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MENTAL HEALTH AND
WELLBEING ACT

ORYGEN SUBMISSION

EXECUTIVE SUMMARY

Orygen welcomes the proposal to enact a new Mental Health and Wellbeing Act to replace the *Mental Health Act 2014*. The development of a new legislative regime provides an opportunity to build the structure of a new mental health system in Victoria that promotes wellbeing and provides a prompt and wide-ranging set of early interventions for mental ill-health.

It has been proposed that the Mental Health and Wellbeing Act will only be reviewed after a period of five-to-seven years. Due to this timeline, it is vital that the development of new legislation occurs following considered and extensive consultation.

Some of the potentially significant changes proposed as part of the Mental Health and Wellbeing Act require further review. In particular, the proposed amendments to compulsory assessment and treatment orders are unlikely to meet the needs of consumers or service providers, and accordingly require further consultation.

In addition to the need for further consideration on certain issues, Orygen has outlined the following key amendments to the proposals in the Mental Health and Wellbeing Act engagement paper:

- introducing a mandatory requirement for the Mental Health and Wellbeing Commission to review complaints against alleged breaches of the objectives and principles of the Mental Health and Wellbeing Act
- lowering the maximum notice period for non-legal advocates to better ensure that consumers can access these supports as soon as possible
- providing statements of rights at all access points to the Victorian mental health system
- ensuring that practitioners or service providers make all reasonable attempts to discuss inconsistency with the consumer where a consumer attaches a note to their records in disagreement with a practitioner's statement
- shortening the maximum 28-day length of compulsory orders to minimise the impacts to a consumer if they are placed under an ill-considered or hastily provided compulsory order for an undue length of time
- reconsidering the proposed criteria for a compulsory order, due to difficulties in defining and operationalising the proposed criterion of 'serious distress' and 'serious and imminent'
- clarifying the definition of 'chemical restraint' to ensure that practitioners are not prevented from prescribing medication for therapeutic purposes
- mandating youth representation within Regional Mental Health and Wellbeing Boards, and one person representing a youth-focused service on Statewide and Regional Multiagency Panels.

ABOUT ORYGEN

Orygen is the world's leading research and knowledge translation organisation focusing on mental ill-health in young people. At Orygen, our leadership and staff work to deliver cutting-edge research, policy development, innovative clinical services, and evidence-based training and education to ensure that there is continuous improvement in the treatments and care provided to young people experiencing mental ill-health.

Orygen conducts clinical research, runs clinical services, supports the professional development of the youth mental health workforce and provides policy advice relating to young people's mental health. Our current research strengths include: early psychosis, mood disorders, personality disorders, functional recovery, suicide prevention, online interventions, neurobiology, and health economics.



ABOUT THIS SUBMISSION

Orygen welcomes the opportunity to provide a submission on the development of the Mental Health and Wellbeing Act (the MH&W Act).

Orygen will provide submission on each of the seven key topics identified within the MH&W Act engagement paper, namely:

1. [Objectives and Principles](#)
2. [Supported Decision Making](#)
3. [Non-legal Advocacy](#)
4. [Information Sharing](#)
5. [Compulsory Assessment and Treatment](#)
6. [Seclusion and Restraint](#)
7. [Governance and Oversight](#)

Orygen's submission is focused on opportunities to optimise the MH&W Act to ensure accessible, appropriate, effective and evidence-based mental health supports for young Victorians (aged 12 to 25 years).

Youth mental health experts across a range of research areas and clinical service delivery were consulted in the development of this submission, along with a number of young people who have had a lived experience of mental ill-health and contact with the service system in Victoria. We would like to acknowledge their time in talking to us and sharing their experiences.

OBJECTIVES AND PRINCIPLES

CONSULTATION QUESTIONS

1. Do you think the proposals meet the Royal Commission's recommendations about the objectives and principles of the new Act? If not, why?
2. How do you think the proposals about objectives and principles could be improved?

ORYGEN RESPONSE

OBJECTIVES AND PRINCIPLES

Orygen considers that the objectives and principles provided in the MH&W Act engagement paper are consistent with the Royal Commission's intent that the new Act '*should include concepts of autonomy, supported decision making, recovery-oriented practice, the protection and promotion of human rights, and the use of compulsory treatment as a last resort. These provisions should also seek to elevate the perspectives of people living with mental illness or psychological distress, families, carers and supporters*' (see page 37 of volume 4).

