format of the statement of rights will not be prescribed in the new Act but will be developed in consultation with consumers and carers

Justice Action's response:
An independent system for the public vs. involuntary patients enables restrictive practices and limited provisions of mental health consumers.

[45] *Mental Health and Wellbeing Act: update and engagement paper*, (Final Report, June 2021) Volume 1, 14

Advance Statements

Mental Health Act, 2014 (Vic) - Advanced Statements

According to the Victorian Mental Health Act (2014) Advance Statement documents involve a patient stating their preferred treatment or treatment options they wish to avoid, should they require compulsory mental health treatment. Clinicians and relevant medical practitioners must consider the preferential treatments outlined in the Advanced Treatment, should the patient require mandatory mental health treatment. The patient is entitled to the option of nominating a person to be involved in the development of the Advanced Statement and share a copy with them, should the need arise.

An authorised psychiatrist can override the preferences included in an advance statement in certain circumstances. An authorised psychiatrist can make a substitute decision that overrides the consumer's advance statement if they are satisfied that the preferred treatment specified in the advance statement is not clinically appropriate or is not a treatment ordinarily provided by the designated mental health service.

What will change under the new Act?, pp. 17

While an authorised psychiatrist will be able to override an advance statement, additional measures will increase the transparency of this decision. These measures will require that:

- a consumer be provided with written reasons for a decision to override their treatment preferences
- these reasons be provided to any other person at the consumer's request.

Measures will also be included to require that:

- an advance statement can include preferences on a broader range of matters; for example, it could include instructions for culturally appropriate foods or mealtimes, or other requests
- a broader range of people will be able to witness the making of an advance statement.

Justice Action's response:

The changes allow patients and consumers of mental health care increased autonomy and involvement in their decision making regarding medical treatments.

The guidelines for consultation of the advanced statements amongst medical practitioners has not been stated. How will coercive and pressuring practices stemming from authoritative figures i.e. medical professionals be controlled and prevented during medical decision making? During an acute episode does the authority of the practitioner supersede the requests and preferences of the patient? How will the management strategy balance consumer rights and supported decision making processes for those who suffer from severe mental health conditions i.e. complex psychotic disorders?

What are the guidelines for how the Advanced Statement is consulted? Will practitioners be required to document prioritised use of the preferential treatment options or avoidance of unwanted treatment options?

Non-Legal Advocacy

Non-legal advocacy, pp. 14

"Non-legal advocacy is an important human rights protection. Non-legal advocacy can reduce feelings of disempowerment among consumers and is well regarded by consumers, even when they do not achieve their desired outcome. Despite this, access to non-legal advocacy is limited."[46]

What is changing in the new Act about non-legal advocacy?

Non-legal advocates provide information and support to consumers and act on their instructions. Like a legal advocate, they do not impose their own beliefs about what would be in the consumer's 'best interest'; rather they represent the consumer's preferences as expressed by them.

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

[46] *State of Victoria, Royal Commission into Victoria's Mental Health System, Final Report, Volume 4: The fundamentals for enduring reform,* Parl Paper No. 202, Session 2018–21 (document 5 of 6), 396.

coercive practices. However, not all consumers are aware of the availability of advocacy support or able to access it.[47]

Creating an opt-out non-legal advocacy system:

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.

Consumers will have the right to opt out of this service if they choose.

Justice Action's response:

Raising awareness and participation in non-legal advocacy services raises the consumer rights to health and community safety.

The 'opt-out' model is moving in the right direction to promote consumer rights, however, the ability to exercise rights and decision-making for treatments and services is still minimal and being restricted. It is imperative that consumer rights not be neglected in the decision making process of clinical treatments.

The new Act will include protections to ensure advocates can connect with consumers. This will include:

- rights for advocates to access inpatient services
- ensuring there can be no restrictions placed on a consumer's right to communicate with an advocate

[47] *State of Victoria, Royal Commission into Victoria's Mental Health System, Final Report, Volume 4: The fundamentals for enduring reform,* Parl Paper No. 202, Session 2018–21 (document 5 of 6), 396, 425.

- rights for advocates, with the person's consent, to access a person's records, meet with the person or attend any meeting or consultation with the person
- obligations on service providers to give reasonable assistance to advocates in performing their functions, including responding to any requests for information within a maximum of three days
- obligations on service providers to notify a person's advocate in certain circumstances, including when a person is subject to seclusion or restraint.

These proposals aim to meet the Royal Commission's recommendation to establish an 'opt-out' model for non-legal advocacy, rather than relying on consumers' ability to access these services.

Providing for non-legal advocacy services

Currently, the department funds Victoria Legal Aid to provide Independent Mental Health Advocacy (IMHA). IMHA is not established under the current Mental Health Act, although it is prescribed that an authorised psychiatrist cannot restrict an inpatient's right to communicate with IMHA. IMHA does not have other statutory rights or powers – for example, to access services or records.[48]

Justice Action's response:

NSW Legal Aid funding cuts demonstrates the need to increase people's choices and mental health advocacy.

Non legal advocacy is an essential service used to support consumers recognise their involvement in assessment, treatment and recovery. The service is currently underfunded affecting its use and efficiency. Will the allocated funding to promote access to non legal advocacy be adequate in reshaping the quality and efficiency of the service?

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

[48] *Mental Health Act 2014 (Vic)* s 16(f).

guidelines will clarify and give effect to the obligations of mental health service providers to engage with non-legal advocacy services.

Supported Decision Making

Supported Decision Making, pp. 16

No single strategy will ensure consumers are supported to make decisions; a concerted effort and multiple strategies are required to embed supported decision making in Victoria's future mental health and wellbeing system.[49]

The new Act will take many approaches to meet the recommendation about supported decision making. The proposals aim to enhance supported decision making in key decisions being made under the new Act. These changes will strengthen a human rights-based culture in mental health services, as well as increasing oversight and monitoring of supported decision making.

Several other recommendations about system design and practice change, designed to promote consumer autonomy, can also support this. In particular, the Mental Health Improvement Unit (within Safer Care Victoria) will:

- offer education and training programs on safeguards and supported decision making for consumers, families, carers and supporters, as well as the mental health workforce
- provide for advance statements and nominated persons registers
- support service providers to ensure consumers receive a statement of rights on entry to the service and to ensure the statement is provided in a range of languages and formats.[50]

The details of these supports will be determined in a separate process to develop the new Act, in collaboration with consumers, families, carers and supporters.

Justice Action's response:

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[49] *State of Victoria, Royal Commission into Victoria's Mental Health System, Final Report, Volume 4: The fundamentals for enduring reform,* Parl Paper No. 202, Session 2018–21 (document 5 of 6), 395.
[50] Ibid 428.

The proposal does not align with a mental health reform to shift from the current clinical paradigm to a consumer-led and person-centred approach. To ensure mental health consumers receive the same basic rights and standards of care as other members of the community, consumer rights and safety must be upheld with focus on 'recovery' rather than the current clinical practices that centre on treatment and reduction of the symptoms of mental illness.

