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# SUBMISSION

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Victorian Mental Health and Wellbeing Act:  
update and engagement paper

**Victorian Department of Health**

sent via [mhwa@health.vic.gov.au](mailto:mhwa@health.vic.gov.au)

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A U S T R A L I A

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## Introduction

Lived Experience Australia is a national representative organisation for Australian mental health consumers and carers, formed in 2002 with a focus on the private sector. Our core business is to advocate for systemic change, empowerment of consumers in their own care, promoting engagement and inclusion of consumers and carers within system design, planning and evaluation and most importantly, advocating for consumer choice and family and carer inclusion.

LEA is represented in Victoria by our Victorian State Advisory Forum and, as such, we are providing a Submission herewith to inform the Victorian Department of Health consultation about the proposed *Mental Health and Wellbeing Act: update and engagement paper*. This comes from the perspectives and experiences of people with lived experience of mental health issues, their families, and carers.

Whilst LEA welcomes the recommendation from the Royal Commission into Victoria's Mental Health System for the replacement of the current *Mental Health Act 2014* with a new Mental Health and Wellbeing Act, we are concerned about some aspects contained within the Engagement Paper which will relate to the new Act.

We note the section 1.2 Why are we developing a new Act? Which details the needs for clarity, the rights of people with lived experience, roles and responsibilities, legal relationships etc that exist in the system. However, our concerns are mostly around what we interpret as aspirational aspects of the new Act and how this will be interpreted into the legal framework. We question how new service models, cultural change, support for reduction in restrictive practices and compulsory treatments can be achieved as a goal, but again within a legal framework.

We fully support the inclusion of a representative from VMIAC and Tandem and feel a sense of confidence as to their inclusion.

## 2 Objects and principles of the new Act

Comments LEA would ask that consideration be given to including the following:

### Language

#### Vagueness and aspirational aspects

As mentioned above, LEA has some concerns around the vagueness and aspirational aspects contained within the Engagement Paper, which will be difficult to interpret into legal definitions with appropriate actions required by law.

We do not believe that changes to systems, models of care or practices can be made through a legislative instrument such as this Act. It concerns LEA that some of the discourse may have the effect of undermining the clinical work of the current workforce where the whole system is designed to provide appropriate, quality, respectful treatment, and care.

This Act seems to be referencing poor clinical practices, and LEA does not believe this is a way to bring about changes. Rather, it may have unintended consequences and adversely affect good clinicians so that they become too cautious given the regulatory monitoring and reporting. LEA does not believe this brings about positive change and reflects badly on those clinicians who work under enormous stress, who are overburdened and doing their best to provide consumers and families with the best possible outcomes.

### Psychological distress

If as suggested, the term psychological distress is introduced, it would cover many people who are not the subject of mental health legislation. The Act pertains to those with serious, complex, enduring mental illness and care must be taken to ensure it is these people who are subject to treatment and care under the Act not a far broader number of people which the term psychological distress would involve.

### Interpretation

Again, LEA is concerned about how aspects of the Engagement Paper will be interpreted if there is vagueness about actions contained within this legislation.

Carer involvement and partnership is welcomed, but this must be couched with appropriate information sharing. We know that carers know the person well, have critical input into how they appear, what struggles they have, are early to recognise deterioration and must have at the very least, an opportunity to provide information and to be taken seriously when expressing their concerns. They must also be provided with appropriate and sufficient information to enable them to continue their responsibilities within the caring role.

### Question 1:

LEA is also concerned how improvements and implementation of systemic changes can be legislated through this Act. We question whether a non-legalistic approach could be adopted and find it hard to reconcile aspects with the wording in the Engagement Paper with specific recommendations of the Royal Commission (Recommendation 42(2)(a) and 56 (1), particularly around these objectives and principles.

### Least restrictive practice

LEA fully supports the focus on providing treatment and care in the least restrictive manner possible. However, there are times when a consumer can refuse to voluntarily take medications for example, in the belief that they are well and do not require anything, despite displaying clear deterioration in their mental health and at high risk of harm to self or others. LEA fully supports self-determination and understands the fear of people taking medications, some in quite high doses, and the resulting side effects, however there are some circumstances, diagnoses, and some crises (e.g. significant self-harm, suicide attempt) where medication is required for stabilisation and recovery, alongside a supporting therapeutic approach underpinned by meaningful person-centred engagement.

### Question 2

LEA would like to see a tightening of language and believe it would go some way to improving the objectives and principles.

