ENGAGE VICTORIA CONSULTATION: NEW MENTAL HEALTH & WELLBEING ACT

DATE: 30 July 2021

Contact:
Michelle Luarte
Senior Policy Lawyer

T: (03) 9607 9413
E: mluarte@liv.asn.au
W: www.liv.asn.au

TABLE OF CONTENTS

INTRODUCTION

The Law Institute of Victoria ('**LIV**') welcomes the opportunity to contribute to the Engage Victoria public consultation ('**the Consultation**') on the new proposed Mental Health and Wellbeing Act ('**MHW Act**'). The LIV commends the Victorian Government for committing to implement all of the recommendations of the Royal Commission into Victoria's Mental Health System ('**the Royal Commission**'), which includes the enactment of a new MHW Act. The LIV notes that its submission to the Royal Commission recommended a review of the provisions and operation of the *Mental Health Act 2014* (Vic).[1]

The LIV, founded in 1859, is the peak membership body for the Victorian legal profession, representing more than 19,000 lawyers and people working in the law in Victoria, interstate and overseas. Its members are legal professionals from all practice areas. They work in the courts, academia, policy, state and federal government, community legal centres and private practice.

In seeking LIV member feedback to contribute to the Consultation, the LIV drew upon the expertise of representatives from the LIV:

- Disability, Elder and Health Law Section;
- Administrative and Human Rights Law Section;
- Criminal Law Section;
- Family Law Section; and
- Litigation Lawyers Section.

In drafting this submission, the LIV also consulted with Simon Katterl (independent Mental Health Consultant) and is grateful for his contributions.

Given this broad representation and the specific expertise of lawyers specialising in assisting people with mental illness and psychiatric disability to exercise their legal rights, the LIV considers itself well placed to contribute to the Consultation.

[1] Law Institute of Victoria, 'Formal Submission to the Royal Commission into Victoria's Mental Health System' (Submission, 5 July 2019) 5.

EXECUTIVE SUMMARY

General Comments

The LIV generally supports the approach of the proposals provided in the Engage Victoria's Update and Engagement Paper ('**the Consultation Paper**'). The LIV believes that the proposed objectives articulate many of the values as well as the vision provided by the Royal Commission, including moving from a medication-based system to an integrated service approach, the inclusion of compulsory treatment as a last resort, the valuing of lived experience and the need to provide a diverse mix of treatment options.

The LIV makes recommendations for improvement of the proposals in order to bring them further into line with the recommendations of the Royal Commission, from a view that:

- **There is a need to clarify the language in some of the key objectives.**
  For example, a need to more clearly define 'personal recovery', and the rights of voluntary consumers.
- **Some of the proposals risk contradicting the values espoused by the Royal Commission**.
  For example, the proposal to permit a broader range of professionals to authorise temporary treatment orders may contradict the intent of Recommendation 42(2)(e) of the Royal Commission's final report that the MHW Act specify measures to reduce the rates and negative impacts of compulsory assessment and treatment.
- **The MHW Act needs to increase accountability of mental health services providers.**
  In its final report, the Royal Commission commented that system leadership is weak, and accountability for how the system is managed is unclear.[2]
- **The MHW Act needs to implement obligations relating to training.**
  The Consultation Paper does not provide any provisions, either in objectives or in specific proposals, for the provision of training for mental health clinicians in non-coercive forms of practice.

Structure of this submission

The LIV will first provide overarching recommendations, derived from feedback of LIV Committee members. The LIV will then address each of the consultation questions in the Consultation Paper. To aid clarity in communicating the LIV's recommendations, 'Appendix 1: Table of Recommendations' is provided. This table provides a summary of the LIV's position and recommendations for each proposal.

2 State of Victoria, Royal Commission into Victoria's Mental Health System, Final Report, Summary and recommendations, Parl Paper No. 202, Session 2018–21 (document 1 of 6) 22.

OVERARCHING RECOMMENDATIONS

The LIV identifies several Overarching Recommendations to be considered in response to the MHW Act, which are frequently referenced though the LIV's submission. These Overarching Recommendations provide high-level guidance as to how the MHW can more effectively align with the recommendations and proposals made by the Royal Commission.

Overarching Recommendation 1: Embed a cultural shift though consumer leadership, co-design and co-production

The LIV believes that success in implementing the Royal Commission recommendations, and in enacting the MHW Act, will be dependent on a cultural shift. A consumer-focused cultural shift will support broader accountability and engagement of the MHW Act. The LIV recommends:

- cohesive and genuine co-production and co-design with consumers; and
- new rights-based training and responsibilities for mental health services (with inbuilt processes to ensure accountability) to actively consider and apply supported decision-making principles.

Overarching Recommendation 2: Ensure that the MHW Act overcomes previous shortcomings with sufficient funding

The LIV notes that the final report of the Royal Commission states that ineffective implementation strategy, combined with insufficient resourcing to support reforms, hindered the realisation of the [2014] Mental Health Act's intent.[3] LIV members anecdotally report experiences which reflect this finding, including delays in lodging forms for hearings about treatment orders. The LIV recommends appropriate levels of funding be made available to overcome previous shortcomings associated with the *Mental Health Act 2014* (Vic), noting that a lack of investment will not cement the changes recommended by the Royal Commission.

Overarching Recommendation 3: Provide clearer definitions

The LIV recommends that the MHW Act:

- Provide clearer definitions and guidance around restrictive practices (LIV members report there are inconsistent standards across mental health services in Victoria);
- Clarify the meaning of 'personal recovery' as opposed to 'clinical recovery';
- Clarify the criteria for compulsory treatment with examples to assist future decision makers and Tribunal members;
- Clarify the rights of voluntary consumers;

[3] 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) 28.

- Clarify the parameters of information sharing; and
- Clearly define 'decision-makers' or more clearly identify decision-makers at all levels who exercise a function under the MHW Act.

Overarching Recommendation 4: Hold mental health services to account

In introducing the MHW Act, the LIV recommends that the Government release accompanying explanatory materials that explain when and how new powers conferred to mental health bodies, intend to be used. The LIV recommends that this could be achieved if the MHW Act replicates the model embodied in section 38(1) of the Victorian Human Rights Charter – see Recommendation (1.1) under 'Objectives and Principles'.

Overarching Recommendation 5: Align substituted decision-making frameworks with existing legislation immediately

The LIV recommends that the MHW Act take steps to better align itself with the substituted decision-making frameworks in the *Guardianship and Administration Act 2019* (Vic), the *Medical Treatment Planning and Decisions Act 2016* (Vic) and the *Victorian Charter of Human Rights and Responsibilities Act 2006* ('**the Charter'**). This should be done now, as opposed to when it is reviewed in the next five to seven years (Recommendation 43). This includes a shift towards human rights grounded terms and principles. A non-exhaustive list of such terms includes: "will and preferences"; "any less restrictive means reasonably available"; and "determining whether the limitation is reasonably justified and proportional".