The advice from the VRC stipulates mental health laws to be aligned over time with other decision-making laws with a view to promoting supported decision-making principles and practices.'[51]

The new Act will increase transparency and accountability of supported decision making. It will require a formal record of how a person's preferences have been considered and where they have been overridden during treatment.

Justice Action's response:
How will accountability and transparency be monitored and regulated?

The new Act aims to promote supported decision-making throughout all aspects of a person's assessment, treatment and recovery. This means exploring supported decision-making for all consumers, not just those on compulsory orders.

Justice Action's response:
How consumers make decisions can be affected by multiple factors. Non-treatments supports such as peer workers, education, housing, employment and social protection sectors need to be considered for promoting right decision-making by consumers. The World Health Organisation (2021) published document, '*Guidance on community mental health services: Promoting person-centred and rights-based approaches'*[52] urge for a radical change in mental health services from the focus of the biomedical model for individual treatments with excessive medicalisation to a person-centred and human rights-based approaches in delivering high quality of care and support services.

To support the new Mental Health and Wellbeing Act, recovery and consumer centred interventions must be integrated in all relevant systems, strategy and policy areas. A

[51] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) Volume 5, 283
[52] *Guidance on community mental health services: promoting person-centred and rights-based approaches* (June, 2021) Volume 1.

paradigm shift with greater support for consumer's to make their own decisions throughout the assessment, treatment and recovery processes offers the opportunity for profound improvement on the consumers care and quality of life.

With legal reform, legislations need to recognise and protect the consumer's right of selecting their own mental health care and services which support the social determinants of health and bring people back to living independently and supporting community inclusion.

Mental Health Improvement Unit

Promotion of Consumer Autonomy: Mental Health Improvement Unit, pp. 16 (Safer-care Victoria)

- Offer education and training programs on safeguards and supported decision making for consumers, families, carers and supporters, as well as the mental health workforce
- Provide for advance statements and nominated persons registers
- Support service providers to ensure consumers receive a statement of rights on entry to the service to ensure their statement is provided in a range of languages and formats

Related mental health plans

Victoria's 10 Year Mental Health Plan 2015 failures - reject Dept of Health's proposal of waiting another 7 years for another VRC review

See Vic's 2015 plan:
https://www2.health.vic.gov.au/about/publications/policiesandguidelines/victorias-10-year-mental-health-plan

The Victorian Royal Commission (VRC) investigated a 'broken' and 'failing' system, and these findings became the urgent and compelling case for comprehensive reform. These reforms are born out of the evidence of and an increasing recognition of the 'burden' of accessing mental health services on consumers, and that current restrictive practices are the consequential 'service failures' that repeatedly breach consumer's human rights, resulting in the unsatisfactory state of our existing mental health system:

> *There are missed opportunities to ensure all parts of government and the community are focused on, with not enough focus on promoting good mental health and wellbeing nor preventing mental illness before treatment is needed.*
>
> (RCVMHS Full Report, Volume 1. page 11)

However, Vic's 10 yr plan that was adopted in November, 2015 is also part of and shares responsibility for the result of a 'broken' and 'failing' system, and 'the urgent and compelling case for comprehensive reform', and the continuation of current restrictive practices that are the result of service failures. The result of the 'over-reliance' or biomedical dominance has skewed our mental health system and resulted in the biomedical practitioner ideology and focus on a-therapeutic pharmaceutical management has resulted in excessive restrictive practices and the undermining of human rights. Also it has ignored the 'psychosocial' model of mental health and the psychosocial support that is the main thrust of the VRC - consumers' voice and the psychosocial support and participation being what VRC calls the 'missing middle'.

VRC referred to the failure of the 2015 - 2025 plan in Victoria to mental health (https://www2.health.vic.gov.au/about/publications/policiesandguidelines/victorias-10-year-mental-health-plan)

VRC argued that it is the Victorian Government that should ensure the *Chief Officer for Mental Health and Wellbeing* develops and leads a strategy to reduce the use of seclusion and restraint. Furthermore, not only does the Vic Govt wish to stay in charge of its own state's mental health system, and create a new Act, but says that families, carers and supporters will be involved in the co-production of a plan to guide elimination of restrictive interventions within 10 years. People working in the mental health and wellbeing service system will: have access to statutory guidance about how the principles of the new Act must be given effect in compulsory treatment decisions and in the use of seclusion and restraint (including chemical restraint) be involved in the co-production of a plan to guide elimination of restrictive interventions within 10 years.

What did Victoria's 10-year mental health plan in Nov 2015 offer?

Essentially, with the Fifth national mental health plan, it was the 2015 Vic MH plan -that relied promoting 'whole of government approach', NDIS, and on govt professionals ie 'EXPERT Taskforce' & 'PRN's' -and this plan is part of the problem that the VRC was left to redress in 2020.

It acknowledged the value of peer support but focus is on delivering clinical care :

> *Peer support gave me the inspiration and empowered me to recover… Peer support should be a part of all mental health services … Workforce planning and development is needed to ensure an equitable and properly funded range of programs to deliver clinical care*

It said that:

> '*Each year 1.2 million (one in five) Victorians will experience mental illness, and nearly half (45 per cent) will experience mental illness in their lifetime. Sometimes, challenges to mental health are eased with time and informal support. At other times, people need more specialised assistance and treatment. We will also strongly advocate for an outcomes approach in the upcoming Fifth national mental health*

plan. Victoria has led the way in Australia with investment in community-based clinical and non-clinical mental health services – but these services are only one part of the picture. There is a broad range of services provided by the Commonwealth, the state, the community and private sectors that make up what is often referred to as the 'mental health system'. Changes to one part of the system can have an impact on other parts of this system for better and worse. That is why the looming Commonwealth budget cuts are a concern. The Commonwealth has flagged $1.8 billion cuts to mental health services over the forward estimates of the next decade.

State-funded clinical mental health services deliver assessment, treatment and clinical case management in acute inpatient settings and in a range of services in the community. They include child and adolescent mental health services, adult mental health services and mental health services for older people. A number of publicly funded specialist clinical mental health services are also delivered on a statewide basis. These services offer treatment for specific types of conditions or high level needs. In 2015-16 these services treated approximately 65,000 people.

The Victorian government also funds the Mental Health Community Support Services, provided by a range of non-government providers, which deliver support services to people with psychosocial disability associated with mental illness. In 2015-16 it is anticipated that these services will provide support to more than 12,000 adults.

State-funded MHCSS, Commonwealth funded Disability and Carer Support Pensions (current). National Disability Insurance Scheme Provided (from 2016) to approx. 0.45% of the population. State-funded Victorian clinical mental health services treat approximately 1.1% of the population each year.

Each year just under half of the 1.2 million Victorians who experience mental illness access Commonwealth-funded or Medicare-subsidised mental health services.

