



Mental Health and Wellbeing Act **Update and Engagement Paper**

Mental Health Victoria's response to key topics

July 2021

1. About MHV

Mental Health Victoria (MHV) is the peak body for the mental health sector in Victoria. Our members include consumer and carer groups, community health and mental health services, hospitals, medical associations and colleges, police and emergency services associations, unions, local governments, and other bodies across the health and related sectors.

Our aim is to ensure that people living with mental illness can access the care they need, when and where they need it. Our view is that all Australians should have access to a core suite of services that they can choose from – be they delivered in the home, community, or hospital.

Our vision is for a mental health system that:

- involves people with lived experience, including unpaid family and friend carers, in decisions which affect their lives
- provides tailored, high-quality supports to people with different care needs and at different life stages
- wraps around a person, ensuring all of their needs can be met
- is easily navigable, providing continuity of care
- is outcomes-focused
- is adequately and sustainably resourced to meet current and future needs including demand.

2. About this submission

This submission provides responses to the proposed reforms contained within the Department of Health's Update and Engagement Paper on the new *Mental Health and Wellbeing Act*.

In preparing this submission, MHV has consulted with member organisations and sector stakeholders including consumer and carer groups, mental health service providers, peak bodies and associations, and members of the Victorian Mental Health Policy Network (VMHPN). The VMHPN is a network of over 40 peak bodies from across the mental health and intersecting sectors.

MHV also partnered with the Victorian Healthcare Association and the Department of Health to host three member forums where sector stakeholders provided their views on the proposed reforms and associated matters. These forums have greatly informed the development of this submission.

This submission provides detailed commentary on the proposed reforms as well as numerous suggestions for adaptation. We appreciate that legislative reform is complex, and that individual reform options may not be possible or worthwhile depending on the approaches taken to other issues, and the ultimate form of the new Act. We have therefore suggested recommendations in broad terms while including more specific suggestions for consideration as appropriate with the goal of achieving a cohesive approach to reform.

3. Introduction

MHV welcomes this opportunity to respond to the Department of Health's proposals for the new *Mental Health and Wellbeing Act*, and thanks the Government for agreeing to extend the consultation period. This was absolutely critical in facilitating engagement across the sector to ensure the new Act is properly informed by the views of consumers, carers and workers in the system.

While legislation reform cannot achieve practice improvements alone, the new Act will be critical in establishing the right foundation for the new system moving forward. The proposed reforms are generally in line with the Royal Commission's recommendations and well-targeted to support practical improvements in the system. As such, we welcome these efforts to turn the Royal Commission's transformational vision into reality.

In particular, we welcome the Department of Health's comprehensive set of proposals and commitment to consultation within an admittedly challenging timeframe. The Royal Commission's timeline for reform is ambitious and we appreciate the Government's efforts to balance the twin objectives of quick reform and meaningful consultation.

We look forward to working with the Department and the sector further as we continue to refine our goals for legislative reform in this and future processes.

4. General comments

Before responding to the specific topics in the Update and Engagement Paper, it is worth making some preliminary remarks. In particular, it is worth recalling the Royal Commission's words that a workable legal framework must go beyond a narrow focus on compulsory assessment and treatment.

Recommendation 1: Broaden the legislative scope of the new Act

MHV would welcome further clarity on how the new Act will address the mental health and wellbeing system in its entirety, providing for not only the treatment of mental illness, but also its prevention, maximising the mental health and wellbeing of all Victorians.

While the proposed reforms do address matters beside compulsory treatment, they maintain a focus on clinical and institutional settings rather than community settings, on mental illness rather than wellbeing, and on treatment rather than prevention. This is in line with the focus of the current Act and does not reflect the Royal Commission's vision of an Act that supports broader mental health and wellbeing matters.