Overarching Recommendation 6: Review the current size and structure of the Mental Health Tribunal

Whilst the LIV acknowledges the Royal Commission's concern that significant changes to the Mental Health Tribunal's role now may undermine systemic reforms in the short-term,[4] some LIV members express concern that the functions of the Tribunal require urgent review and adjustments for the following reasons:

- The Tribunal would benefit from improved case management and greater opportunities to access it. The LIV understands that only a limited number of cases before the Tribunal attract case management, and many more consumers would benefit from a dedicated, continuing Tribunal comprised of the same members over a period of time to advance agreed recovery objectives and/or progress to less restrictive treatment. The LIV notes that the Tribunal was intending to trial alternate approaches to the rostering of members from July 2020, however this did not proceed due to the COVID-19 pandemic[5].
- Similarly, the Tribunal's effectiveness would be arguably advanced by continuity of legal and non-legal advocacy at these hearings. LIV members anecdotally report that there is usually no legal (or non-legal) advocate present at hearings. Given the unique vulnerabilities of consumers who are facing compulsory treatment applications, the need for assistance and advocacy is high.

[4] 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), p. 433.
[5] Mental Health Tribunal, 'Further Submission from the Victorian Mental Health Tribunal' (Submission, August 2020) 18.

- The Tribunal's effectiveness would be enhanced by consistent attendance of key members of the treating team. The absence of the Consultant Psychiatrist in all but a handful of hearings (predominantly ECT) (and the inability to compel attendance) and rotating placements of medical registrars every six months makes both continuity of care and accountability challenging. Measures to ensure effective oversight as well as improved accountability would better facilitate the achievement of the Royal Commission recommendations.
- The Tribunal currently sits within the Department of Health. Although there are obvious reasons for this, there are also potential limitations, including access to the judicial college for training of members, and a potential perception of bias by consumers whose communication with the Tribunal is to addressees that bear the name of the department and whose telephone answering messages confirm the same. Some members have suggested that a repositioning of the Tribunal within the Department of Justice, may help facilitate the requisite cultural shift within the Tribunal too to align with a consumer, rights-based focus.

The LIV recommends consideration be given to changing the Tribunal's administration from the Department of Health to the Department of Justice. The LIV also recommends conferring additional powers to the Tribunal to properly perform its oversight role, including powers to facilitate greater accountability of the mental health team.

1. OBJECTIVES AND PRINCIPLES

Question 1: Do you think the proposals meet the Royal Commission's recommendations about the objectives and principles of MHW Act? If not, why?

The LIV are of the view that the proposed objectives and principles of the MHW Act do not currently meet the Royal Commissions' recommendations. A concern identified by the LIV is that the principles do not generate clear responsibilities on mental health services to act in a way that is compatible with human rights. The LIV further submits that the MHW Act lacks judicial oversight, and it is unclear whether a breach of the principles is justiciable, giving rise to a cause of action.

Question 2: How do you think the proposals about objectives and principles could be improved?
In order to improve the proposals on objectives and principles, the LIV recommends that the MHW Act:

(1.1) Create clearer obligations on how to comply with human rights principles, modelled off existing human rights legislation.

The Royal Commission recommended a transition to a consumer-focused, human rights-based mental health system in Victoria. This requires strengthening compliance of mental health services providers with supported decision-making and human rights principles.

The Charter provides an ideal framework for embedding these rights, and to satisfy the MHW Act's objective to reflect contemporary human rights practice and thinking.[6] The Charter makes it a legal imperative for health service providers to consider the rights of patients and consumers, and to demonstrate how a clinician arrived at a decision that is contrary to a patient's wishes.

Specifically, The LIV are of the view that the MHW Act would benefit from replicating the model embodied in section 38(1) of the Charter, which provides:

38 Conduct of public authorities

(1) Subject to this section, it is unlawful for a public authority to act in a way that is incompatible with a human right or, in making a decision, to fail to give proper consider to a relevant human right.

Section 38(1) provides two distinct obligations on public authorities when making decisions. The

[6] Victorian Department of Health, 'Mental Health and Wellbeing Act: update and engagement paper' (Consultation Paper, June 2021) 6.

Supreme Court has described section 38(1) as having a procedural limb and a substantive limb. The substantive limb requires public authorities to act compatibly with human rights and the procedural limb requires public authorities to give proper consideration to relevant human right when making a decision.[7] The procedural limb is required to be undertaken before the decision-making has been exercised. Proper consideration requires:

- Having a general understanding of which rights of the person affected are relevant;
- Having regard to how those rights will be interfered with the decision;
- Identifying countervailing interests or obligations; and
- Balancing public and private interests.[8]

The two limbs are often intertwined and provide a prudent decision-making framework to ensure that consideration is given to how a decision may impact an individual's human rights and whether it is demonstrably justifiable. The LIV notes that the jurisprudence of s 38(1) of the Charter provides some clarity on how the provision operates and could provide guidance to legislators on how a similar section should be drafted in the MHW Act.

If the MHW Act were to include a similar section, this would create clearer obligations for mental health services to act in way which seeks to protect and promote the rights and dignity of people living with mental illness or psychological distress.

To ensure consistency with existing human rights principles, the LIV further recommends:

- Linking the first proposed principle relating to the "respect, dignity and autonomy of consumers" with the decision-making principles under section 9 of the *Guardianship and Administration Act 2019* (Vic) and section 4(5) of the *Medical Treatment Planning and Decisions Act 2016* (Vic).
- Creating an objective and principle for the protection of voluntary consumers, consistent with the findings of Bell J in *PBU & NJE v Mental Health Tribunal* [2018] VSC 564.

These suggested changes would create a consistent supported decision-making framework that draws on the guiding principles of the Convention on the Rights of Persons with Disabilities (CRPD). Further, it would create a distinct opportunity to legislate uniform standard of care principles that apply equally across all health settings. This needs significant investment in training to bring about an understanding of this and effect a cultural change. The focus of this education and training must be that medical decision makers cannot accentuate risk factors to curtail the human rights of a consumer.

[7] *Bare v Independent Broad-based Anti-Corruption Commission; Certain Children v Minister for Families and Children (No 2)* [2017] VSC 251 [177]
[8] *Castles v Secretary of the Department of Justice* (2010) 28 VR 141; [2010] VSC 310.

(1.2) Amend the Charter to strengthen compliance with the MHW Act.

To give full effect to the Charter and to strengthen compliance with the MHW Act, the LIV considers it necessary that amendments be made to the Charter.

(i) All public and privately funded mental health services should be prescribed as a public authority under s.4 of the Charter.

The LIV submits that the Charter should apply to all health settings, including the non-public sector.

Unlike the Australian Capital Territory's *Human Rights Act 2004*, the Charter:

- Does not provide an option for private entities to elect to be subject to the human rights obligations imposed on public authorities;[9] and
- Does not provide an explicit list of entities that perform a function of a public nature. In contrast, the *Human Rights Act 2004* (ACT) specifically includes public health services.[10]

Currently, section 4(2) of the Charter provides several factors to consider in determining whether an entity performs a function of a public nature. It is difficult to navigate the application of these factors, which are not exhaustively listed.[11] Further, the fact that one or more factors are present does not guarantee that the entity is performing a function of a public nature.[12] It is therefore unclear whether section 4 of the Charter would cover privately funded mental health services.