Public clinical mental health services deliver valuable and important treatment to about 65,000 people per year, or about one per cent of the population. This means that many people, including people with severe mental illness, do not access public

mental health services. For some this is by choice. For others the right services are not available at the right time in the right place.

People with mental illness are over represented in the justice system, as offenders, victims and people in need of assistance. There is a critical need to better address the needs of people with mental health problems who become involved with the justice system at all points of contact: at arrest or apprehension, in police custody, at court, during community-based corrections orders, in prison, and at all transition points. The drivers of offending and reoffending are complex and interdependent. They can include issues such as family violence, mental illness, alcohol and drug misuse, the stress of living in regional, rural and drought-affected areas, unemployment, poor educational attainment and insecure housing. The multi-faceted disadvantage experienced by ex-offenders on returning to the community is a key factor driving re-offending.

In Victoria we are proud to have a strong commitment to upholding the human rights and dignity of all people. Over the past decade, policy and human rights developments, both at the state and national levels, have created a strong impetus for positive and lasting change in the way governments, services and communities conceptualise and approach mental health, mental illness and wellbeing. A person's self-determined goals and self-defined recovery are of huge importance .... [In 10 years' time I hope there is] no more compulsion. Ever. Freedom of choice. Many services options available and the person is really in charge of their life and choices.

The Victorian Government proposed in 2015 to stop 'compulsion' in 10 years time. In 2015, the Victorian Government in its MH Plan said, 'People outlined a vision for the next 10 years in which services are more timely, local, accessible, affordable, family inclusive and more focused on recovery. People imagined kind and curious communities that are free from stigma and discrimination.' In 2015, the MHP said, 'We will only achieve this goal if we have a clear way to measure our progress and lay out a path forward. This plan translates our long-term goal into clear, measurable outcomes.'

Action will be linked with our Public health and wellbeing plan 2015–2019, which prioritises the improvement of Victorians' mental health. Like that plan, this plan focuses on prevention and promotion and our efforts to achieve the outcomes outlined in this plan will include a focus on environments that create good health. We will aim to change attitudes and behaviours, and improve workforce participation, social connection, civic participation, community resilience and suicide prevention. In some cases, our actions will aim to drive change through the community sector and private sector.

This plan is all about targeting outcomes that matter, and being accountable for achieving them. Prevention actions will address all of the outcomes and will include:

- working closely with existing school-based programs and supports to build resilience and influence attitudes that support mental wellbeing of children and young people
- strengthening partnerships and sharing information about what works across local communities, government jurisdictions, non-government providers and private industry so that everyone across the Victorian community is able to support the mental health and wellbeing of all Victorians
- implementing whole-of-Victorian government approaches to guide suicide prevention and mental health promotion
- with leadership from Aboriginal community controlled health organisations and communities, developing an Aboriginal mental health and social and emotional wellbeing framework that supports resilience and promotes protective factors, while addressing risk factors for poor mental health
- working with LGBTI leaders and communities, community-controlled services and other experts, we will continue and expand proven strategies to build resilience, address discrimination and minimise the factors that threaten good mental health
- working with people with mental illness, their families and carers, other experts and across government to identify better responses to mental illness co-occurring with homelessness, harmful drug and alcohol use and poor physical health
- implementing a comprehensive strategy to divert people with mental illness from the criminal justice system by strengthening pathways to early community treatment and support, and supporting reintegration for people leaving prison with serious mental illness

- strengthening collaboration between public specialist mental health services for children and young people and paediatricians, other social and community services and schools
- improving prevention, early intervention and treatment for vulnerable mothers from pregnancy through
- the post-partum and early infancy period
- working with health and other social and community services to develop effective consumer and carer
- peer support practice models for children and young people, families and carers.

These actions will be developed and finalised, and supplemented with other actions, based on advice from the expert taskforce. We will also explore ways to improve prevention in Commonwealth-funded primary care. All general practitioners have a role to respond to people's mental health needs and to help people build their resilience and manage any chronic mental illnesses they have. We will work with Primary Health Networks to develop clear strategies to promote mental health. These strategies should be tailored to the strengths and vulnerabilities of different communities, including people and groups who are at greater risk.

We have provided an extra $117.8 million for mental health in the 2015–16 budget. The largest figure of $10 mil was towards capital investment to make acute inpatient facilities safer for all. It announced development of new forensic mental health beds at Thomas Embling Hospital, and planned to develop the Orygen Youth Mental Health Care and Research Centre at Parkville.

Fifth National Mental Health and Suicide Prevention Plan

The Fifth National Mental Health and Suicide Prevention Plan (Fifth Plan) was endorsed by the COAG Health Council in August 2017. The Fifth Plan represents commitment from all governments to work together to achieve integrated planning and service delivery of mental health and suicide prevention related services.

The Fifth Plan is accompanied by an implementation plan that establishes responsibilities for agreed actions under each of the eight Priority Areas specified in the Fifth Plan.

The Commission has been given responsibility for delivering an annual report, for presentation to health ministers, on the implementation progress of the Fifth Plan actions and performance against the identified indicators. To achieve this, we are working with the coordination points identified in the Fifth Plan implementation plan, the Australian Government Department of Health, state and territory governments, Primary Health Networks and state mental health commissions.

https://www.mentalhealthcommission.gov.au/monitoring-and-reporting/fifth-plan/5th-national-mental-health-and-suicide-prevention

Australian Institute of Health & Welfare

Mental Health Services in Australia May 2021:

Restrictive Practices Paper

Data on seclusions, invol hospital acute unit admissions (separations), seclusion duration and frequency of events, physical restraint events including mechanical restraint events, 19.3% ie 1 in 5 residential MH Care episodes were for people with Invol mental health legal status in 2018-19

2018-19: Of and 1 in 7 community m h service contacts (14%0 were involuntary. Community m h care contacts: 86% vol, 14% invol

See Aust govt AIH&W web report last updated 18 may 2021

VMIAC

WE'RE COMMITTED TO ADVOCATING FOR RADICAL CHANGE.

As the peak organisation for consumers and survivors in Victoria, we are continually seeking ways to influence government policies and sector practice through systemic advocacy.