In order to meet both the words *and spirit* of the Royal Commission's recommendations, it will be necessary to consider further opportunities for legislative reform beyond that which is specifically recommended by the Royal Commission, or canvassed in the Update and Engagement Paper. As a starting point, this should include:

- defining words like "wellbeing" and "recovery" under the Act
- clarifying and expanding the relevance of the Act to community services, the private sector and voluntary patients
- applying suicide prevention, and mental health promotion and prevention, lenses
- reorienting away from deficit language and a focus on risk management
- exploring options for supporting social inclusion and the social determinants of health
- canvassing ideas from other Acts such as the *Public Health and Wellbeing Act*.¹

Recommendation 2: Facilitate the practical realisation of legislative advancements with careful attention to implementation needs

Implementation supports will be vital to ensure legislative reforms translate to practical improvements. Where relevant this should include education, training and practice resources about legislative changes, empowerment of workers and innovative models of care, especially peer workers and peer-led models, as well as practical arrangements to support information-sharing and other system-wide needs. Most critically, none of these reforms will work without adequate service resourcing and considerable and sustained attention to workforce development.

Recommendation 3: Bring forward the review of the Act and introduce more regular reviews to complement progressive advancements

Legislation and practice are intertwined in complex ways. While it is true that legislative reform is required first to provide the necessary foundation for practical reform, it is also true that legislative reform must follow practical improvements to maximise reform options and avoid perverse outcomes. The only way to resolve this dilemma is through iterative reform in both law and practice. To that end, we support fast-tracking the review of the Act with more regular reviews moving forward.

¹ See, eg, section 26 which includes a direction for local governments to develop municipal public health and wellbeing plans.

5. Summary of recommendations

1. Broaden the legislative scope of the new Act.
2. Facilitate the practical realisation of legislative advancements with careful attention to implementation needs.
3. Bring forward the review of the Act and introduce more regular reviews to complement progressive advancements.
4. Implement and refine the objectives and principles in line with stakeholder feedback.
5. Clarify accountability mechanisms for compliance with the principles and support compliance with clear guidance and practical tools.
6. Implement the opt-out model for non-legal advocacy services while clarifying finer details.
7. Implement proposed reforms for supported decision-making in addition to further reforms that strengthen decision-making supports.
8. Implement further reforms that strengthen the operation of advance statements.
9. Explore opportunities to strengthen consumer access to health records.
10. Clearly define categories of information which may be shared with carers without a consumer's consent.
11. Develop a more nuanced approach to information-sharing between services based on categories of information and purpose-based decision-making.
12. Seriously reconsider proposed amendments to the criteria for compulsory treatment, and consider options for introducing a capacity criterion.
13. Implement proposed reforms for authorisation processes, with the exception of proposals to expand authorising professions, while considering further opportunities for reform.
14. Consider further opportunities for legislative alignment and reform to reduce the use and impacts of seclusion and restraint.
15. Implement, strengthen and simplify proposed governance reforms.

6. Objectives and principles of the new Act

The proposed objectives and principles of the new Act are broadly in line with the Royal Commission's recommendations. In particular, the first objective provides an important foundation for an Act grounded in respect for human rights. Nevertheless, there are a number of further refinements that may be made, as well as more clarity around the accountability mechanisms.

Recommendation 4: Implement and refine the objectives and principles in line with stakeholder feedback

The proposed objectives would benefit from the following changes:

- **Objective 1:** Specify that the objective relates to “all” people of Victoria, and include sub-objectives that make reference to:
 - enhancing the environments in which people grow, learn, work and live
 - addressing social determinations of mental health and wellbeing
 - ensuring the safety of workers in the mental health system
 - resourcing Aboriginal Community-Controlled Health Organisations as the preferred providers of social and emotional wellbeing services.
- **Objective 3:** Make reference to the importance of information-sharing and support
- Include an additional objective to “Adopt a whole-of-government approach to promote and protect the mental health and wellbeing of all Victorians”, including by strengthening governance arrangements and facilitating integrated care.