The LIV notes that Recommendation 12 of the 2015 Review of the *Charter of Human Rights and Responsibilities Act 2006* (Vic)[13] remains supported in principle by the Victorian Attorney-General. Recommendation 12 provides:

Section 4 of the Charter be amended to set out a non-exhaustive list of functions of a public nature under section 4(1)(c), including:

…. (b) the provision of public health services

The LIV recommends that Recommendation 12 of the 2015 Review of the *Charter of Human Rights and Responsibilities Act 2006* (Vic) be implemented in full, and that it further clearly covers public health services which are publicly and/or privately funded.

(ii) Include a right to health in the Charter.

The benefits of enshrining a right to health in the Charter are succinctly summarised in the witness statement of Kristen Hilton, former Commissioner of the Victorian Equal Opportunity and Human Rights Commission ('**VEOHRC**'). These include that it would provide a unifying standard for the analogous rights contained in other acts and instruments, would help set priorities for cultural and service change by government, and would create a framework for public authorities to navigate

[9] *Human Rights Act 2004* (ACT) s40D(1).
[10] Ibid, (3)(b)(iii).
[11] *Charter of Human Rights and Responsibilities Act 2006* (Vic) 4(3)(a).
[12] Ibid, 4(3)(b).
[13] Michael Brett Young, 'The 2015 Review of the Charter of Human Rights and Responsibilities Act 2006' (Report, September 2015).

difficult ethical and moral decisions.[14] Improving compliance for the Charter is vital when administering the MHW Act and thus including a right to health will place an added onus on government to promote a strong human rights culture within the mental health legal framework.

(iii) VEOHRC be empowered with regulatory functions to promote compliance with the MHW Act, and to refer matters to the Mental Health and Wellbeing Commission (WHWC).

The LIV has previously recommended that VEOHRC be empowered with regulatory functions to promote effectiveness of legislation and provide redress for victims.[15] Before the *Equal Opportunity Act 2010* (Vic) was introduced, amendments were made with the effect of removing inquiry powers from the Commission. These amendments prevent VEOHRC from conducting an investigation if the matter could reasonably be expected to be resolved by dispute resolution or VCAT.

Whilst the LIV previously recommended that VEOHRC be reinstated with these powers in relation to the regulation of vilification, the LIV considers this recommendation is valuable in the context of responding to mental health complaints. The LIV therefore recommends that the Victorian Government consider granting the VEOHRC a dispute resolution function to manage individual complaints about allegations of a human rights breach against public authorities as defined in the Charter[16]. This proposed function is akin to the power currently provided under the *Equal Opportunity Act 2010* (Vic). The LIV notes that the 2015 Review of the Charter recommended that VEOHRC be given the statutory function and resources to offer dispute resolution for disputes under the Charter.[17] In response, VEOHRC has stated that it is well placed to fulfil this function, with the addition of additional resources.[18]

(1.3) The role and purpose of mental health services should be clearly defined as a principle of the MHW Act.

In addition to recognising the role of families, carers and supporters (including children), the MHW Act must also clearly define the role and purpose of mental health services. The LIV recommends that the wording of this provision reflect the new objectives outlined under Recommendation 42(2)(a) of the Royal Commission's final report.

(1.4) Clarify the definition of 'personal recovery'.

The proposed objectives refer to 'promoting recovery of people living with mental illness and psychological distress' however it is unclear whether this refers to personal recovery or clinical recovery. The LIV recommends inserting the term 'personal recovery', which is consistent with the Royal Commission's recommendation that the focus on personal recovery needs to be

[14] Royal Commission into Victoria's Mental Health System, 'Witness Statement of Kristen Statement' (Witness Statement, 15 July 2020) <http://rcvmhs.archive.royalcommission.vic.gov.au/Hilton_Kristen.pdf> 5-6.
[15] Law Institute of Victoria, 'Inquiry into Anti-Vilification Protections' (Submission, 31 January 2020) 14.
[16] Victorian Equal Opportunity and Human Rights Commission, 'Submission to the Royal Commission into Victoria's Mental Health System (Submission, July 2019) 3.
[17] Above n 13, Recommendation 23 (pg. 13).
[18] Victorian Equal Opportunity & Human Rights Commission, 'Improving the Operation of the Charter' (Webpage, accessed 26 July 2021) <https://www.humanrights.vic.gov.au/legal-and-policy/advocacy-and-law-reform/improving-the-operation-of-the-charter/>.

strengthened.[19] The LIV further recommends that the MHW Act clarify the definition of personal recovery, and that this reflects the Royal Commission's comments that personal recovery means being able to create a meaningful and contributing life, with or without mental health challenges.[20] These recommendations give effect to the LIV's Overarching Recommendation (3).

(1.5) Clarify the rights of voluntary consumers.

The LIV recommends that the MHW Act insert a statutory objective to the effect of:
"Ensuring that mental health and wellbeing services, decision-makers and the community are aware of and respect the rights (including those protected by the Victorian Charter of Human Rights and Responsibilities Act 2006) of both voluntary and involuntary consumers".

Whilst this provision would not create any additional rights apart from those currently legislated, it reinforces the existence and obligation to protection of these rights. This further supports Recommendation (1.1) under 'Objectives and Principles' – to create clearer obligations on how to comply with human rights principles, modelled off existing human rights legislation. This recommendation gives effect to the LIV's Overarching Recommendation (3).

(1.6) Apply a justice lens.

The LIV recommends that the MHW Act include a principle to recognise and respond to the needs of people receiving mental health services in justice settings such as prisons. The LIV notes that the Consultation Paper does not refer to mental health in correctional settings, except for the extension of the Chief Psychiatrist's jurisdiction. Given the over representation of individuals experiencing mental health issues in Victorian prisons, this would have a dual benefit of facilitating a rehabilitative goal of sentencing and an objective of MHW Act. This recommendation gives effect to the LIV's Overarching Recommendation (6).

(1.7) Include an additional proposed principle that is elder abuse focused.

The LIV expresses concern that the protection of older people's rights is notably absent. In recognition of the recent findings stemming from the Royal Commission into Aged Care Quality and Safety, the LIV recommends an additional principle be added that is focussed on addressing the issue of elder abuse. The LIV suggests wording to the effect of: "*recognising and eliminating elder-abuse, as it occurs within and outside of mental health services*".

(1.8) Appropriate funding and resourcing by Government should be a principle of the MHW Act.

The LIV makes reference to Overarching Recommendation (2), which recommends appropriate levels of funding be made available to overcome previous shortcomings associated with the *Mental Health Act 2014* (Vic).

[19] Above n 2, 12.
[20] Ibid.