## 3. Non-legal advocacy, supported decision making and information sharing

### 3.1 Non-legal advocacy

LEA believes a consumer must be provided with a written copy of their Rights under this legislation and agree with the right to access an advocate to support them. LEA is not convinced that at some times a consumer has the ability to decide whether to 'opt out' of such an important service. This could be a role for suitably trained peer workers. LEA notes at present there is only one advocacy service, Victoria Legal Aid which provide Independent Mental Health Advocacy, but is not established under the current Mental Health Act.

We note from the Engagement Paper that under the new Act, there will be the issuing of operating guidelines for these types of services. Whilst operating guidelines are useful, there is no mandatory

requirements attached to these as we understand and, given the crucial nature of this type of service, we believe care needs to be taken in appointing a suitable service.

### Question 3:

LEA considers 3.1 does meet the proposal of the Royal Commission Recommendation 56(2) with the above references.

### 3.2 Supported decision making

Supported decision making is crucial for a consumer to make decisions which are in his/her/their best interest.

#### Statement of rights

LEA supports the promotion of statement of rights, advance statements, nominated persons and second psychiatric opinions.

Statement of Rights and Responsibilities are made available to consumers within inpatient units etc and are to be expressed verbally to them to ensure an understanding. Evidence is provided by the consumer signing as to receiving a copy. LEA suggests that extending this to ensure that people who are subject to compulsory assessment or treatment orders are provided with a secondary more specific Statement of Rights.

#### Advance Statements

Advance Directives or Statements are being promoted through the 2<sup>nd</sup> Edition of the National Safety and Quality in Health Services Standards and LEA believes this is a good approach. Assistance and support should be provided to consumers, families, and carers to ensure the Statement reasonably reflects the consumer's wishes which could be provided via a pamphlet, poster etc made whilst the consumer is well. However, it should be noted that, whilst the Advance Statement details a person's preference, the Advance Statement can be overridden by clinician determination as they do not have relevance under the law.

LEA believes that communication is a key to good care, and this is also reflected in the requirements of various aspects of the Act.

#### Nominated persons

Clarification is required as to whether families, carers, and peer workers would be considered under this aspect of the Act.

#### Second psychiatric opinions

Given the powers bestowed under the Act, LEA believes, as with all aspects of health, the right to obtain a timely second opinion should be embedded across the system, not just articulated within this Act.

#### Oversight and monitoring

LEA is of the view this is a reflection on clinicians' practices and as articulated earlier, we do not believe the Act is the way to bring about change.

We are seeing enormous reporting requirements and loads currently, and this takes time away from talking with consumers. For stabilisation and recovery, what is urgently needed is clinicians spending time away from administrative duties, and doing what they do best, engaging with consumers in conversations. Consumers complain about clinicians now spending too much time in the nurses' station in inpatient units, rather than talking with them, supporting their needs and requests.

LEA believes that adding any further load to an already overburdened system of reporting is not necessarily in the consumer's best interest.

#### Question 6

LEA believes there is an over requirement articulated within the Engagement Paper on clinicians' time and therefore believe a review of this section is needed to make it relevant, without constricting clinician time for more administrative tasks.

### 3.3 Information collection, use and sharing

Enabling a process for consumers to access their own information is already available, but LEA supports the issuing of guidelines, but note also that the Health Complaints Commission can make recommendations, but LEA does not believe they can mandate any actions.

We certainly agree with increased information sharing with families, carers and supporters but wonder how this might be initiated. How will this be achieved; how will it be implemented in a practical sense, i.e., changes to electronic records, noting next of kin is not necessarily the person providing the main support.

Also of concern is the sharing of information across and between services where consent to that sharing will not be required. Consumers have the right to request information is not shared, and it will be crucial that this is articulated within any Statement of Rights.

#### Questions 7 and 8

LEA agrees that this section fulfills recommendation 42(2)(g) of the Royal Commission and note that Recommendations 30(4); 61 and 62(1) we believe do not necessarily apply to the Act. LEA questions the development of the standards for services and practitioners and believes this is outside the mandate of the Act including which entity will develop the standards, i.e., Victoria Health, the Australian Commission on Safety and Quality in Health Services, or another entity.

LEA similarly questions Recommendation 62(1)(d) and wonders whether the MyHealth record would contain this information and (e) noting that any data repository and associated clinical registries especially for mental health, requires strict monitoring of access, collection, and reporting in a de-identified manner, together with cyber-attack or data breach prevention or monitoring as much as is possible, particularly when outcome measures are incorporated into any data.

