



# RANZCP CONSULTATION RESPONSE

*ENGAGE VICTORIA*

The Victorian Mental Health and Wellbeing Act 2022



The Royal  
Australian &  
New Zealand  
College of  
Psychiatrists



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Victorian Branch

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## **Introduction**

The RANZCP is a membership organisation responsible for training and maintaining professional standards of medical specialists in the field of psychiatry in Australia. Its roles include support and enhancement of clinical practice, advocacy for people affected by mental illness and it plays a key advisory role to governments on mental health care. The RANZCP Victorian Branch currently represents over 1600 members, including over 1100 specialist psychiatrists and around 400 specialists-in-training.

The RANZCP Victorian Branch partners with people with lived experience, including through an active partnership on our Branch Committee as well as collaboration with Lived Experience Organisations. We respectfully acknowledge the importance of lived experience perspectives, wisdom and leadership in helping create system level changes.

In developing this submission, the Branch Committee has drawn on the generous feedback from its wider membership through surveys, emails and discussions. Multiple in-depth workshops and group discussions were convened to draw on expertise and experience of members. We had extensive engagement opportunities with Victorian committees of various Faculties, Sections, Networks along with the Racism Awareness Working Group and partnered with other professional groups and various peak organisations throughout this process. The extensive collaborative work has guided this initial submission to the development of the new Mental Health and Wellbeing Act.

Throughout the consultation many important issues raised in the Royal Commission have been highlighted repeatedly regarding need for system reforms and implications for service delivery. A major challenge is workforce shortages, with challenges in the attraction and recruitment as well as the retention of existing staff. Job dissatisfaction, turnover intention, burnout, staff morale and workplace violence are major issues for the Victorian mental health workforce that has been working within a broken system. This needs to be a priority to allow for the effective implementation of the recommendations of the Royal Commission into Victoria's Mental Health System (RCVMHS) and the new Mental Health and Wellbeing Act.

We anticipate there will be many opportunities ahead for discussion and input, including further targeted discussions on identified gaps such as the provision of treatment, care and support in emergency care settings. Also, importantly, in the care for people with intellectual disability, governed by the Disability Act.

I am deeply indebted to the generosity of spirit and collegiality demonstrated by so many stakeholders throughout this process. It was humbling to witness the commitment to redesign of the mental health and wellbeing system to best meet the Victorian community's needs.

**Dr Astha Tomar**  
**Chair, RANZCP Victorian Branch**

## Objectives and Principles

### **Question 1: Do you think the proposals meet the Royal Commission's recommendations about the objectives and principles of the new Act?**

No.

### **Question 2: How do you think the proposals about objectives and principles could be improved?**

The RANZCP Victorian Branch welcomes implementable legislative reform to support development of the best possible mental health system for consumers, carers, and the community.

However, it is difficult to legislate for system quality. Legislative change alone will not deliver this. To make a difference, system changes need to be in place before legislative changes. There must be appropriate resourcing to meet community expectations that have been further highlighted by the RCVMS. This includes equitable access to quality care and the structures to support and regulate system performance issues, in a new system enshrining lived experience in partnership with clinical expertise.

We do not want to repeat the failure of MHA 2014. It must be acknowledged that a poorly funded and broken system has led to the current disenchantment and struggles of consumers, carers and clinicians, with higher use of restrictive practices and inability to deliver the full range of evidence-based treatment options.

In the system reform, priority needs to be given to people already struggling with serious mental illness (SMI). This most vulnerable group frequently doesn't have a voice to express needs for holistic care which includes treatment, care and support, long advocated for by psychiatrists and other clinicians. We need to ensure that we do not further stigmatise people by unintentional messaging that mental illnesses do not need clinical interventions or worse that clinical disorders should not exist.

We emphasise the importance of building on existing research, evidence, and clinical and academic expertise. The RCVMS report has built a foundation with the huge contribution of many people with lived experience. In the framework building it will be a pity if existing evidence, research and clinical expertise is not included. Even in the current proposed Act the clinical input has not been included in the initial stages. Going forward we hope there is the opportunity to work in partnership to enable input of all voices.