2. NON-LEGAL ADVOCACY

Question 3: Do you think the proposals meet the Royal Commission's recommendations about non-legal advocacy? If not, why?

The LIV are of the view that the proposed non-legal advocacy proposals largely meet the Royal Commissions' recommendations, however there is room for improvement in order to bring the proposals in line with the recommendations. The LIV strongly supports the creation of opt-out non-legal advocacy, and views this as a response to broad consumer support for Independent Mental Health Advocacy ('**IMHA**'). The LIV, however, makes several further recommendations as to how to expand consumer access to non-legal advocacy services and to strengthen their independence.

Question 4: How do you think the proposals about non-legal advocacy could be improved?

In order to improve the proposals about non-legal advocacy, the LIV makes the following recommendations.

(2.1) Significantly expand the eligibility criteria for free non-legal advocacy services.

Currently, a person must be 'at risk' or on a compulsory order to receive non-legal advocacy. The LIV is concerned that this severely limits the number of individuals able to access advocacy. The LIV recommends there should be greater scope to allow both voluntary and involuntary mental health consumers to access free non-legal advocacy services. While the LIV supports the positive introduction of an opt out non-legal advocacy system, the consumer should be provided with opportunities to revoke non-legal advocacy representation and seek other forms of representation if needed, that is, another IMHA provider or legal advocacy services.

(2.2) The MHW Act consider how to leverage existing health justice partnerships.

Given the focus on a compassionate, consumer-focused and right-based approach to mental health highlighted in the recommendations of the Royal Commission, the future role of health justice partnerships should be considered. In such a framework (currently operative in different health settings around Victoria and nationally) legal services are provided to support vulnerable individuals within a collaborative context with clinical and health professionals, to achieve better health and legal outcomes for the clients. This operates with an aim to reach individuals who are disproportionately burdened with legal need but less likely to seek help directly from lawyers. Such structures remove the adversarial nature of engagement that can detract from positive health outcomes. The LIV suggests that the MHW Act consider how it can leverage the health justice partnership models from Health Justice Australia and First Step Legal.

(2.3) Non-legal advocacy services remain independent from the mental health system.

The LIV queries whether advocacy stemming from a healthcare provider's own support facilities can remain unbiased. Given this concern, the LIV recommends that non-legal advocacy options be independent from clinicians, family and friends. The LIV further recommends that the proposed 'non-legal advocate' come from an expansion of the IMHA, as opposed to a hospital-based advocate. To ensure that IMHA remains independent of the mental health system, it should not be separately commissioned by Regional Boards or Regional Multiagency Panels.

(2.4) Co-produce non-legal advocacy services guidelines with consumers who have lived experience of the mental health system.

The LIV recommends that the Chief Officer for Mental Health and Wellbeing's powers to issue operating guidelines with respect to IMHA services be developed with wide consultation to ensure the needs of consumers are met. This recommendation gives effect to the LIV's Overarching Recommendation (1).

3. SUPPORTED DECISION-MAKING

Question 5: Do you think the proposals meet the Royal Commission's recommendations about supported decision-making? If not, why?

The LIV are of the view that the proposed supported decision-making proposals partially meet the Royal Commissions' recommendations. The LIV recommends that the MHW Act further enhance the effectiveness of advance statements, clarify an intention to move from a 'best interests' model to a supported decision-making model, and clarify protections for voluntary consumers.

Question 6: How do you think the proposals about supported decision-making could be improved?

In order to improve the proposals on supported decision-making, the LIV makes the following recommendations:

(3.1) Enhancing compliance with advance statements to the best extent possible, through the appointment of an independent consumer-focused advocate and broadening the scope of persons authorised to provide a second opinion.

LIV members expressed concern that advance statements are regularly not complied with, and that compulsory treatment orders are often made in circumstances where the potential risks of not providing the treatment are presented as overwhelming. LIV members, however, appreciate that mandating blanket compliance with the preferences expressed in advance statements may also be counterproductive. The LIV recommends that the MHW Act provide additional responsibilities for clinicians to document and evidence the decision-making process, in making an order for compulsory treatment, (and/or not complying with an advance statement) including:

- The consumer's will and preferences, if known;
- Setting out alternative treatment options which were considered, and why these were not applicable or possible to trial under the circumstances; and
- Any phobias if known, for example, social, agoraphobia, claustrophobia etc. or generalised anxiety disorders if known, which need to be closely monitored.

The LIV suggests that an independent consumer-focused advocate could assist to mediate between the consumer's and psychiatrists' views, to brainstorm an appropriate middle-ground position or test alternative considerations. Such advocates could also assist voluntary consumers to prepare a detailed advance statement, to ensure that it is an accurate reflection of the consumer's will and preferences if they are later subjected to compulsory treatment. The LIV also recommends widening the scope of persons authorised to provide a second opinion, such as the consumer's treating general practitioner and funding this service appropriately. This would assist with the current delays in seeking a second psychiatric opinion and allow

greater independence of advice from the service provider. The MHW Act should specify that this second opinion must always come from an independent source outside of the clinical ward.

(3.2) Statement of Rights for both voluntary and non-voluntary consumers.

The LIV supports the proposal to provide a statement of rights that sets out a person's rights when receiving mental health services. The LIV recommends that this statement be provided to both voluntary and non-voluntary consumers and be drafted with consumers with lived experience of the mental health system. This recommendation gives effect to the LIV's Overarching Recommendation (1).

(3.3) Clinicians move away from a 'best interests' model to a supported decision-making model.

The LIV notes that the current framework was intended to bring about a seismic shift in mental health service delivery from a 'best interests' model characterised by substituted model to one of a recovery-oriented practice focussed on supported decision making. As was clear in the submissions provided to the Royal Commission, the aspirations of the 2014 were not realised. The LIV considers the introduction of the MHW Act to present a unique opportunity to implement a true supported decision- making model. To achieve this, the LIV makes the following recommendations:

- Doctors, nurses, and case managers must receive sufficient upfront and ongoing training to better implement the rights-based model. This may involve a complete re-design of nursing and medical training, which emphasises the onus of supported decision-making.
- The term 'views and preferences' in the Consultation Paper should be replaced with 'will and preferences' which is consistent with the decision-making principles under section 9 of the *Guardianship and Administration Act 2019* (Vic). This is consistent with Recommendation (1.1) under 'Objectives and Principles'.
- Clinicians must endeavour to understand the person who is being treated – who they are, what preceded their current situation, their future goals and the decisions they want to make.[21]
- Tribunal decision-making needs to be informed by what is understood to constitute best practice in relation to compulsory treatment, accordingly, this would need to form part of the induction and professional development of Tribunal members and relevant staff.[22]
- Clinical staff be educated on the legal definition of 'informed consent'.
- Clinical staff be educated and trained in trauma informed practice and the impact of trauma.

[21] Above n 4, 9.
[22] Ibid, 10.

(3.4) Greater consideration of other avenues to engage with consumers.