## 4. Treatment, care, and support

As mentioned previously, LEA does not support the inclusion of psychological distress within an Act which has restrictive powers over individuals. LEA does not support using the Act to change or guide the elimination of restrictive interventions, rather other mechanisms or processes would be preferable.

Further, a clinician's requirement to consider the impact of compulsory treatment on an individual is very subjective and will be hard to determine as many consumers can appear quite rational (especially during a brief assessment process) yet are very unwell.

LEA is further concerned about allowing professionals other than a well-qualified doctor (in that of a psychiatrist) to authorise temporary treatment orders. We believe that this power should be restricted to that of a psychiatrist.

### 4.1 Strengthening principles and accountability

Trauma issues are prevalent in the mental health system with many consumers experiencing this in some form. Being aware of and responding appropriately to people with a history of trauma is and

should be a crucial issue for clinicians across the system, and LEA believes the Act is not the appropriate place for this. However, LEA does agree that taking into consideration a person's trauma history is crucial in determining action under the Act. Restrictions reflect a person's lack of power in a situation, loss of control, isolation, and re-traumatisation. This is also part of the mental health system's requirements in any areas in which people are treated and supported more broadly.

LEA again highlights the wording in the Engagement Paper around 'formal reporting requirements established under the new Act to help drive widespread change in the use of compulsory treatment'. This language again reflects poorly on the clinicians who work in the difficult area of mental health inpatient settings. It infers that clinicians are enforcing the use of compulsory treatment across the board, and this is particularly unhelpful if any governments are to attract and retain the mental health clinical workforce. It may also have the effect of clinicians questioning themselves or others, and this may not be in the best interests of consumers, especially families, carers, supporters, or the community.

LEA is also concerned about the proposed changes to language from 'preventing serious deterioration in the person's mental or physical health' with 'preventing the person experiencing serious distress'. These represent two entirely different foci in our opinion and are therefore open to interpretation, which is a situation that an Act should not have. Rather, clear directives are required under the legislation.

#### Mental Health Tribunal

Consumers' ability to request a conference is crucial, but LEA believes this should be mandatory given the implications of the application to their freedom under the Act. The Engagement Paper also references that a conference WILL NOT be required if a consumer objects. Surely this is a misstatement, as LEA believes that this is the most crucial aspect and the time when a conference MUST be held. We do not understand the logic of this as it is currently reflected.

#### Use of regulation to enable further changes

LEA again stresses that we disagree with a broader range of professionals to authorise temporary treatment orders. We query the range of understanding of social workers, for example, as to the medications, side effects, reliability, efficacy etc. LEA a Treatment Order is the area which should be restricted to psychiatrists only.

#### Questions 9 and 10

Per our comments above.

## 4.2 Reduce the rates and negative impacts of seclusion and restraint

### Greater transparency of the use of seclusion and restraint as a last resort

LEA is of the understanding that, unless there have been changes in this legislation over the last couple of years, psychiatrists are required to complete and sign a form when determining the use of seclusion and/or restraint.

### Accountability

LEA supports the Mental Health and Wellbeing Commission to have the power to undertake audits, investigations and to report to parliament. We query the powers of the Health Complaints Commission and whether there is duplication.

### Chemical restraint

The use of chemical restraint is questionable, i.e., will the Act relate to the aged care sector, for example. Or could a consumer complain that because of the medication they are accessing, their mornings are affected by undue tiredness as a result. This section needs careful consideration.

## 5. Governance and oversight

LEA considers this is an area that is beyond our ability to comment on, except to say that the new Act will create numerous new entities in what is often considered more broadly as an over representation of bureaucracy.

We believe the Mental Health and Wellbeing Commission is a necessary entity and LEA hopes this will be established as a statutory entity. The powers to require the responses to issue arising from complaints is a crucial component and to issue compliant notices however, caution is required as this also refers to service providers. A clarification as to whether this term also relates to service clinicians is needed. This could raise issues with AHPRA if a clinician falls under this category.

LEA also has concerns that the position of Chief Psychiatrist will report to the Chief Officer for Mental Health and Wellbeing and wonder if this position should have a clinical background.

## 6. Conclusion

LEA thanks Victoria Health for the opportunity to consider the ramifications of the changes to the proposed Victorian Mental Health and Wellbeing Act.

We would be very pleased to provide any clarification of the issues raised by Lived Experience Australia on behalf of our Victorian State Advisory Forum.

## 7. Contact

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