With regard to the proposed principles, some suggestions for improvement include:

- **Principle 3:** Clarify that this principle does not preclude the use of compulsory treatment when otherwise allowed under the Act, with acknowledgment that adherence to this principle will be achieved through the provision of adequate resources and training supports.
- **Principle 4:** Replace “Involve” with “Work with” or “Work in partnership with”.
- **Principle 4:** Expand the concept of supported decision-making to align with other statutory provisions,² encompassing:
 - all decisions which affect a person's life
 - a duty to provide supports “as far as practicable”
 - support for expressing a person's will and preferences
 - support for developing a person's decision-making capacity.
- **Principle 6:** Include reference to lived experience entities and partnerships.
- **Principle 7:** Replace “medical and other health needs” with “mental health and wellbeing needs”.
- **Principle 8:** Include “visa status” and “intersectionality” as diversity-related characteristics, but otherwise maintain the list.
- Include additional principles that impose duties to:
 - commit to research, evaluation and innovation
 - recognise and respond to a variety of traumatic experiences
 - engage consumers, carers and other stakeholders in the design, planning and delivery of services
 - respect the dignity of risk.

² Especially ss 7(1) & 8(1), *Guardianship and Administration Act 2019*.

Recommendation 5: Clarify accountability mechanisms and support compliance with clear guidance and practical tools

Accountability mechanisms to ensure compliance with the principles are an important and welcome tool to ensure the new Act has practical effect. However, we suggest further work is required to provide increased clarity on the process of these mechanisms, the interpretation of the principles, and remedies available for breaches. Some consideration needs to be given to ensuring accountability mechanisms provide adequate protections to consumers while avoiding excessive litigation that would overwhelm the system.

The development of statutory guidelines is also welcome. These will require clear, tangible actions that can be implemented, and should be accompanied by education, tools and case studies to assist services in meeting the requirements without the need to resort to overly prescriptive accreditation models.

7. Non-legal advocacy services

The opt-out model for non-legal advocacy services is in line with the Royal Commission's recommendation, and stands to provide important and necessary supports to consumers. Similarly, the rights and responsibilities, and development of guidelines, proposed each provide necessary supports for the safe and effective operation of non-legal advocacy supports in practice. However, there are still questions around some of the finer details which require resolution.

Recommendation 6: Implement the opt-out model for non-legal advocacy services while clarifying finer details

The opt-out nature of the model provides an important guarantee for adequate and sustainable funding. However, work will still be required to ensure supply meets demand, both in terms of the size and model of services provided, particularly in rural and regional areas. The Regional Boards may prove crucial in this regard.

Another question to resolve concerns the independence of non-legal advocates. While the Royal Commission noted broad support for independent non-legal advocacy services, both its recommendation and the Department of Health's proposals are silent on whether the new model will diverge from this. Depending on that decision, other issues will need to be worked through, such as how best to impose relevant confidentiality and duty of care obligations, and to ensure accountability.

Further suggestions for consideration include:

- clarity around the "reasonable assistance" services must provide, including timeframes for notifying advocates after events of seclusion and restraint
- provisions regulating the appointment of non-legal advocates for consumers found to lack sufficient capacity to give informed consent
- role of safeguarding mechanisms and governance bodies to oversee both the operation of non-legal advocacy services, and the assistance provided to advocates by treating services
- legislative duties for non-legal advocacy services to be delivered in ways that are culturally safe and responsive, including through linking with interpreter services, and ensuring the appropriate diversity and training of staff.

8. Supported decision-making

The proposed reforms for supported decision-making are broadly in line with the Royal Commission's recommendation. They will provide useful safeguards to support consumers to exercise their decision-making capacity, increasing transparency around override decisions and broadening consumer access to meaningful and practical supports. However, even when taking into account the Royal Commission's recommendation for progressive reform, there are considerable lost opportunities in the proposals put forward.