LIV members anecdotally reported that some consumers have significant distrust with the mental health system, particularly when there is a historical and/or generational trauma regarding compulsory treatment. The LIV therefore recommends that the MHW Act should consider other avenues to assist a person to engage with the mental health system. This could include a NDIA Community Engagement worker, medically supervised injecting centres and other entities outside the medical sphere.

(3.5) Increase public awareness of the use of advance statements, nominated persons, advocacy and second opinions.

As noted in various submissions to the Mental Health Royal Commission, including from the Victorian Mental Illness Awareness Council (VMIAC)[23] and cohealth,[24] the uptake of advance statements and nominated persons is very low at less than 3%. Whilst the LIV supports the MHW Act's proposal to permit a broader range of people to witness the appointment of a nominated person, the LIV remains concerned that without an increase of public awareness campaign, the uptake of advance statements and nominated persons may remain low. The LIV recommends that information about advance statements, nominated persons, advocacy and second opinions should be promoted throughout mental health services. The LIV recommends that further education and support for mental health practitioners be provided to ensure that consumers are provided with this information.

(3.6) Improve safeguards in relation to supported decision-making.

The current Mental Health Act provides that the appointment of a nominated person can only be revoked by the person who has made the nomination, or if the nominated person declines to act as a nominated person[25]. It provides no ability for a Court or Tribunal to review or revoke an appointment of a nominated person, unlike the provisions in other Victorian legislation that provide for oversight over the appointment of a guardian or an attorney[26]. The LIV expresses concern that if a nominated person is inappropriately or improperly appointed, there is currently no legal mechanism to review the appointment to ensure the human rights of a vulnerable consumer are protected. Further, the proposals in the Engagement Paper provide that "the new Act will also permit a broader range of people to witness the appointment of a nominated person", which would increase the risk of an inappropriate appointment of a nominated person and therefore the potential abuse of a consumer's human rights. In order to protect the human rights of vulnerable consumers, the LIV recommends much tighter safeguards regarding the role, appointment process and review of supported decision-makers.

[23] (Victorian Mental Illness Awareness Council, 'Royal Commission into Mental Health – Terms of Reference Consultation' (Submission, January 2019) 21.
[24] Cohealth, 'Submission to: Royal Commission into Victoria's Mental Health System' (Submission, July 2019) 26.
[25] *Mental Health Act 2014* (Vic) s. 25.
[26] *Guardianship and Administration Act 2019* (Vic) s. 167(1)(b).

4. INFORMATION COLLECTION

Question 7: Do you think the proposals meet the Royal Commission's recommendations about information collection? If not, why?

The LIV are of the view that the proposed information collection proposals largely meet the Royal Commissions' recommendations, however there is room for improvement in order to bring the proposals in line with the recommendations. The LIV largely supports the proposals on information collection and commends the suggested action to be taken by the Government to establish standards which guide services and practitioners in what information is appropriate to share with families, carers and supporters. The LIV, however, notes that a more productive conversation could be had with external stakeholders, once the wording of the proposed information sharing provisions are shared. At present, commentary is limited to the need to balance continuity of care, with safe and appropriate treatment that promotes compliance with patients' rights.

Question 8: How do you think the proposals about information collection could be improved?

In the absence of any suggested wording on the proposed information sharing provisions, the LIV makes the following recommendations:

(4.1) The MHW Act must seek to achieve balance between the necessities of sharing information such as medication regimes, and the consumer's right to choose where their information is shared.

The LIV submits that provisions allowing information sharing where there is no patient consent beforehand must be carefully considered and worded in the MHW Act. The consumer's right to choose must be respected to the greatest practicable extent, allowing for the revocation of consent at any time. Clinical discretion to access information without the consumer's consent should only be permitted where there is a serious risk of harm to the consumer or to others if the information is not shared.

Anecdotally, LIV members report that there is an over-reliance from mental health services on the confidentiality provisions under section 346 of the *Mental Health Act 2014* (Vic). This has the effect of preventing the disclosure of information where there is a serious risk to public safety. In response, the LIV recommendations that the information sharing provisions must balance consumer rights and the rights of others, by applying the proportionality test under section 7(2) of the Charter.

The LIV notes the inherent conflicts of interest between consumer privacy and balancing the concerns of family members. It is the view of some LIV members that inpatient mental health consumers may feel threatened or paranoid in instances where family members – who may have been involved in them being hospitalised – receive their medical information without consent. Additionally, information sharing without consent may lead to an individual being less inclined to voluntarily seek health care, particularly where their privacy has been compromised. Conversely, some LIV members report instances whereby family members with genuine concerns are refused access to medical information and then have to navigate freedom of information applications.

(4.2) There be careful consideration as to how the information sharing provisions in the MHW Act/guidelines may be impacted by existing confidentiality obligations and information sharing schemes.

The LIV are of the view that the information sharing provisions in the MHW Act must ensure consistency with the information sharing provisions under the *Health Services Act 1988* (Vic), *Health Records Act 2001* (Vic), the *Freedom of Information Act 1982* (Vic), Family Violence Information Sharing Scheme, the Child Information Sharing Scheme and the Family Violence Multi-Agency Risk Assessment and Management Framework (MARAM).

(4.3) The MHW Act should provide statutory protections for health professionals to disclose in good faith.

Health service providers must have statutory protections against claims regarding a breach of privacy/breach of professional obligations, when sharing information in accordance with the MHW Act/guidelines in a bona fide manner. The LIV recommends that the MHW Act refer to Part 6B of the *Health Services Act 1988* (Vic) which provides for information sharing for quality and safety purposes. This permits limited disclosure of personal information and provides protections of disclosures done in good faith. Explanatory memorandum/guidance material could provide several case examples where information is shared in a bona fide manner.

(4.4) More efficient review mechanisms for intervention orders made on the basis of situational and temporary safety risks, due to a person experiencing a mental illness.

The LIV recommends that there be more efficient review mechanisms for intervention orders (IVOs) made due to a person experiencing the effects of a situational and temporary mental health illness. For example, LIV members report that police sometimes apply for a full IVO against a respondent who is experiencing a manic episode, with the respondent being evicted from their home. When the respondent seeks immediate treatment for their manic episode and is assessed as being clinically well upon their release, the respondent may be subject to a long court return date of several months to amend the intervention order. Whilst the LIV recognises an important need to balance safety risks, the LIV recommends that in such circumstances, respondents be granted a return court date no longer than 28 days post release of a mental health treatment facility. Under appropriate circumstances, with the medical assessment of treating clinicians and family members supporting the removal of the IVO, mental health consumers should be able to return to their home if safe to do so.

5. COMPULSORY TREATMENT

Question 9: Do you think the proposals meet the Royal Commission's recommendations about compulsory treatment? If not, why?

The LIV are of the view that the proposed compulsory treatment proposals partially meet the Royal Commissions' recommendations. While the LIV commends the proposed changes to the criteria for compulsory treatment, the LIV makes further recommendations to cement a human rights-based approach.

Question 10: How do you think the proposals about compulsory treatment could be improved?