In 2018 we surveyed consumers and survivors about the policy issues that matter most. These were the top priority issues identified, in priority order:

1. Compulsory treatment

Download our Policy Position Paper on Compulsory Treatment hereDownload
Informed consent
Autonomy, bodily integrity and self determination
Supported decision making
Dignity
2. Safety, abuse, assault, cruel, inhuman & degrading treatment

Download our Policy Position Statement on Violence, Abuse and NeglectDownload
Safety, not to be retraumatised, mental & physical safety
Cruel, inhumane & degrading treatment in MH services
3. Seclusion & restraint

Chemical restraint
Download our Policy Position on Seclusion and Restraint Position hereDownload

4. Adherence to Mental Health Laws

Inadequate protection of human rights
Inconsistent adherence to mental health or human rights legislation
There is a lack of accountability and oversight under the Act
The Act fails to ensure procedural fairness

7. Discrimination

8. Gaps in care for trauma & abuse survivors

9. Less/no access to community support services (NGOs)

10. Housing and homelessness

11. Issues & impacts of ECT

12. Reduced life expectancy for consumers (10-20yrs)

13. Sexual violence in hospital

Download our Policy Position Paper on Sexual Safety in Psychiatric Inpatient Units hereDownload

14. Myths and facts about mental illness and violence

15. Psychiatric medication & side effects

16. Police Misconduct and Accountability

https://www.vmiac.org.au/policy-campaigns/policy-issues/

Community responses

Articles

‘What to expect as Victoria's mental health royal commission wraps up’

Source:

https://www.abc.net.au/news/2019-07-28/victorian-mental-health-royal-commission-wraps-up/11351220

- Vrinda Edan, from the Victorian Mental Illness Awareness Council (VMIAC), expressed doubt about how much the commission could achieve without investigating individual cases.
    - *"We know that in order to get substantial change, we need to acknowledge what's happened in the past,"* she said.
- Not investigating individual cases of treatment has left some sceptical about the commission's work.
- And while the inquiry heard numerous stories from people struggling to get into the system, it heard less about what it was like once inside.
- **One senior psychiatrist with two decades' experience as a consultant in a large metropolitan hospital said he was concerned the focus would remain on access, not the quality and appropriateness of treatment.**
- Doctor Gerry Naughtin is a mental health adviser to the National Disability Insurance Agency and said health professionals lacked the answers to key questions.
    - *"What is the evidence about what works? Do we have the outcome measures to understand what is actually being achieved? The answer is we don't,"* he said.
- **The focus seems to be largely placed on the practical recommendations:**
    - Expansion of mid-level care — between GPs and secure facilities — to address what was frequently described as the "missing middle", and widely considered crucial to getting people help before they qualify for full-blown crisis care.
    - Another is more mental health beds to alleviate pressure on hospital administrators, who the commission heard conduct twice-a-day conference

calls shuffling patients between facilities so they can accommodate as many as possible.

- *"I think we'll be able to point to significant progress in those areas," The Premier said.*
- Mr Andrews identified mid-level care and alleviating the pressure on emergency facilities as key objectives in this term of Government.

Summary Response to the Royal Commission Report

Source:

https://www.vmiac.org.au/wp-content/uploads/VMIAC_A4_4pp_SummaryResponse_V1-11.pdf

- **New Act is weak in its mechanisms for accountability:**
  - Governance and decision-making structures could mean breaches of the new Act go unchecked
  - Legal status of Advanced Statements may not be sufficiently covered
  - Holding prescribers and the use of pharmacology to account is inadequate
  - No sanctions or penalties for breaches of the Act
- **The risk of tokenism in consumer positions:**
  - VMIAC is concerned that the recommendations that include the provision for one consumer position is not sufficient and will not address current power imbalances.
  - VMIAC believes that the Chair Commissioner should be someone with lived experience and Regional Boards should be redesigned to include at least two consumer positions with the intent to move towards 50% representation.
  - VMIAC believes that the Mental Health and Wellbeing Division should aim to employ people with lived experience throughout its internal structures and in its leadership positions.

Centre for Multicultural Youth Response to Royal Commission Report

Source

https://www.cmy.net.au/cmy-news/royal-commission-into-victorias-mental-health-system-final-report/

Recommendation 53 Implementation

- "I believe lived experience is critical to ensuring we have more inclusive, accessible, and relevant support for all Victorians, regardless of background, ability, or identity." - Emily Unity, a participant of CMY's REVERB mental health program
- "We are deeply encouraged by the vision and roadmap that has been put forward, and urge the Victorian Government to continue to engage meaningfully with multicultural young people and their communities to implement the recommendations." – CEO Carmel Guerra
- The CMY particularly commends the Victorian Royal Commission final report for mentioning the importance of addressing racism to aid mental health, the focus on holistic mental health especially within young people and the important role community plays in a sense of belonging and protecting mental wellbeing.

Enabling our people: Transforming Victoria's mental health system: Perspectives on the Royal Commission's Final Report

Source:
https://www.pwc.com.au/health/enabling-our-people-transforming-victorias-mental-health-system.pdf

Legislative change assessment

- Legislative needs for the implementation of this act extends beyond repealing the 2014 Mental Health Act and making a new one.
    - Making new roles, such as peer workers and changing the responsibilities of existing roles may change workplace legislation
    - The creation of digital platforms will impact privacy and data legislation

Recommendation 53 Implementation

- **System design and planning**
    - Service integration will be needed. COVID and the move to digital platforms may provide guidance.
    - Need stronger partnerships between various sectors extending beyond the healthcare system broadly

- **Collection and integration of data to measure impact and outcomes**
    - The collection of data will enable services to measure programs and outcomes and understand where burdens on the system lie
- **Advisory panels and subject matter experts, including those with lived experience**
    - There needs to be adequate representation within the advisory panels, encompassing youth, elderly, Aboriginal and Torres Strait Islander people, rural inhabitants etc.
    - *"The expertise of people with lived experience should be acknowledged for their contribution and compensated adequately in the same way as other experts in government processes. Clear pathways for career progression, through certifications, leadership opportunities and opportunities for skills development are also needed to better engage people with lived experience in implementing programs and research."*
- **Leveraging interdependencies with other reforms and program intersections**
    - Understand reform and programs from other organisations and governmental bodies to avoid double ups and maximise efficiency of system overall

Are We There Yet? Five Human Rights Questions After Our Mental Health Royal Commission

Source:

https://rightnow.org.au/analysis/are-we-there-yet-five-human-rights-questions-after-our-mental-health-royal-commission/

- Royal Commission advanced without a Consumer Commissioner, potentially reinforcing the status quo of excluding consumers from these decisions
- Author is concerned that the new Mental Health Act will not resolve the contradiction between compulsory mental health treatments and the Convention on the Rights of Persons with Disabilities
- Questions remain as to the role that the Charter of Human Rights and Responsibilities Act 2006 (Vic) will play in the implementation of the recommendations
    - Calls for human rights impact assessments

'We are failing': Premier vows to put mental health at centre of biggest social reform in generation:

Source:

https://www.theage.com.au/national/victoria/we-are-failing-on-mental-health-premier-pledges-biggest-social-reform-in-generation-20210302-p576xe.html

- Victoria's failing mental health system will be fundamentally reformed with a new mental health act, a new independent authority to hold the government to account and up to 60 new services.
- The 3195-page final report from the Royal Commission into Victoria's Mental Health System **found people continued to have their human rights breached through compulsory treatment, seclusion and restraint – treatments which it insists must be curbed or stopped.**
- Premier Daniel Andrews has committed to implementing all 65 recommendations made in the report, which he said would "serve as our blueprint for the biggest social reform in a generation".
- The final report found the system was overwhelmed and could not keep up with the number of people who sought treatment. There was an over-reliance on medication, the perspectives of people with mental illness were overlooked, families and carers were left out, stigma and discrimination were ever present and services were difficult for many people to afford.