It is important to recognise clinicians who have long worked in an inadequately funded system to support consumers and carers despite their own frustrations in not being heard. They have experienced moral distress in not being able to provide

treatment, care and support which from their professional expertise they know would help but have been unable to so due to the system not providing those options. The new Act is the opportunity to support change for the better, but it will also be important to ensure protection for clinicians in relation to any unintended consequences or impacts in enacting the principles.

The proposed objectives and principles should be carefully checked to ensure congruence with other legislation (e.g., Disability Act) as well as regulations, standards and clinical guidelines. For example, some concerns have been raised about conflating mental illness and psychological distress. Psychological distress is at times a normal life experience and, unless part of a mental illness, is not a condition for which there are strong evidence-based treatments. Also concerning is the use of the terminology 'as a last resort' in the context of clinical decision making.

In summary, we urge careful review of the proposed objectives and principles to ensure the terminology captures all the issues and concerns outlined. For further information see **RANZCP Mental health legislation and psychiatrists: putting the principles into practice.**

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

### **Question 3: Do you think the proposals meet the Royal Commission's recommendations about non-legal advocacy?**

Yes.

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

We support measures to enhance availability and awareness of advocacy services for consumers and carers. We agree that many consumers are not aware of, or do not have access to, rights-upholding mechanisms such as non-legal advocacy, legal representation, and safeguards such as Advance Statements and nominated persons.

Genuine increased engagement by mental health service providers with non-legal advocacy services are likely to be resource intensive. This needs to be recognised in funding models, especially around staffing resources.

We provide the following suggestions and considerations to improve the proposals:

- The current wording in the proposals is of concern as implies that psychiatrists would restrict access to a person's communication with an advocate/legal support. We request that the wording be reviewed.
- People need support to understand the various support options available to them including those of the nominated person, non-legal advocate, legal advocate, families, carers, and next of kin.
- Non-legal advocacy should be an addition to resources for consumers and carers, and not become a replacement for legal advocacy at Mental Health Tribunal hearings. As per the RCVMS Report, in Victoria in 2018–19, consumers were legally represented in only 13% of hearings which contrasts with 83% of hearings before the NSW Tribunal where legal representation was provided. Funding limitations are a major reason for Victoria's low representation rate. This is concerning and needs to be addressed.
- It is important to define the scope and role of a non-legal advocate and ensure consideration is given to a code of practice, education, support, training, oversight, and governance.

- Ensuring consumers receive their statement of rights not just at some points but throughout their journey with the mental health system would be a useful element of non-legal advocacy.
- Accountability of the non-legal advocacy service should be in line with that of the service providers, for example: being required to notify non-legal services within 24 hours. Currently the proposal does not specify in what duration of time does the service have to respond back and with what specifics.
- Ensure protections for confidentiality in the context of notifying the non-legal advocacy service. For example, a person who is not able to make a clear decision about opting in or out, may later be very concerned that their personal details and information have been shared, or not, with the non-legal advocacy service.

**Question 5: Do you think the proposals meet the Royal Commission’s recommendations about supported decision making? (Section 3.2 in the paper)**

Yes.

**Question 6: How do you think the proposals about supported decision making could be improved? (Section 3.2 in the paper)**

Psychiatrists are strong advocates for supported decision making (SDM). However, as the 2014 Act implementation demonstrated, legislation alone for quality SDM does not work. This highlights the need for appropriate funding for initial and ongoing education and resources, such as the [DHHS-Victorian Branch Enabling Supported Decision Making Project](#). Clinicians and others involved in care have a key role in this process as a source of education for consumers when providing evidenced-based recommendations and support to maximise decision making capacity. Therefore, we recommend regular training on principles of SDM for service providers and consumers/carers, including a role for dedicated Mental Health and Well-being Act education and training.

In terms of improving the proposals, whilst Advance Statements are valuable tools for enabling SDM, the authoring of an Advance Statement is *not* evidence of supported decision making. The process of working with a person to assist in completing an Advance Statement is a key part of the supporting process. Advance Statements are more likely to be effective when completed in a supportive manner, especially with a clinician able to work with a person in recognising and understanding advanced care directives to be followed in the event of compulsory care.

Understanding the options is a key part of expressing a future preference. Being aware of the different situations that may arise helps the Advance Statement to be more comprehensive. While appropriate and progressive, there are concerns about adding other measures in Advance Statements e.g., regarding food or mealtimes, which can be difficult to implement.