In order to further improve the proposals about compulsory treatment, the LIV makes the following recommendations:

(5.1) A reconsideration of the proposal to expand the range of professionals authorised to give temporary treatment orders.

The LIV is concerned that the proposal to expand the range of professionals to authorise temporary treatment orders, such as nurse practitioners and social workers, contradicts the recommendation of the Royal Commission. The Royal Commission recommended that the MHW Act specify measures which reduce the rates of compulsory assessment and treatment;[27] therefore, the LIV submits that limiting the cohort of clinicians authorised to issue compulsory treatment orders would better align with this goal.

(5.2) Personalising consumer's experience with the Victoria's mental health system to meet individual strengths, needs, and culture.

The compulsory treatment regime must be complemented by well-funded and supported voluntary treatment services, as recommended in the LIV's Overarching Recommendation (2). To create a more sustainable treatment model that also achieves greater continuity of care, mental health service consumers must be given alternatives to enable a transition away from compulsory treatment.

The Consultation Paper provides that the new Mental Health Improvement Unit will support the design and implementation of local programs to reduce compulsory treatment. The LIV recommends that this include consultation with ethnic, gender and minority groups, as well as people who are currently living in correctional settings and people aged 65 and over.

[27] Above n 2, Recommendation 42(1)(e).

(5.3) The MHW Act should ensure that the limitation of rights using a 'last resort' approach is not applied by providers freely.

The MHW Act should be consistent with section 7(2) of the Charter, which provides that rights can only be limited in certain circumstances if it is reasonable, necessary, justified and proportionate. This is the first test – the 'last resort' is secondary. There must also be a test of reasonableness where the situation requires the imposition of a compulsory assessment or treatment.

(5.4) Increased accountability from those who order the compulsory treatment, including a mandatory obligation for a consultant psychiatrist to attend hearings or reviews relating to the consumer.

As detailed in the LIV's Overarching Recommendation (6), the LIV submits that consultant psychiatrists must be compelled to provide evidence to the Mental Health Tribunal on matters affecting their patient when applying to the Tribunal for a treatment order. Presently, the busy schedule of consultants, combined with voluntary submissions of evidence to the Tribunal, results in the delegation of duties, registrars and medical officers. Although registrars are well-trained clinicians, their rotating placements result in less familiarity with a patient's history, affecting their capability to give evidence to the Tribunal. This can result in potentially harmful outcomes for patients. The evidence presented to the Tribunal must be of the highest quality and accuracy to secure the best outcome for the patient and should include evidence of the factors which led to the use of compulsory treatment. This can only be provided by the consultant psychiatrist managing the patient's case. The LIV also emphasises a need for the Tribunal to ensure the continuity of the care of the patient if their treating clinician is no longer able to provide care.

(5.5) Provide clear examples of conduct which can be considered serious distress and clarifying that this must involve serious risk to the individual or another person.

The LIV supports the proposal to replace the reference to 'preventing serious deterioration in the person's mental or physical health' with 'preventing the person experiencing serious distress'. However, the LIV is concerned that this may lead to a prima facie presumption that psychological distress justifies compulsory treatment. LIV members note that psychological distress is common during traumatic life events. In such instances, imposing a compulsory treatment order may be unnecessary and further deteriorate a person's mental or physical health. To address these concerns, the LIV recommends that the MHW Act or accompanying explanatory material should clearly define what conduct may and may not amount to serious distress. This could include individual case examples. The LIV notes that the term 'serious distress' is currently not defined by the Australian Commission on Safety and Quality in Health Care, in their report on 'Recognising Signs of Deterioration in a Person's Mental State[28]'

[28] Gaskin C and Dagley G, 'Recognising Signs of Deterioration in a Person's Mental State', *Australian Commission on Safety and Quality in Health Care* (Report, February 2018) 6.

(5.6) There must be mandatory training for practitioners who are permitted to place patients under compulsory orders. This may include establishing a register of trained practitioners.

It was noted in the Royal Commission's final report that there are different levels of understanding of how mental health services are meeting people's needs, leading to different approaches of performance improvement.[29] The LIV recommends additional training for psychiatrists who are issuing temporary treating orders or applying for treating orders, to make informed initial decisions about a person's need for involuntary/compulsory admission. This could take the form of accreditation and adopt the NSW model of Accredited Persons, who include senior mental health practitioners with a minimum five years' clinical experience in direct mental health consumer care. The LIV recommends the adoption of the obligations and responsibilities of a 'Accredited Person' under the *Mental Health Act 2007* (NSW), which includes an obligation to act lawfully and humanely when making a clinical assessment.[30] Finally, the LIV recommends that a register of trained accredited practitioners be established.

(5.7) The Mental Health Tribunal be structured like a specialist court, with better case management capacity.

As detailed in the LIV's Overarching Recommendation (6), the LIV believes that the present structure and function of the Mental Health Tribunal is inadequate for addressing the needs and concerns of mental health service consumers and providing intended oversight. In response to concerns about its inability to compel the attendance of consultant psychiatrists, limited case management opportunities, and challenges in a Tribunal being comprised of different disciplines approaching hearings and their obligations in a common way, the LIV suggests that the Victorian Government consider changing the Tribunal's administration from the Department of Health to the Department of Justice. This would also assist in effecting uniform training through the judicial college and a justice and rights focused approach. The LIV also recommends adding powers to the Tribunal to deal with the administrative failures of treating teams. These suggested changes would assist the Tribunal to provide more appropriate outcomes for consumers under compulsory treatment orders, particularly those who have engaged with the criminal justice system.

[29] Above n 3, 112.
[30] NSW Government, 'Health Education and Training' (Webpage, accessed 26 July 2021) <https://www.heti.nsw.gov.au/education-and-training/courses-and-programs/the-accredited-persons-training-program>.

6. SECLUSION AND RESTRAINT

Question 11: Do you think the proposals meet the Royal Commission's recommendations about seclusion and restraint? If not, why?

The LIV are of the view that the proposed compulsory treatment proposals partially meet the Royal Commissions' recommendations. The LIV maintains concerns that the ten-year timeframe for eliminating restrictive practices is unnecessarily long, and that the MHW Act requires more prescriptive definitions of physical and chemical restraints.

Question 12: How do you think the proposals about seclusion and restraint could be improved?

In order to improve the proposals about seclusion and restraint, the LIV makes the following recommendations:

(6.1) The timeframe for the elimination of seclusion and restraint practices should be reduced to five years, a further reduction from the ten-year timeframe recommended.