Lived Experience at the Heart of our Mental Health System

Source:

https://www.premier.vic.gov.au/lived-experience-heart-our-mental-health-system

Quotes attributable to Acting Premier and Minister for Mental Health James Merlino:

"For too long we haven't listened to those who know our system best. Victorians with lived experience offer a unique – and personal – insight into what works and what doesn't."

"With this Budget, we'll make sure Victorians with lived experience are at the heart of building a new mental health system from the ground up."

..As we begin to build our new mental health system from the ground up, we're putting Victorians with lived experience at the heart of our efforts.

- That includes investing $5 million towards establishing Victoria's very first residential mental health service designed and delivered by people with lived experience.
    - This service will provide short-term treatment, care and support in a community setting, providing an alternative to acute hospital-based care. Importantly, it will be designed and delivered by a workforce of people with lived experience.
- The Victorian Budget 2021/22 also delivers $18 million towards a new entity, the Victorian Collaborative Centre for Mental Health and Wellbeing.

The Centre will bring together people with lived experience, researchers and clinicians to establish best practice in adult mental health services, including conducting research, sharing knowledge and ensuring the real, lived experience of Victorians is at the heart of our response.

MEDIA RELEASE 'Lives will be saved: Mental Health Victoria welcomes Royal Commission's bold vision for the Victorian mental health system':

Source:
https://www.mhvic.org.au/images/PDF/media_releases/MHV_Ltd_RC_Media_Release_02.03.21_FINAL.pdf

Mental Health Victoria welcomes today's public release of the final report of the Royal Commission into Victoria's mental health system. **Mental Health Vic CEO Angus Clelland** said the release of the Royal Commission's final report during an historic joint sitting of both houses of the Victorian Parliament today was the most significant development in mental health since deinstitutionalisation in the 1990s. It is the culmination of more than two decades of outstanding advocacy efforts from individuals, carers, families, academics, and mental health professionals from across Victoria.

- "Far from just recommending more of the same, the Royal Commission's final report articulates a bold new vision for mental health service design, commissioning, delivery and governance," Mr Clelland said.

- "We commend the Royal Commission's focus on removing the barriers Victorians face when trying to get help and emphasis on making services available in the community, particularly in regional Victoria. "For too long, Victorians have had few options but to present to hospital emergency departments or to suffer in silence. The reforms announced today will change all that," he said.
- *"The reform process will create thousands of new mental health jobs across Victoria and across all mental health disciplines – including peer workers, nurses, social workers, occupational therapists, psychologists, psychiatrists and community workers. Growing the workforce will be a critical early priority," he said.*

VCOSS

A call to action on mental health:

Last month the Victorian Auditor General delivered a clear and direct wake-up call to the Victorian Government, on its failure to address the gaps in mental health services in Victoria.

"DHHS has done too little to address the imbalance between demand for, and supply of, mental health services in Victoria."

On almost every key statistic in the report, Victoria went backwards:

More people with mental illness presented to emergency departments
More people were admitted to hospital for acute mental health care
More people were readmitted within 28 days of leaving hospital
The rate of suicide has remained relatively stable, but there will need to be significant change if we are to get close to our target of halving the rate of suicides by 2025.

Echoing long held concerns of many in the community sector, VAGO was critical of the Government's 10-year mental health plan; citing its lack of actions and measurable targets and failure to demonstrate how we will address the growing demand for help.

"The lack of sufficient and appropriate system-level planning, investment, and monitoring over many years means the mental health system in Victoria lags significantly behind other jurisdictions in the available funding and infrastructure, and the percentage of the population supported."

It feels like a call to action. Victoria cannot keep doing what it has been doing; filling up hospital beds, reducing services, risking people's lives.

The Royal Commission into Mental Health presents a once-in-a-lifetime opportunity to promote a mentally healthy Victoria, and change the way we as a society support people experiencing mental health concerns. In the meantime, VCOSS is calling for emergency funding to save community mental health services affected by the transition to the NDIS, and stop the loss of some of our most experienced and valuable staff.

https://vcoss.org.au/analysis/2019/04/a-call-to-action-on-mental-health/

Ensure that people experiencing mental illness continue to get the support they need:

Provide emergency funding to the community mental health sector
The Victorian Government has taken a bold step in calling a Royal Commission into Mental Health, which can examine the pressures at every point of the mental health system. We hope that the Royal Commission will give us a roadmap for the future. But the Victorian Government must also act now, to address immediate issues.

An estimated $200 million each year is needed to provide adequate community mental health support to 35,900 Victorians.[2] The Government's commitment to $70 million over two years for community mental health will help, but will not reach everyone.
An extra funding boost will attract experienced mental health workers back into the workforce to support people who no longer receive community mental health services.

...Invest in assertive outreach suicide prevention programs

VCOSS applauds the Victorian Government's recent announcement of an expansion of the Hospital Outreach Post-suicidal Engagement Program (HOPE) to six more hospitals.[11] The Victorian Government can continue investing in and expanding assertive suicide prevention responses.

https://vcoss.org.au/delivering-fairness/healthy-victorians/

Nurses & Midwifery - Victorian Branch website

On The Record - Re-writing the mental health legislation
7 July 2021

...ANMF (Vic Branch) Assistant Secretary Madeleine Harradence, who chairs the working group, said 'Mental health nurses inherently know that rights of consumers are very important, however it is critical that we also acknowledge nurses' rights and we get the balance right'.

'Nurses, midwives and personal care workers know their consumers, patients and residents are falling through the gaps in our the mental health system.

'Our members' holistic perspective will be critical to getting this right and ensuring that mental and physical health are viewed as equally important.'

... The new legislation

The Andrews Government says the new Act will be in place mid-2022.

This new legislation, according to the royal commission recommendations, should go 'beyond permitting compulsory treatment' and 'reflect the views, values and preferences of people living with mental illness or psychological distress, families, carers and supporters,

promote human rights, enable strong governance, and communicate how the intentions behind the legislation should apply in practice'.

The royal commission said the purpose of the new Act was 'to promote mental health and wellbeing in Victoria'.

The successful implementation of the other royal commission recommendations, including ongoing workforce education and training, will be critical to legislative reform.

...

The new Act should have three purposes:

to promote good mental health and wellbeing;

to reset the legislative foundations underpinning the mental health and wellbeing system

to support the delivery of services that are responsive to the needs and preferences of Victorians.