Recommendation 7: Implement proposed reforms for supported decision-making in addition to further reforms that strengthen decision-making supports

While the proposed changes are welcome, there are a number of opportunities to further strengthen supported decision-making more broadly, including:

- strengthening Principle 4 to align with sections 7(1) and 8(1) of the *Guardianship and Administration Act 2019* to include:
 - all decisions which affect a person's life
 - a duty to provide supports "as far as practicable"
 - support for expressing a person's will and preferences
 - support for developing a person's decision-making capacity
- inclusion of a definition of "supported decision making" or a "supported decision", in line with the *Guardianship and Administration Act 2019*
- imposition of a specific duty to support, or acknowledgment regarding the importance and continued relevance of supporting, decision-making during periods of compulsory treatment
- drafting of general provisions to guide supported decision-making practices, taking into consideration:
 - the primacy of a consumer's right to determine who should be involved in supported decision-making processes, including their choice of worker where possible
 - the importance of facilitating the involvement of families and carers
 - the utility and translatability of the goal-setting framework in the NDIS Act
 - relevant considerations when implementing supported decision-making for children and adolescents, including:
 - the general benefits of supported decision-making for all consumers, regardless of age-based distinctions regarding legal capacity
 - the specific suitability of supported decision-making for an individual, considering their developmental stage
 - the role of carers and family members
 - mechanisms for resolving disagreements.

We also note our support for further consultation to determine the content and format of statements of rights. It will be important that this process ensures the provision of content that is legally accurate, with the level of detail necessary for such, with multiple formats provided to suit different consumer needs (eg video recordings, translated/accessible versions). Consideration should also be given to the role of peer workers and safeguarding measures to ensure consumers have appropriate and necessary supports to understand their rights in practice.

Recommendation 8: Implement further reforms that strengthen the operation of advance statements

To strengthen the operation of advance statements in practice, it will be important to capitalise on existing processes while also considering further options for legislative reform. There is already a lot of good work happening in this space, and many services have their own methods of negotiating and recording agreements for treatment plans. It will be important to align these existing processes with formal advance statement arrangements to avoid duplication of work and capitalise on existing system strengths.

In addition to these practical considerations, there are a range of legislative options with the potential to strengthen the operation of advance statements. Options for further consideration in legislative reform include:

- imposition of duties for governance bodies to monitor and oversee the preparation and use of advance statements, including override decisions
- establishing an online registry to ensure all services across the state have access to advance statements at all times
- clarification around powers of consumers to initiate reviews of their advance statements
- clarification around how language imposing a duty to “consider” advance statements will be strengthened
- clarification of compliance measures and remedies for breaches
- allowance for consumers to appoint substitute decision-makers if they wish, in line with rights under other statutes³
- inclusion of an acknowledgment of the inherent harm of overriding a person’s will and preferences expressed in an advance statement
- expand the factors that decision-makers must consider when making treatment decisions to include:
 - the inherent harm of overriding a person’s will and preferences
 - the balance of harm and benefit likely to result from an override decision⁴
 - factors that may impact the person’s experience of having treatment preferences overridden, such as age, disability, culture, and trauma history
- imposition of a duty on decision-makers to discuss the (re)drafting of advance statements with consumers at defined points, such as after treatment preferences have been overridden
- considered revision of the power to override advance statements when the preferred treatment is not ordinarily provided by the service to when the treatment is not “reasonably able to be provided”, with consideration otherwise given to the option of referral to a service that can respect the consumer’s preferences
- consideration of the practicability of differentiating between treatment preferences that may be overridden and preferences which should be non-negotiable (for example, prescription decisions vs cultural requirements).

³ *Medical Treatment Planning and Decisions Act 2016; Powers of Attorney Act 2014.*

⁴ Cf. Section 71(4)(h) of the current Act which only requires consideration of the consequences if the treatment is not performed.

9. Information-sharing

Proposed reforms for information-sharing do not go far enough in protecting consumers' rights and further details are required to ascertain whether the proposals will result in the adequate balancing of consumer rights with other relevant factors in practice. As such, while not technically out of step with the Royal Commission's recommendations, it is unclear whether the proposals will result in genuine improvements, either because they do not strike the right balance between competing objectives, or because they lack adequate detail to ensure this balance will be achieved in practice.

Other issues that require further consideration include information-sharing practices between the public and private sector, and the alignment of information-sharing laws and processes with other statutes,⁵ including the wider health system.

Recommendation 9: Explore opportunities to strengthen consumer access to health records

The core principle of information-sharing should be the maximisation of consumer control over their information. This should occur as far as possible while taking into account the imperatives of family-inclusive practice, continuity of care and risk management.