An Advance Statement, at times, may need to be re-considered when an individual who is under a restrictive order and is needing an urgent treatment. It is vital that written reasoning be provided wherever this occurs, to support the consumer and their carers/family to understand the need.

With regards to obtaining second opinions, it is important to provide timely second psychiatric opinions, and the funding and workforce needed should be available for this. Review of the current second opinion scheme must be completed prior to its consideration in the new Act.

Consideration must also be given to culturally informed practices and supporting individuals and families from diverse backgrounds in accessing information and support. People from Culturally and Linguistically Diverse (CALD) communities are overrepresented on treatment orders, making up 22% of active clients in Victoria and have the longest periods of compulsory treatment (RCVMHS). There should be explicit mention of family, carer, Aboriginal Liaison Officer, nominated persons and CALD support worker involvement, at times of crisis or safety planning. Also important is consideration when a person does not have family/carers supports available.

The Act should include data collection/research needs to capture details of variables for future system changes. In the interim, support for Aboriginal and Torres Strait Islander Peoples and CALD groups should include access to all information needed in their preferred language, with access to cultural support persons and active efforts to reduce barriers in communicating their views and preferences, not just for persons under the Act but for all accessing services.



**Question 7: Do you think the proposals meet the Royal Commission's recommendations about information collection, use and sharing?**

Yes.

**Question 8: How do you think the proposals about information collection, use and sharing could be improved? (Section 3.3 in the paper)**

Appropriate and sensitive information sharing plays a vital role in enhancing consumer outcomes by ensuring consistency in communication to all members of the multidisciplinary team, internal and external care providers, carers, and support persons involved. It also decreases the need for the person to repeat their story and be able to review (and be in control of) their progress in the recovery journey. However, it is critical to ensure the information is available/transferred in real time and that safeguards are in place to protect privacy and confidentiality.

We provide the following comments:

- With privacy and confidentiality being of key concern, and paramount in ethical standards, careful consideration of definitions is vital to ensure clarity and use. More information is required on what constitutes 'basic information' sharing, privacy and confidentiality issues and what constitutes relevant information as decided/provided by the consumer.
- The tension between timely need for critical access to accurate clinical information for care providers and privacy for consumers needs to be addressed with clear guidelines for operationalisation of the data custody and access based on privacy principles.
- Clarity is needed on specific provisions around basic information, and what this constitutes. As consumer confidentiality is the primary consideration, data deemed 'relevant information' must be explicitly defined, together with personnel/ agencies authorised to access this also defined by the consumer in the healthcare setting. For this to be a useful exercise, the concerns and perceptions of data security in previous projects like MyHealthRecord must be avoided.
- Healthcare providers must have statutory protections against claims of breach of privacy and confidentiality when they share information in 'good faith' to support treatment and care.
- Urgent priority should be given to developing/improving IT infrastructure that can integrate all health (and mental health) information, enable real-time access and entry and have protections in place to adjust access and editing rights (as per the user) to ensure privacy and confidentiality. Lived experience

and clinical input in design and development of such a system is highly recommended to ensure it is fit for purpose.

- The system will only be effective if previous versions of health records and databases existing within the State are incorporated. There needs to be acknowledgement and consistency between the proposed Act and other Acts that influence/affect Information Sharing/Ownership such as the *Carer's Recognition Act*, *Health Services Act*, *Health Records Act*, *Freedom of Information Act*, *OH&S Act*, Information Sharing Schemes and MARAM, with regards to sharing of information (with and without consent).
- We recommend that the person stays in control of their information and who accesses it, to what extent and for what purpose. This could be a fairly dynamic process and the system needs to support changes in accordance with the person's preference and needs.
- We suggest incorporation of consumer preference regarding information sharing in making and revising an Advance Statement.

## Treatment, care, and support

### **Question 9: Do you think the proposals meet the Royal Commission's recommendations about reducing the use and negative impacts of compulsory assessment and treatment?**

Yes.

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

Recovery and person-centred approaches emphasise the importance of empowerment and self-agency for an individual when struggling with a mental illness. An initial evaluation of the need for protection from serious harm and capacity can set the parameters for subsequent considerations of choice and responsibility. The long-term therapeutic aim is to foster personal responsibility for recovery and wellness.