We are particularly supportive of proposed principle six, which recognises the value of people with lived experience in their role as active partners. This principle is enshrined throughout the Royal Commission's report and is a very worthwhile addition to the principles currently provided in the *Mental Health Act 2014*.

While Orygen is supportive of the intent of the principles and objectives, there are some potential opportunities to amend the proposed language:

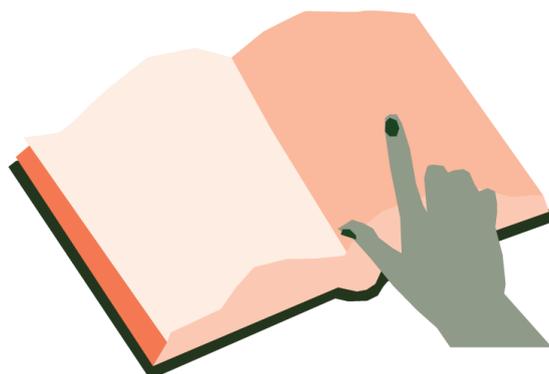
- **Principle two.** This principle provides that the 'needs and preferences' of people experiencing mental ill-health is to be taken into account. In order to give this principle more depth and utility, it may be worth outlining the various ways in which mental ill-health intersects and interacts with other domains (i.e. physical health, education/employment, relationships, housing).
- **Principle six.** It is proposed that this principle could be split into two separate principles. The first of these is to recognise the value of people with lived experience of mental ill-health or psychological distress, while the second would recognise the importance of the lived experience of carers, families and supporters. The purpose of splitting principle six is to recognise that the experiences and needs of people experiencing mental ill-health are sometimes distinct from the experiences of carers, families and supporters, yet both cohorts have a key role to play in Victoria's mental health system and warrant separate identification in the principles of the MH&W Act.
- **Principle nine.** As with principle six, Orygen considers this principle to be a valid addition to the principles of the *Mental Health Act 2014*. However, while the principle mentions family violence and trauma, it should also include specific reference to gender-related violence, which can occur outside the family environment. Gender-related violence is a particular risk for young women and transgender young people.(1, 2)

While there is a heightened risk of violence within the family, there is also increased rates of gender-related violence within intimate partner environments and outside the family or partner relationship.(1, 2) Accordingly, Orygen proposes that this principle be amended to provide for 'histories of gender-related violence, family violence, and trauma'.

- **Objective three.** Objective three is centred around the role that families, carers and supporters play in aiding people experiencing mental ill-health. Orygen considers that there is value in also recognising that families, carers and supporters often require their own supports.

This recognition could occur through a sub-point to objective three, providing *that families, carers and supporters are provided access to a diverse mix of supports, taking into account the needs and*

preferences of the family, carer or supporter, to best enable assistance to people living with mental illness or psychological distress. This language is akin to principle two.



SUPPORTING THE OBJECTIVES AND PRINCIPLES

The engagement paper provides three primary methods through which the objectives and principles may be supported: statutory guidelines issued by the Mental Health and Wellbeing Commission; a principles and objectives section within the annual reports of certain entities; and a new ground of complaint to the Mental Health and Wellbeing Commission if there is believed to have been non-compliance with the principles.

Orygen welcomes the intent to provide support to the objectives and principles, but considers that there are means in which these provisions could be strengthened.

Mandatory consideration of complaints

The engagement paper is unclear as to whether the Mental Health and Wellbeing Commission is required to investigate complaints of a possible breach of the principles. On page 36 of the paper, it is provided that the Commission '*will ... respond to complaints about mental health and wellbeing service delivery*'. This language indicates mandatory intent. However, page 30 provides that the Commission will '*receive complaints*' which indicates a possible discretion to respond or investigate complaints.