The proposed reforms do not go far enough in respecting this principle by maintaining the onus on the consumer to seek access to their records. Instead, it may be preferable for Victoria to adopt a system where consumers have open access to their files. Such an approach has already been implemented in some Victorian services and is standard practice in other jurisdictions, including the UK.

In the absence of open access, a consumer's right to add information to their file may be accompanied by the imposition of a duty on workers to discuss file notes with the consumer, with a view to identifying differences of opinion and, where possible, to resolving them.

Recommendation 10: Clearly define categories of information which may be shared with carers without a consumer's consent

Regarding information-sharing with carers and families, the utility of the proposals depends largely on the details of what information can be shared without the consumer's consent, and when. The delineation of clear purposes for which information may be provided without the consumer's consent has the potential to provide crucial guidance to decision-makers, orienting decision-making processes towards appropriate considerations such as the necessity and proportionality of information-sharing. These should be clearly explained to consumers in the statement of rights.

Additionally, MHV acknowledges the need for information-sharing between services and carers and families to be a two-way process so that families and carers can also have meaningful input into the care of their care recipients/family members.

⁵ *Health Records Act 2001; Carers Recognition Act 2021.*

Recommendation 11: Develop a more nuanced approach to information-sharing between services based on categories of information and purpose-based decision-making

Further details are also required about the proposed distinctions between 'basic' and 'detailed' information that can be shared between services. It is difficult to provide even in-principle support for this proposal without greater clarity on what it will look like in practice. While the Update and Engagement Paper recognises that consultation will occur regarding which services will have access to information under this provision, it does not acknowledge whether consultation will inform the definitions of information relevant to this provision.

It may be that the 'detailed' information will require further categorisation, rather than an all-or-nothing approach. The dangers of such an approach are well-evidenced in the roll-out of My Health Record. A more nuanced approach would ensure that information is only shared with services when necessary for a given purpose, thereby balancing the consumer's rights to privacy and safety, with their right to continuous care.

10. Compulsory treatment and assessment

The broad goal of reducing compulsory treatment attracts support from across the sector. It is concerning that, while some of the Department of Health's proposals are in line with that goal, some appear to be directly counter to it. Legislative reform in this space therefore requires considerable further work and thought.

It is also worth recalling here that the best way of reducing compulsory treatment is by increasing access to voluntary services. The most important changes needed to achieve the Royal Commission's goals are therefore administrative in nature, with a particular need for increased funding and workforce development. This does not mean that legislative reform is not required, only that it cannot be relied on alone.

Recommendation 12: Seriously reconsider proposed amendments to the criteria for compulsory treatment, and consider options for introducing a capacity criterion

The proposed changes to the criteria for compulsory treatment have attracted little support across the sector. In particular, introduction of a "distress" criterion is seen as both too broad and too narrow, and difficult to implement in practice. That is, it has the potential to:

- *increase* compulsory treatment rates by broadening the treatment criteria, particularly in light of the distress often experienced with the current system
- exclude some people who require compulsory treatment due to the lack of a feeling of "distress"
- result in different interpretations of the law, with variances between objective assessments and subjective experiences of distress.⁶

The introduction of an imminent qualifier in the harm criterion is also fraught. While this change would narrow the application of the law, and therefore be in line with Royal Commission's recommendation, it may be impractical considering the risks relevant to psychiatric risk assessments are often medium- to long-term. Restricting compulsory treatment to situations where risk is "imminent" may result in people not receiving care when they need it.

Instead, it is worth considering the addition of a criterion limiting compulsory treatment to people who lack decision-making capacity, in line with approaches taken in other Australian jurisdictions. This has the potential to reduce the use of compulsory treatment without resulting in exclusion or over-inclusion, while relying on established legal concepts. It is also in line with other statutes⁷ and therefore has the benefit of treating consumers on a more equal basis to others in the community.