We strongly reject the following proposed criteria:

#### 1.1 Replacing reference to 'preventing serious deterioration in the person's mental or physical health' with 'preventing the person experiencing serious distress'

A proportion of individuals with the most severe forms of mental illness, such as psychosis, mania, and severe depression, at times may not seek out or accept treatment due to lack of insight. Frequently these periods are not accompanied by a high level of distress. Left untreated, there is a high risk of self-neglect, loss of independence, profound psychosocial deterioration and serious harm to themselves or others, including suicide, violence, and other criminal offending. Since 'experiencing serious distress' seems to clearly come within the meaning of experiencing 'serious harm', the use of this phrasing seems unnecessarily confusing.

#### 1.2 Requiring that the harm being prevented must be both serious and imminent

To insert 'imminent' as proposed, a term that has no agreed definition, would set clinicians a task they have no ability to carry out. The removal of this terminology from the RC into Family Violence is well documented. While mental health clinicians cannot accurately predict the likelihood of a serious harm befalling a person with a mental illness into the very near future, they could reasonably come to views on the likelihood of serious harm into the longer-term

1.3 Require that all other treatment and support options to prevent the distress or harm have been considered and eliminated

In clinical practice there is always a range of 'treatment and support options' that might be considered. To require that clinicians have considered and eliminated 'all' of them is impracticable especially when people present in acute situations with significant risk to themselves or others.

**Further suggestions:**

Most Australian jurisdictions have amended their MHA so that a lack of the relevant decision-making capacity is included among the treatment criteria. We recommend careful consideration that capacity be considered as a criterion in the proposed review of the Act in 4-5 years. For that purpose, there must be a review of the evidence base on the addition of capacity as a criterion for compulsory treatment.

Capacity assessment needs a nuanced approach, and has had concerns quoted frequently:

*[T]he presumption of capacity...is widely misunderstood by those involved in care. It is sometimes used to support non-intervention or poor care, leaving vulnerable adults exposed to risk of harm. In some cases, this is because professionals struggle to understand how to apply the principle in practice. In other cases, the evidence suggests the principle has been deliberately misappropriated to avoid taking responsibility for a vulnerable adult. (UK House of Lords, 2005).*

We recommend MHT Hearings to be conducted earlier than the current scheduled 4 weeks, similar to NZ and ACT. This would provide for earlier and more timely discussion with a person, their supports and the clinical team. This has implications for resourcing and workings of the Tribunal as well as that of the services, which would need to be addressed.

Psychiatrists are best placed to assess and make recommendations with respect to the provisions of compulsory treatment within the Act and carry the responsibility of applying the Act in a consistent and appropriate manner, based on expert clinical judgement drawn from an evidence-based approach and their appropriate and extensive training.

**Question 11: Do you think the proposals meet the Royal Commission's recommendations about reducing the use and negative impacts of seclusion and restraint, and regulation of chemical restraint?**

Yes.

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

We are fully supportive of reducing use of seclusion and restraint but express caution regarding the goal of eliminating seclusion and restraint, with a possibly unrealistic expectation of achieving this in the next 10 years.

Seclusion and restraint are used as an emergency measure to manage violent behaviour or agitation in acute and mental health settings. The primary aims, when used, are to reduce the risk of traumatic experience and/or injury to individuals involved (the consumer, their carer/s, and staff).

Appropriate use of medications to treat mental illness must not be confused with 'chemical restraint'. There is a significant risk that the most unwell people may not receive appropriate treatment because of unnecessary focus on considering side effects of current treatments as chemical restraint. The RCVMHS recommends that use of chemical restraint is 'legislatively regulated'. We suggest that a similar regulatory approach to Tasmania be adopted. There, chemical restraint is defined broadly within their MHA and OCP guidelines as 'medication given primarily to control a person's behaviour, not to treat a mental illness or physical condition'. Excluded is medication to treat a mental illness or physical condition that may have a sedating effect. Rather, 'chemical restraint occurs when medication is intentionally given to exert control over a patient's movements or behaviour'.

Reducing seclusion and restraint requires education, support and resourcing for cultural change, as well as rigorous oversight and formal records. Where restrictive interventions have been reduced, clinicians are invested in and supported by building on and developing their existing skills and capacities. This has not been achieved by means of externally set targets but rather by clinical leadership, together with learning from lived experience and empowerment of staff.