The government should also ensure the Mental Health and Wellbeing 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; and providing a diverse range of comprehensive, safe and high-quality mental health and wellbeing services.

clarifies the roles, responsibilities and governance arrangements of the new mental health and wellbeing system

establishes the bodies and roles referred to in other recommendations, including the Mental Health and Wellbeing Commission (refer to recommendation 44), the Chief Officer for Mental Health and Wellbeing (refer to recommendation 45(1)) and Regional Mental Health and Wellbeing Boards (refer to recommendation 4(2))

strengthens accountability mechanisms and monitoring arrangements for service delivery

specifies measures to reduce rates and negative impacts of compulsory assessment and treatment, seclusion and restraint

simplifies and clarifies the statutory provisions relating to compulsory assessment and treatment such that they are no longer the defining feature of Victoria's mental health laws

specifies the ways in which information about mental health and wellbeing may be collected and used.

RECOMMENDATION 43

FUTURE REVIEW OF MENTAL HEALTH LAWS

The Royal Commission recommended that the Victorian Government:

commission an independent review of Victoria's mental health laws five to seven years after the enactment of the Mental Health and Wellbeing Act.

co-design terms of reference for the review that focus on ensuring mental health laws remain contemporary, effective and responsive to the needs and preferences of consumers, families, carers and supporters.

as part of this review, consider the role and functions of the Mental Health Tribunal and Chief Psychiatrist to ensure they remain appropriate.

https://otr.anmfvic.asn.au/articles/re-writing-the-mental-health-legislation

2021-22 Victorian State Budget: Response to the VRC's Recommendations.

Mental Health Reform Victoria Strategic Plan 2020-2022

Source:

1. https://www.mhrv.vic.gov.au/sites/default/files/documents/202101/Mental%20Health%20Reform%20Victoria%20Strategic%20Plan%202020-22%20--%20November%202020_0.pdf
2. https://www.dhhs.vic.gov.au/mental-health-reform-victoria-questions-and-answers

The seven recommendations MHRV is responsible for implementing are:

1. The creation of a Victorian Collaborative Centre for Mental Health and Wellbeing to bring together different skills and expertise to drive better mental health outcomes for all Victorians.
2. An additional 170 youth and adult acute mental health beds to help address critical pressures in areas of need.
3. Expansion of the Hospital Outreach Post-suicidal after Engagement (HOPE) program into all area mental health services and linked to sub-regional health services as well as a new assertive outreach and follow up care service for children and young people, to increase the availability of support and outreach for Victorians at risk of suicide.
4. The creation of an Aboriginal Social and Emotional Wellbeing Centre and expansion of Aboriginal social and emotional wellbeing teams across the state.
5. Establishing Victoria's first residential mental health service, as an alternative to an acute admission, designed and delivered by people with lived experience of mental illness.
6. Expanding and supporting consumer and family-carer lived experience workforces.
7. Addressing workforce shortages and preparing for reform including through the provision of more training and recruitment pathways to boost the number of graduate nurses and allied health professionals in public mental health services.

- Recommendation eight, to adopt a new approach to mental health investment, is being implemented by the Department of Treasury and Finance, and the Department of Premier and Cabinet.
- Recommendation nine is to establish a new administrative office. This has been achieved with the establishment of MHRV.

2021-22 Victorian State Budget Mental Health Highlights: Response to the VRC's Recommendations.

Source:
https://www2.health.vic.gov.au/mental-health/mental-health-reform/vic-state-budget-mental-health-highlights-2021-22

Proposal Includes:

1. **A New System with Community Based Systems at its Core:**

The Victorian Government is investing in a range of new services so people can access treatment, care and support in their local community. This means for most people, help will be available close to home, their families, carers and support networks.

A new service system to meet individual needs:

- $264 million for the first 20 of up to 60 new Local Adult and Older Adult Mental Health and Wellbeing Services to help people access treatment, care and support close to their home and community. This includes six fast-tracked sites in Benalla, Brimbank, Frankston, Greater Geelong, La Trobe Valley and Whittlesea. *This responds to Recc 3 in the Royal Commission's Final Report.*
- $954 million for 22 reformed Adult and Older Adult Area Mental Health and Wellbeing Services to help people with more complex needs. This will help better support the mental health and wellbeing of adults and older adults with higher levels of need. *Royal Commission Final Report Recc 3.*
- $196 million for dedicated services to support families through 13 new Infant, Child and Youth Area Mental Health and Wellbeing Services. *Royal Commission Final Report Recc 3 and 19.*

2. **Supporting Children & Young People**

Early Intervention: The Victorian Government is investing in more mental health support for children and young people. The State Budget provides extra funding for schools to prioritise the mental health and wellbeing of students.

Tailored care for young people:

- $266 million to deliver treatment, care and support for young people aged 12-25 through a dedicated youth mental health and wellbeing system. *This responds to Recc 20 in the Royal Commission's Final Report.*

Mental health reform in education:

- $200 million for schools to deliver mental health programs and activities that meet the needs of their students and school community. This means extra programs, staff and supports to help students when and where they need it most. *Royal Commission Final Report Recc 17.*

More care options for young Victorians:

- $141 million for five new Youth Prevention and Recovery Care Units (Y-PARCs), totalling 50 beds specifically for young people aged 16 to 25 years. The units will provide sub-acute treatment, care and support in

Melbourne's North Eastern Metropolitan region as well as the Barwon South-West, Gippsland, Grampians and Hume regions. *Royal Commission Final Report Recc 21.*

- $16 million for four new Child and Youth HOPE (Hospital Outreach Post-suicidal Engagement) sites, specifically designed and delivered for children and young people. *Royal Commission Interim Report Recc 3.*
- $16.3 million to expand our Youth Mobile Targeted Assertive Outreach teams, which provide support to young people in their homes or other settings. This will see these services delivered state-wide. *Royal Commission Final Report Recc 20.*

3. **Recognising Lived Experience Leadership**

Nobody knows our mental health system better than the people who've experienced it. That is why the expertise of people with lived experience of mental illness or psychological distress will be central to the work ahead.

A mental health and wellbeing system with lived experience at the centre

- Funding is provided for a new non-government agency, residential service and website led by people with lived experience of mental illness or psychological distress.
- People with lived experience will be partners throughout the design and delivery of both the new lived experience agency and the new residential service. Importantly, people with lived experience will deliver the new services and programs run by both these organisations. *This responds to Recc's 29 and 6 in the Royal Commission's Final Report, and Recc 5 of the Royal Commission's Interim Report.*

4. **Supporting Families & Carers**

This funding package ensures the voices of families are being heard at the heart of our system, while also recognising the additional support they need in caring for a loved one.

Families, carers and supporters:

- $93 million in dedicated support for families and carers, including eight new family and carer-led centres across the state. The centres will provide tailored information, connections to services, access to emergency funding, and links to local family and carer support groups. Programs will expand supports for young carers, children and young people who have a family member living

with mental illness through peer-support, workshops, educational programs, camps, mentoring and personal and social development initiatives. *This responds to Recc's 31 and 32 in the Royal Commission's Final Report.*

5. Supporting Aboriginal Victorians

   Aboriginal people in Victoria will have more choice in how and where services are provided and where they receive care. These new initiatives will help Aboriginal people, communities, and families to access and receive safe, inclusive, respectful, and responsive services.