⁶ 'Deterioration', on the other hand, can be more objectively defined: see Australian Commission of Safety and Quality in Health Care, *National Consensus Statement: Essential elements for recognising and responding to deterioration in a person's mental state* (2017)

<<https://www.safetyandquality.gov.au/publications-and-resources/resource-library/national-consensus-statement-essential-elements-recognising-and-responding-deterioration-persons-mental-state>>.

⁷ *Guardianship and Administration Act; Medical Treatment Planning and Decisions Act 2016.*

Recommendation 13: Implement proposed reforms for authorisation processes, with the exception of proposals to expand authorising professions, while considering further opportunities for reform

Many of the changes proposed to the authorisation process stand to produce tangible benefits to achieving the Royal Commission's goals. MHV supports proposals to reduce community treatment order periods and empower the Mental Health Tribunal to initiate and facilitate conferences, and exercise discretion in making treatment orders. However, the broadening of authorising powers is likely to result in the increased use of compulsory treatment orders, while reducing regulatory safeguards (depending on the professions involved). This is completely out of step with the Royal Commission's recommendation.

Further changes which should be considered include:

- including an acknowledgment of the inherent harm of compulsory treatment
- imposing a duty on decision-makers to balance consideration of the harm likely to be caused by compulsory treatment and the harm sought to be prevented by it
- requiring treatment orders to be reviewed by the Mental Health Tribunal at an earlier stage, perhaps even to the point where temporary treatment orders may be unnecessary
- empowering the Mental Health Tribunal to issue limited treatment plans rather than open orders
- providing suitable medical indemnity protections for psychiatrists to allow safe and effective practice
- imposing duties for services working with consumers during and after periods of compulsory treatment to:
 - provide decision-making supports
 - liaise with previous healthcare providers
 - facilitate concurrent provision of relevant services such as NDIS supports.

11. Seclusion and restraint

The Department of Health's proposals to reduce seclusion and restraint are welcome and in line with the Royal Commission's recommendations. In particular, acknowledging the harm caused by these practices, and requiring of clinicians to balance relevant harms and benefits, are important introductions that will help guide clinicians towards decision-making processes that are conducive to good mental health and wellbeing, and in line with proportionality assessments under human rights law.

At the same time, it is important to note that practical supports will be crucial in achieving real change, and ensuring that these strengthened regulations do not result in perverse outcomes. Administrative burdens impact care quality, and services must never be placed in a position where admittance and discharge decisions are made on the basis of concerns for staff safety. Thus, it is principally the resourcing of services that will be critical to reducing rates of seclusion and restraints. Other practical supports that require fast-tracked roll-out include:

- staff training on alternatives such as de-escalation techniques and behavioural supports
- improved designs of facilities, such as through the provision of sensory rooms and other trauma-informed approaches to building design
- supports and strategies to reduce distress experienced in mental health and wellbeing facilities, such as policies that provide clear access to smoking areas.

Recommendation 14: Consider further opportunities for legislative alignment and reform to reduce the use and impacts of seclusion and restraint

There are a number of further opportunities for legislative reform that may assist in achieving the Royal Commission's vision. In particular, legislative alignment⁸ of seclusion and restraint regulations is important to:

- ensure the equal treatment of people, regardless of disability or diagnosis
- ensure the rights of consumers are protected equally across all service settings
- facilitate continuity of care for people with dual diagnoses.

If consumers remain subject to seclusion and restraint in other settings, and variances in their protections against seclusion and restraint across different settings, the practical benefits of any improvements in the mental health sector will be seriously compromised. As such, it is imperative that the Government look to legislative alignment in this area beyond the current reform process.

Other suggestions for consideration include:

- strengthening of targets set by the Chief Officer for Mental Health and Wellbeing, such as through legislative enshrinement or links with key performance indicators
- development of practical guidance to support interpretation of relevant definitions (eg "seclusion", "chemical restraint") and associated reporting requirements
- clarity around the enforceability of guidelines, principles and regulations, and the role of safeguarding mechanisms and governance bodies in overseeing the use and response to events of seclusion and restraint.

⁸ Particular statutes that require consideration for alignment include the *Disability Act 2006* and the *Medical Treatment Planning and Decisions Act 2016*.