The LIV queries the reasoning behind the Royal Commission's view that a ten-year timeframe would be necessary for the elimination of restrictive practices such as seclusion and restraint.[31] Noting the significant trauma that may occur as a result of both seclusion and restrictive practices, the LIV recommends this timeframe be reduced to five years. The 10-year timeframe recommended by the Royal Commission is incongruent with the Royal Commission's comments that the case for comprehensive reform in compulsory treatment, seclusion and restraint remains urgent and compelling.[32] The LIV notes that the Consultation Paper does not provide rationale for the ten-year timeframe, except to state that systemic changes and supports are needed to make sure these changes are safe for consumers and the workforce. The LIV recommends that further reasoning be provided, as to how the Royal Commission arrived at the determination of a ten-year timeframe. As a minimum, the LIV recommends that the MHW Act provide wording to the following effect: "the elimination of seclusion and restraint practices is expected to occur by [date] *if not earlier".* The LIV draws on its knowledge of other jurisdictions, in particular the United Kingdom, where such restraints are not used.

[31] Above n 2, Recommendation 54(1).
[32] Ibid, 5.

(6.2) The MHW Act must include prescriptive definitions of all forms of restraint.

Definitions of seclusion, restraint and restrictive practices must be clearly defined and prescriptive as to when their use should be allowed in the MHW Act to facilitate and promote consistency in practice and across the state. This will assist consumers to better understand the wide range of restraints, and to identify restraints that are not commonplace.

. The LIV recommends that the definition makes clear:

- That physical restraints include environment and mechanical restraints, such as removing wheelchair access and obstructing a doorway; and
- That chemical restraints include increasing the dosage of medication in order to achieve a sedating effect.

In reassessing any current definitions of physical and chemical restraints, the MHW Act could be guided by comparative jurisdictions that have departed from the use chemical restraints, such as the United Kingdom. Occupational Health and Safety laws should be considered during the drafting of the MHW Act, noting that although the aim is to eliminate the use of restrictive practices, clinicians nevertheless have the right to a safe workplace.

(6.3) The MHW Act should include documented intended timeframes for the implementation of a restraint.

The LIV recommends that the MHW Act include an obligation for a clinician to document the intended timeframe for the implementation of a restraint for each individual. This documentation needs to support the decision-making principles and be subject to review/auditing by a regulatory authority, such as the Mental Health and Wellbeing Commission.

(6.4) To facilitate consistency and clarity, the definitions of seclusion and restraint should align with those in other legislation as much as is practicable.

The LIV views continuity and consistency of care across public services as paramount to achieving clarity and success. Therefore, the MHW Act should integrate definitions of restraint and seclusion from the *National Disability Insurance Scheme Act 2013*[33] and the aged care *Quality of Care Principles 2014*,[34] where possible. These instruments provide a strong foundation for the different kinds of restraint and provides a framework for noting the use of such practices as 'reportable incidents'.

[33] *NDIS Act 2013* (Cth) s 9.
[34] *Quality of Care Principles 2014* (Cth) s 15E.

7. GOVERNANCE AND OVERSIGHT

Question 13: Do you think the proposals meet the Royal Commission's recommendations about governance and oversight? If not, why?

The LIV are of the view that the proposed governance and oversight proposals largely meet the Royal Commissions' recommendations, however there is room for improvement in order to bring the proposals in line with the recommendations. The LIV supports the Regional Mental Health and Wellbeing Boards' goal of providing a platform for greater integration of services across Victoria, noting that it is critical that the system be designed with flexibility in mind. The LIV further supports the proposal for the Mental Health and Wellbeing Commission's (MHWC) to be allocated a broader remit than the current Mental Health Complaints Commissioner.

Question 14: How do you think the proposals about governance and oversight could be improved?
In order to further improve the proposals about governance and oversight, the LIV makes the following recommendations:

(7.1) The MHW Act should identify the statutory functions of the MHWC.

The LIV notes that the *Mental Health Act 2014* (Vic) does not clearly delineate which regulatory agency is responsible for ensuring compliance with the Act and for protecting consumer rights. The LIV recommends that the MHW Act should clearly define and delineate roles and duties of governing bodies to avoid confusion, unnecessary duplication of resources and efforts, and the dilution of accountability across the governing bodies.

The LIV further recommends that the MHW Act should clearly articulate that it is the responsibility of the MHWC to protect the rights of consumers, their families and their carers under the MHW Act, and to ensure compliance with the MHW Act. The LIV suggests wording to the effect of:
(a) To promote, support and ensure compliance with the Act; and
(b) To promote, support and protect the rights of consumers as well as families and carers.

(7.2) Strengthen the regulatory powers of the MHWC.

While the LIV supports the introduction of own motion powers for the MHWC to perform investigations, the LIV recommends that this be accompanied with preventative interventions. This could include a power of the MHWC to require information from a mental health service about how they intent to comply with the MHW Act in a person's assessment, treatment, or care, if there are concerns that a breach of the MHW Act is imminent. Such concerns could be based on a

consumer's history of complaints, or any recent findings of serious breaches by a particular mental health service provider.

The MHWC should be empowered to compel compliance with MHW Act and issue warning notices or prohibition notices for potential breaches of the MHW Act. These notices should define conduct which would carry a serious risk of being unlawful, or that the failure to undertake particular conduct risks being unlawful. The LIV notes that such notices are common for regulators,[35] and enable the MHWC to prevent imminent harms, such as unlawful medical treatment decision-making or the unnecessary use of restrictive practices.

(7.3) The MHW Act should specify that the MHWC will consider complaints with paramount consideration to both voluntary and involuntary consumer's rights.

To promote the rights of both compulsory and voluntary mental health service consumers, the LIV submits that the MHWC must view all complaints equally. This further supports Recommendation (1.1) above under 'Objectives and Principles' – to create clearer obligations on how to comply with human rights principles, modelled off existing human rights legislation.

(7.4) The MHWC should mandate appropriate training for the mental health workforce.

As detailed in the LIV's Overarching Recommendation (1), the LIV views the MHW Act as an opportunity to rebuild the mental health system in Victoria with consumer-focused objectives and support structures. To secure this change there must be adequate training that instils the values and practices the new system will embody. This should include human rights training, which would then be reported on regularly to ensure the MHWC is fulfilling its remit to promote compliance with the MHW Act. Including mandatory training for the mental health workforce, as an objective of the MHWC will help maintain consistent quality standards across the mental health workforce. The aim of MHWC-mandated training should be the utilisation of best-practice techniques in supporting and caring for mental health consumers.

[35] Arie Freiberg, Regulation in Australia (Federation Press, 2017) 402–405.

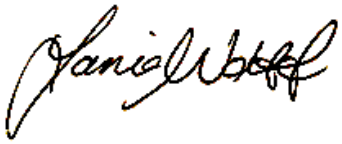
CONCLUSION

The LIV's submission is informed by the expertise and experience of lawyers who regularly assist people with mental illness and psychiatric disability to exercise their legal rights, who have significant experience in dealing with the Mental Health Tribunal, as General Counsel for leading public hospitals, and in working for disability rights organisations.

The LIV views the Mental Health and Wellbeing Act as an invaluable opportunity to reset the legislative foundations for the mental health and wellbeing system. The LIV welcomes the Royal Commission's ambitious reinvention of the mental health system including the phasing out of seclusion and restraints and moving away from a medication-based system to an integrated service approach.