   - $116 million to fund Aboriginal-led centres and services to provide culturally safe and appropriate care for Aboriginal people, families and communities. This includes funding to Aboriginal community-controlled health organisations for social and emotional wellbeing services for children and young people. *This responds to Recc 33 in the Royal Commission's Final Report and Recc 5 in the Royal Commission's Interim Report.*

6. **Supporting Victoria's Diverse Communities**

   The Victorian Government supports the Royal Commission's vision of a safe, responsive and inclusive mental health and wellbeing system. This State Budget includes new and expanded existing programs to ensure Victoria's diverse communities have equal access to mental health and wellbeing services.

   Improving accessibility for diverse communities:

   - $6.4 million in funding for Switchboard's Rainbow Door to increase support for young LGBTIQ+ Victorians, and additional support for young carers. *This responds to Recc 34 in the Royal Commission's Final Report.*

7. **Delivering Acute Mental Health Care**

   The State Budget delivers alternatives to a hospital emergency department for people in crisis, including home-based care. Additional mental health beds will improve access for Victorians needing acute care, and ease pressure on hospital emergency departments.

   More beds for acute care:

   - Commissioning a total of 104 new acute mental health beds across Victoria – including 35 acute mental health beds specifically for Victorian women in need. *This responds to Recc 11 in the Royal Commission Final Report.*
   - $10.9 million will deliver five additional acute mental health beds at South West Healthcare in Warrnambool.

- $36.3 million will support 24 ‘Mental Health Hospital in the Home’ beds, to continue delivering an alternative to acute hospital based treatment, providing wraparound care for Victorians within the comfort of their own homes and close to their support network.
- $5.1 million for the development and trial of an intensive 14- day support program for adults who are experiencing psychological distress, including outreach within 24 hours of referral. *Royal Commission Final Report Recommendation 27.*

Improvements for Thomas Embling Hospital in Fairfield:

- $349.6 million to expand and improve the Thomas Embling Hospital in Fairfield so it can continue to meet the needs of people who require a very high level of care, treatment and support. *Royal Commission Final Report Recc’s 38 and 13.*

More information: https://www.vhba.vic.gov.au/mental-health

8. Promoting Good Mental Health & Wellbeing

New funding ensures that mental health and wellbeing promotion and suicide prevention will focus on the places that positively shape our mental health and wellbeing, such as our schools, workplaces and homes.

Suicide prevention and response:

- $173.3 million over four years to deliver new and expanded suicide prevention programs and services for children, young people and adults. A new Suicide Prevention and Response Office will facilitate a government and community-wide suicide prevention and response effort. This includes continued support for the successful HOPE (Hospital Outreach Post-suicidal Engagement) program. *This responds to Recc’s 26 and 27 in the Royal Commission’s Final Report.*

Promoting good mental health and wellbeing and preventing mental illness:

- Funding is provided for a new Mental Health Promotion Office to deliver a mental health and wellbeing strategy for Victoria that prioritises public health principles, human rights and reducing inequalities. *Royal Commission Final Report Recommendation 2.*
- Funding is provided for social prescribing trials to connect adults, particularly older people to activities in their community to combat loneliness and social isolation. Social prescribing allows healthcare professionals to refer people to

local activities to help in their recovery. *Royal Commission Final Report Recc 15.*

Housing support for adults and young people living with mental illness:

- $46 million for 2,000 dwellings for adults living with mental illness who require ongoing intensive treatment, care and support, and to start planning for a further 500 Youth Supported Housing places for young people with mental illness who are experiencing homelessness. *Royal Commission Final Report Recc 25.*

9. **Supporting Rural & Regional Victoria**

The Victorian Government is taking action to improve access to mental health and wellbeing services in rural and regional Victoria. This State Budget invests in regional mental health support services – making sure help is available in every corner of our State.

Support for people in rural and regional Victoria:

- $2.3 million to trial two new digital services, so rural and regional Victorians can access care from their own homes. *Royal Commission Final Report Recc 39.*
- $17 million for the HOPE (Hospital Outreach Post-suicidal Engagement) program to extend to nine sub regional sites in Bairnsdale, Bass Coast, Central Gippsland, West Gippsland, Hamilton, Horsham, Echuca, Swan Hill, and Wangaratta. *Royal Commission Interim Report Recc 3*

Good mental health and wellbeing in local communities:

- Funding is provided to continue the current 'Youth Live 4 Life' and 'Be Well in the Ranges' programs, tailored regional mental health programs that work closely with young people and those affected by bushfires, respectively. *Royal Commission Final Report Recc 15.*

Building the mental health and wellbeing workforce in country Victoria:

- $11 million for a Rural and Regional Workforce Incentive Scheme, attracting, training and recruiting more mental health professionals to our country communities. *Royal Commission Final Report Recc 57.*

10. **Supporting People with Higher Levels of Needs**

The new system will be more responsive to individual needs. State-wide services will be better linked and coordinated, and more services will be provided locally for people with higher levels of need.

Mental health-led emergency responses for Victorians in crisis:

- $7.5 million will commence work to establish Ambulance Victoria as the lead responder to triple zero calls primarily concerning mental illness or psychological distress, This ensures Victorians have access to a health professional when they're experiencing a crisis and need the support of emergency services. *Royal Commission Final Report Recc's 3, 8 and 10.*

Support for people with lived experience of trauma:

Support to design a new State-wide Trauma Service to bring together mental health practitioners, trauma experts, peer workers and Victorians with lived experience of trauma to undertake research, education and training to support our mental health workforce deliver trauma-informed care. *Royal Commission Final Report Recc 23.*

Support for people living with mental illness and substance use or addiction:

- Programs for specialist services and integrated support for people living with mental illness and substance use or addiction. *Royal Commission Final Report Recc 36.*

Support for people in the criminal justice system:

- Programs to ensure consistent treatment and support for adult and young people at risk and suitable treatment for people within the justice system and linking them to appropriate mainstream services after their release. *Royal Commission Final Report Recommendation 37.*

11. Building a Sustainable Workforce

Plans to fundamentally redesign our mental health system cannot be delivered without the support of a highly skilled workforce. This budget will create new jobs in the mental health sector and more training and education opportunities. The reforms will further expand, diversify and support the mental health workforce. There will be new incentives and supports for mental health professionals to train, live and work in regional and rural communities.

Expanding and supporting the mental health workforce:

- $206 million to expand and support the mental health and wellbeing workforce to deliver a reformed system. *This responds to Recc 57 in the Royal Commission's Final Report and Recc 7 in the Royal Commission's Interim Report.*

This total funding includes:

- $120.4 million for training support, delivering 120 graduate placements for nurses, 140 postgraduate mental health scholarships, and additional graduate placements for allied health professionals and additional psychiatry rotations for junior doctors.
- $40.7 million to expand Victoria's lived experience workforces. This includes continuation of our Free TAFE course for Certificate IV in Mental Health Peer Work, improving organisational readiness, increasing cadetship positions as well as improving educational and career pathways to build a pipeline of lived experience workers.