12. Governance

The governance arrangements proposed stand to introduce critical supports to the mental health and wellbeing system. These proposals are broadly welcome as supporting the Royal Commission's recommendations for increased oversight and accountability of the system. However, the introduction of multiple bodies and processes risks introducing more complexity into an already-complex system. If not implemented with care, this may result in perverse outcomes for care quality.

Recommendation 15: Implement, strengthen and simplify proposed governance reforms

Complex governance and oversight present risks for quality of care. This is particularly so where multiple reporting lines and obligations, and overlaps and duplication in oversight functions, result in increased administrative burdens. These issues must be addressed to ensuring governance arrangements function as intended and result in actual improvements in practice.

In addition to reductions in complexity, further options to consider include:

- imposing duties on governance bodies to adhere to the principles of the Act
- vesting of broad experiences in all bodies, including lived experience, and people with understanding of other service sectors and support needs
- provision of suitable remuneration and support for all staff
- activities to celebrate successes with positive feedback to services, and other methods of recognition, in addition to compliance monitoring and supports for practice improvements.

To ensure the Mental Health and Wellbeing Commission can discharge its duties in line with the Royal Commission's recommendations, it should be further required to:

- oversee suicide prevention and mental health promotion activities, as well as mental health activities
- support suitable safeguarding arrangements to ensure that, among other things, workers can report on service issues themselves
- employ a diverse workforce, including decision-makers and complaints panels
- provide advice to Mental Health and Wellbeing Regional Boards on required considerations for service provision, to mitigate the risk of regional variation in service access and quality
- draw on the learnings and model of the Victorian Senior Practitioner.

To support Mental Health and Wellbeing Regional Boards, the Act may include a non-exhaustive list of powers and responsibilities with the option of refinement at the review stage. Such powers and responsibilities should include:

- valuing the lived experience of consumers and carers
- overseeing suicide prevention and mental health promotion activities, as well as mental health and wellbeing activities
- facilitating connections between the mental health and wellbeing sector and other wellbeing domains
- considering and providing for the needs for diverse groups and smaller/remote communities within their regions
- monitoring and promoting the use of co-produced/co-designed models
- considering the advice of the Mental Health and Wellbeing Commission, and providing reasons as to when advice is not followed in line with regional needs.

13. Conclusion

MHV commends the Victorian Government for its thoughtful and comprehensive approach to legislating a new *Mental Health and Wellbeing Act*. With targeted and practical implementation mechanisms to support it, the new Act has the potential to provide a foundational blueprint to better the lives of Victorians through a stronger, more resilient mental health and wellbeing system grounded in respect for human rights and dignity.

To maximise its effectiveness in turning the Royal Commission's vision of reform into a reality, the new Act must broaden its scope in order to truly reorient the system away from compulsory treatment toward the promotion of good mental health, the prevention of mental illness, and the provision of timely, voluntary options for mental health treatment.

The new Act should also embed greater supports for the exercising of decision-making capacity, and clarify details for information-sharing, non-legal advocacy and governance arrangements.

The proposed changes to seclusion and restraint regulation, and the authorisation process for compulsory treatment are broadly welcome. However, serious reconsideration of proposed changes to the criteria for compulsory treatment are required, with investigation recommended into the utility of adopting criteria-based approaches taken in other jurisdictions.

Clearly, there is still considerable work ahead in reforming the legislative underpinnings of the mental health and wellbeing system. We recognise that the current process is not intended to provide the complete reform necessary to ground the new system. To that end, an earlier review of the Act will be required, along with more regular reviews of the Act moving forward to facilitate an iterative process combining progressive and complementary improvements in legislation and practice. Only in this way can we ensure that we continue to advance the Royal Commission's vision of better mental health and wellbeing for all Victorians.



For further information contact

Joshua Finn

MHV Senior Policy Advisor

j.finn@mhvic.org.au

03 9519 7000

Mental Health Victoria

Website: www.mhvic.org.au

Twitter: @MentalHealthVic

Email: mhvic@mhvic.org.au