The LIV would welcome the opportunity to discuss any of the issues raised in this submission further with the Department of Health. Should the Department wish to discuss any aspect of this submission further, please do not hesitate to contact Michelle Luarte, Senior Policy Lawyer, at mluarte@liv.asn.au or (03) 9607 9413.

Yours sincerely



Tania Wolff
President
Law Institute of Victoria

APPENDIX 1: TABLE OF RECOMMENDATIONS

Consultation Proposals	Do the proposals meet the Royal Commission's recommendations?	LIV recommendations for how the proposals could be improved
(1) OBJECTIVES AND PRINCIPLES	**Recommendations not met** The LIV is of the view that the proposed objectives and principles of the MHW Act do not currently meet the Royal Commissions' recommendations. The main concern identified by the LIV is that the principles do not generate clear responsibilities on mental health services to act in a way that is compatible with human rights. The LIV further submits that the MHW Act lacks judicial oversight, and it is unclear whether a breach of the principles is justiciable, giving rise to a cause of action.	(1.1) Create clearer obligations on how to comply with human rights principles, modelled off existing human rights legislation.
		(1.2) Amend the Charter to strengthen compliance with the MHW Act.
		(1.3) The role and purpose of mental health services should be clearly defined as a principle of the MHW Act.
		(1.4) Clarify the definition of 'personal recovery'.
		(1.5) Clarify the rights of voluntary consumers.
		(1.6) Apply a justice lens.
		(1.7) Include an additional proposed principle that is elder abuse focused.
		(1.8) Appropriate funding and resourcing by Government should be a principle of the MHW Act.

(2) NON-LEGAL ADVOCACY	**Recommendations largely met** The LIV is of the view that the proposed non-legal advocacy proposals largely meet the Royal Commissions' recommendations, however there is room for improvement in order to bring the proposals in line with the recommendations.	(2.1) Significantly expand the eligibility criteria for free non-legal advocacy services.
		(2.2) The MHW Act consider how to leverage existing health justice partnerships.
		(2.3) Non-legal advocacy services remain independent from the mental health system.
		(2.4) Co-produce non-legal advocacy services guidelines with consumers who have lived experience of the mental health system.
(3) SUPPORTED DECISION-MAKING	**Recommendations partially met** The LIV is of the view that the proposed supported decision-making proposals partially meet the Royal Commissions' recommendations. The LIV recommends that the MHW Act further enhance the effectiveness of advance statements, clarify an intention to move from a 'best interests' model to a supported decision-making model, and clarify protections for voluntary consumers.	(3.1) Enhancing compliance with advance statements to the best extent possible, through the appointment of an independent consumer-focused advocate and broadening the scope of persons authorised to provide a second opinion.
		(3.2) Statement of Rights for both voluntary and non-voluntary consumers.
		(3.3) Clinicians move away from a 'best interests' model to a supported decision-making model.
		(3.4) Greater consideration of other avenues to engage with consumers.
		(3.5) Increase public awareness of the use of advance statements, nominated persons, advocacy and second opinions.
		(3.6) Improve safeguards in relation to supported decision-making.

(4) INFORMATION COLLECTION	**Recommendations largely met** The LIV is of the view that the proposed information collection proposals largely meet the Royal Commissions' recommendations, however there is room for improvement in order to bring the proposals in line with the recommendations. The LIV largely supports the proposals about information collection and commends the suggested action to be taken by the Government to establish standards which guide services and practitioners in what information is appropriate to share with families, carers and supporters. The LIV, however, notes that a more productive conversation could be had with external stakeholders, once the wording of the proposed information sharing provisions are shared. At present, commentary is limited to the need to balance continuity of care, with safe and appropriate treatment that promotes compliance with patients' rights.	(4.1) The MHW Act must seek to achieve balance between the necessities of sharing information such as medication regimes, and the consumer's right to choose where their information is shared.
		(4.2) There be careful consideration as to how the information sharing provisions in the MHW Act/guidelines may be impacted by existing confidentiality obligations and information sharing schemes.
		(4.3) The MHW Act should provide statutory protections for health professionals to disclose in good faith.
		(4.4) More efficient review mechanisms for intervention orders made on the basis of situational and temporary safety risks, due to a person experiencing a mental illness.
(5) COMPULSORY TREATMENT	**Recommendations partially met** The LIV is of the view that the proposed compulsory treatment proposals partially meet the Royal Commissions' recommendations. While the LIV commends the proposed changes to the criteria for compulsory treatment, the LIV makes further recommendations to cement a human rights-based approach.	(5.1) The MHW Act reconsider its proposal to expand the range of professionals authorised to give temporary treatment orders.

		(5.2) Personalising consumer's experience with the Victoria's mental health system to meet individual strengths, needs, and culture.
		(5.3) The MHW Act should ensure that the limitation of rights using a 'last resort' approach is not applied by providers freely.
		(5.4) Increased accountability from those who order the compulsory treatment, including a mandatory obligation for a consultant psychiatrist to attend hearings or reviews relating to the consumer.
		(5.5) Provide clear examples of conduct which can be considered serious distress and clarifying that this must involve serious risk to the individual or another person.
		(5.6) There must be mandatory training for practitioners who are permitted to place patients under compulsory orders. This may include establishing a register of trained practitioners.
		(5.7) The Mental Health Tribunal be structured like a specialist court, with better case management capacity.
(6) SECLUSION AND RESTRAINT	**Recommendations largely met** The LIV is of the view that the proposed compulsory treatment proposals partially meet the Royal Commissions' recommendations. The LIV maintains concerns that the ten-year timeframe for eliminating restrictive practices is unnecessarily long, and that the MHW Act requires more prescriptive definitions of physical and chemical restraints.	(6.1) The timeframe for the elimination of seclusion and restraint practices should be reduced to five years, a further reduction from the ten-year timeframe recommended.
		(6.2) The MHW Act must include prescriptive definitions of all forms of restraint.
		(6.3) The MHW Act should include documented intended timeframes for the implementation of a restraint.
		(6.4) To facilitate consistency and clarity, the definitions of seclusion restraint should align with those in other legislation as much as is practicable.

(7) GOVERNANCE AND OVERSIGHT	**<u>Recommendations largely met</u>** The LIV is of the view that the proposed governance and oversight proposals largely meet the Royal Commissions' recommendations, however there is room for improvement in order to bring the proposals in line with the recommendations. The LIV supports the Regional Mental Health and Wellbeing Boards' goal of providing a platform for greater integration of services across Victoria, noting that it is critical that the system be designed with flexibility in mind. The LIV further supports the proposal for the Mental Health and Wellbeing Commission's (MHWC) to be allocated a broader remit than the current Mental Health Complaints Commissioner.	(7.1) The MHW Act should identify the statutory functions of the MHWC.
		(7.2) Strengthen the regulatory powers of the MHWC.
		(7.3) The MHW Act should specify that the MHWC will consider complaints with paramount consideration to both voluntary and involuntary consumer's rights.
		(7.4) The MHWC should mandate appropriate training for the mental health workforce.