12. Leading Research & Innovation

The Victorian Government will commence work on realising the Royal Commission's vision of a system that is digitally-enabled, continually learning and evolving.

Establishing the Collaborative Centre for Mental Health and Wellbeing:

- $18 million to establish the Collaborative Centre for Mental Health and Wellbeing. The Collaborative Centre will bring together people with lived experience, researchers and clinicians to develop and provide adult mental health services, conduct research and share knowledge, including working with services and research organisations in rural and regional areas. The Government intends to introduce legislation to establish the Collaborative Centre in 2021, so an independent Board can be established early in 2022.

  This responds to Recc 63 in the Royal Commission's Final Report and Recc 1 in the Royal Commission's Interim Report.

A new approach to information management to facilitate better information-sharing for consumers:

- $2.5 million commence work to improve service planning, commissioning, and performance monitoring in future. This includes planning for a new user-friendly online consumer portal connected to the Mental Health Information and Data Exchange – allowing consumers to view information about themselves and authorise sharing of information with members of their care team, including families, carers and supporters. *Royal Commission Final Report Recommendation 62.*

The Royal Commission has outlined immediate priorities and a series of key dates for delivery of the recommendations:

Source:

https://www2.health.vic.gov.au/mental-health/mental-health-reform

The Victorian Government has announced a record $3.8 billion investment in mental health and wellbeing. The 2020-21 Budget provided $868.8 million in mental health funding, of which over **$578 million** is for the implementation of Royal Commission recommendations.

Progress includes:

- Delivery of new mental health beds
- Strengthening the mental health workforce
- Expanding existing services to make them available to more Victorians.

The Victorian Budget 2020/21 $868.6 million includes funding the rollout of the interim recommendations from the Royal Commission into Mental Health

Source:

https://www.premier.vic.gov.au/putting-mental-health-victorians-first

- $492 million to deliver 120 mental health beds in Geelong, Epping, Sunshine and Melbourne. This is an addition to the 24 Hospital in the Home beds announced earlier this year bringing the total to 144.
- An additional $18.9 million is provided for 35 acute treatment beds for public mental health patients in private health services.
- The Budget invests $21.4 million to support the statewide expansion of the Hospital Outreach Post-Suicidal Engagement (HOPE) service, with individual, intensive and one-on-one support for Victorians as they rebuild their lives.

"As we begin the work to rebuild our system, learning from the lived experiences of Victorians is vital".

- $2.2 million will help design the Victorian Collaborative Centre for Mental Health and Wellbeing, a new centre dedicated to bringing together the experts on our mental health system – researchers, academics and those who've experienced it firsthand.
- A further $16 million will help those same Victorians use their own very real and personal experience to support and champion for others in need – with new training positions, education and opportunities for employment. This includes $7.3 million for a service designed and delivered by people with lived experience.

- The Budget also includes $8.7 million to establish a residential mental health service, specifically designed and delivered by those with lived experience. This service will deliver short-term care and support in a residential community setting, designed as a true alternative to acute hospital-based care.
- The Budget includes additional training opportunities to support students and job seekers looking to pursue a career in the mental health sector. It includes $1.9 million for allied health, nursing and medical undergraduates to work part-time in community mental health settings while completing their studies. A further $3.1 million will support experienced general nurses to retrain as mental health nurses; and $7.7 million for specialist training roles in child and adolescent psychiatry to address the shortage of trained psychiatrists in these roles, including in regional areas.
- A further $7.7 million in funding is provided to begin to address workforce shortages in the mental health sector, to support future expansion of the workforce. This includes funding to increase the annual number of junior medical officer psychiatrist rotations, graduate nurses and postgraduate mental health nurse scholarships.
- The Budget also delivers $20 million towards upgrading state-owned facilities across Victoria. The Budget will also deliver an extra 19,000 hours for community mental health support.
- Supporting the mental health of our young people will remain critical as we begin our recovery, with this year's Budget investing $47.8 million dedicated to early intervention support for young people – recognising that sometimes the most important help is the earliest help, as well as $7 million to support critical research into youth mental health and operations at the Orygen centre.

Other key Budget investments include:

- $19.4 million to support mental health clinicians at the Victorian Fixed Threat Assessment Centre and deliver specialised services to meet the needs of people referred by the Centre
- $4.4 million to improve culturally appropriate support for Aboriginal Victorians
- $3.9 million for providing mental health and wellbeing support for asylum seekers
- $152 million to support and provide mental health services in direct response to the COVID-19 pandemic.

Mental Health and Wellbeing Act: Update and Engagement Paper Summary

Russell Kennedy Lawyers, Australia July 8 2021

See extracts about Compulsory treatment, seclusion and restraint:

The Victorian Department of Health (Department) last month released an Update and Engagement Paper (Engagement Paper) addressing the Final Report (Report) of the Royal Commission into Victoria's Mental Health System (Royal Commission) delivered on 2 March 2021. The Engagement Paper describes the development of the new Mental Health and Wellbeing Act (new Act), expected to be in place by mid-2022, and proposals on policy issues that require more input to make sure they meet the Commission's recommendations, which the Victorian Government has committed to implementing in full….

Compulsory treatment

The Engagement Paper foreshadows a redesigned system for compulsory treatment and assessment under the new Act that may provide, among other things, that compulsory treatment only be used as a last resort and with the least possible restrictions on people's rights.

Under the new Act, the criteria for compulsory treatment orders and treatment orders will be made more onerous. There will also be greater flexibility around who may be authorised to make a 28-day temporary treatment order beyond only authorised psychiatrists.

Seclusion and restraint

In light of the Royal Commission's recommendations, the Engagement Paper flags changes under the new Act in respect of seclusion and restraint, including:

greater transparency on the use of seclusion and restraint as a last resort; and

introducing the regulation of chemical restraint
Governance and oversight

On the recommendation of the Royal Commission, the Engagement Paper confirms that the new Act will establish the following new entities / roles:

Mental Health and Wellbeing Commission The Commission will primarily be responsible for system-wide oversight of the quality and safety of mental health service delivery, advising government on areas of concern and improvement and play a key role in monitoring achievement of some of the Royal Commission's key goals.
Chief Officer for Mental Health and Wellbeing The Chief Officer will principally develop mental health and wellbeing strategy, policy and guidelines and develop and support the mental health and wellbeing workforce.

Regional Mental Health and Wellbeing Boards The Regional Boards will provide a platform for greater integration across services beyond the mental health and wellbeing system, including both Victorian Government and Commonwealth Government funded services.
Statewide and Regional Multiagency Panels The Regional Multiagency Panels will aim to bring together different service providers to support collaboration and accountability in providing integrated treatment, care and support to this group of consumers. A statewide panel will be legislated under the new Act and chaired by the Chief Officer for Mental Health and Wellbeing. It will comprise the chairs of each Regional Multiagency Panel.

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