The RCVMHS reported that overall rates of seclusion and restraint are consistently higher than the national average and there can be variation in reporting. Clarity and agreement are required on definitions of seclusion and of chemical, mechanical and physical restraint. The Act is an opportunity to create a new narrative and to better understand practices, monitor use, identify areas of concern and ultimately, support greater transparency and elimination where possible. We support 'least restrictive' terminology as more appropriate than 'as a last resort' in the context of clinical decision making.

Also noted by the RCVMHS is that the 'design of inpatient units may be contributing to high rates of restrictive practices...as may overcrowding, excess noise and lack of privacy' and that improved design of units has significant potential. Therefore, we encourage review of the research on design of inpatient facilities, amongst other measures.

It's imperative to support services to fulfill their 'responsibility to provide a safe environment for both consumers and staff—although this can be difficult within the current system. Safety concerns within inpatient units have negative effects on people living with mental illness and their families, carers and supporters, as well as the workforce' and as advised by WorkSafe Victoria 'the major safety challenge facing the mental health service is work-related violence, which can result in stress, vicarious trauma, and mental injuries, as well as physical harm' (RCVMHS).

Consideration is also needed of alignment with state/national OHS/WHS Acts where employers have a legislated duty of care to provide environments conducive to mental and physical wellbeing.

Note: The RANZCP is currently reviewing our Position Statement on minimising, and where possible eliminating, seclusion and restraint. We will be able to provide a copy when finalised in the coming months.

## Governance and Oversight

### **Question 13: Do you think the proposals meet the Royal Commission's recommendations about governance and oversight?**

Yes.

### **Question 14: How do you think the proposals about governance and oversight could be improved?**

The balance between governance and oversight is critical to the operation of an effective mental health system. The AMHS are currently subject to rigorous controls, oversight and reporting mechanisms. Caution is recommended, with an increase in compliance requirements carrying risk of diverting clinical staff away from front line clinical services.

With an increase in the number of entities in the proposed governance structure, there is a risk of duplication and overlaps. We suggest roles be defined in detail to minimise overlaps and possibly nomination of a lead agency in a particular matter.

We recommend provision of clinical leadership by psychiatrists in each of the new entities, alongside lived experience voices, to strengthen the new system architecture envisioned by the RCMHS.

Psychiatrists should be an integral part of every Regional Mental Health and Wellbeing Board to enable treatment, care and support to be planned and resourced to meet the needs of communities.

The Office of the Chief Psychiatrist (OCP) is essential in providing clinical leadership in statutory functions along with engagement with the sector. We recommend ensuring the OCP is reasonably independent within DH, with direct reporting to the Chief Psychiatrist to ensure oversight and accountability for decisions that relate to restrictive treatments, including use of the Act, and services complying with the principles of MHWB Act.

The OCP should be adequately funded and resourced, reflecting the RCMHS Report which identified that high demand for services has an impact on the capacity of OCP to help improve practices. It is also imperative that OCP has a multidisciplinary team approach with clinical seniors across all disciplines e.g., Social Work, Psychology, OT, Mental Health Nursing.

Currently in correctional settings, physical and therapeutic interventions are provided by a range of separate state and national agencies. The responsibility for providing elements of treatment is sometimes unclear, notwithstanding that the overall governance is overseen by Justice Health. Better outcomes would be achieved through a joined-up trajectory delivered by a more integrated system This could be overseen by OCP to ensure better outcomes for people.

We also recommend Safer Care Victoria have a Clinical Lead in Psychiatry to provide clinical leadership in helping develop and make available training and guidance for use of compulsory treatment. This Clinical Lead could also contribute to the role the new Mental Health Improvement Unit will take in contemporary quality and safety improvement approaches.

The MHWB Commission, in addition to having a Lived Experience Commissioner needs to have a Clinical Commissioner (psychiatrist) to provide clinical leadership in an independent statutory body whose purpose is to hold the Government to account. This would ensure replication of collaborative and equal relationships expected at all levels of governance.

We recommend optimisation of collaboration across individual therapeutic relationships and across/between services to avoid siloing of governance and operations. It's important to embed clinical and lived experience expertise and a transdisciplinary approach at all levels to achieve ownership of value driven outcomes. Solutions such as rotation of senior clinicians and lived experience leaders to all parts of governance structures from all services as 1–2 year secondments would enhance leadership capabilities.





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