In order to promote trust within the Victorian mental health system, it is recommended that there be a clear statement in the MH&W Act requiring the Mental Health and Wellbeing Commission to investigate and respond to complaints. An example of how these provisions could be drafted can be seen in the *Veterinary Practice Act 1997* (Vic), which provides for how the Veterinary Practitioners Registration Board investigate complaints about professional conduct. Section 21(1) of that Act provides that the Board must investigate a complaint, unless the Board has determined the complaint to be lacking in substance or vexatious. A similar provision to this would greatly strengthen the principles and objectives of the MH&W Act.

Orygen recognises that putting a mandatory duty on the Mental Health and Wellbeing Commission to investigate all complaints will place a high resource burden on the Commission. A possible alternative to limit this burden is to provide for an in-house complaints role at mental health service providers of a certain size (i.e. hospitals) that is staffed by employees of the Commission. This would enable relatively prompt responses from within the service provider to an alleged breach of the objectives or principles.

Providing equivalent support to the objectives of the Act

The engagement paper provides there will be a new ground of complaint '*when it is believed a service provider or decision-maker has not made all reasonable efforts to comply with the principles*'. This ground of complaint should be extended to apply if a service provider or decision-maker has not made all reasonable efforts to comply with the objectives.

Such a change would be in line with the intent of the Royal Commission. On page 39 of Volume 4 of the final report, it is provided that the new MH&W Act should include new objectives and *'the requirement that the Department of Health and mental health and wellbeing services funded by the Victorian Government make decisions in line with the objectives.'* It is considered that the support mechanisms outlined in the paper fall short of the Commission's intent as they do not provide a means that require entities to act in accordance the objectives.

While Orygen notes that there is provision for reporting around the MH&W Act's objectives, this is unable to provide real-time compliance. However, the capacity to submit complaints regarding compliance with the objectives would allow for a considered examination of compliance in an effective manner.

GIVING DEPTH TO THE OBJECTIVES AND PRINCIPLES

As the objectives and principles are being provided with a degree of support and enforcement, it increases the need for all parties to understand how the objectives and principles operate in practice.

In this respect, Orygen welcomes the proposal that the Mental Health and Wellbeing Commission will be empowered to issue statutory guidelines on the interpretation and application of these principles. It is vital to ensure that these guidelines have been considered and developed prior to the commencement of the Act to minimise any confusion upon commencement of the MH&W Act.

NON-LEGAL ADVOCACY

CONSULTATION QUESTIONS

1. Do you think the proposals meet the Royal Commission's recommendations about non-legal advocacy? If not, why?
2. How do you think the proposals about non-legal advocacy could be improved?

ORYGEN RESPONSE

The provision of a new opt-out model of non-legal advocacy is a valuable change to mental health legislation and is in line with the intent of the Royal Commission. However, opportunities for improvement remain.

NOTICE PERIOD FOR NON-LEGAL ADVOCATES

The engagement paper notes that non-legal advocates are to be notified 'as soon as practicable', but within the first 24 hours after the making of an assessment order or temporary treatment order. There is a risk that the relatively high upper-bound of 24 hours may result in this initial notice not being provided until near to that time limit.

Using the language 'as soon as practicable' provides for a subjective examination of the circumstances of the party providing the notification. If a service provider or staff member is busy or otherwise unavailable, this could potentially justify notice not being provided until the end of the 24-hour period. This is important as there are potentially significant impacts that can occur to a consumer in that period, meaning that it is vital to ensure that notifications occur promptly.

There are two potential options that could significantly improve the operation of these provisions. The first option is to reduce the maximum time from 24 hours to eight hours. Shortening the upper-bound time to eight hours lessens the chance that a consumer would be left without non-legal advocacy in the vital first 24 hours. The challenge with this option is that it will be of greatest burden to mental health services at times of low-staff availability (i.e. overnight). For example, if a consumer is put on an assessment order or temporary treatment order near to the time a service provider closes, then it may not be feasible to provide notice in an eight-hour timeframe.

A second option, which potentially resolves this issue, is adapting the system to ensure that notification occurs with the assessment order or temporary treatment order. In this respect, when treatment orders are registered electronically, there would be a passive notification to non-legal advocacy providers. For this option to be viable, assessment orders and treatment orders must themselves be registered in a reasonable time.

Ultimately, for either option to be viable, they will need to be supported by a simplified notification process that best enables real-time reporting. This should be considered as part of the response to recommendation 62 of the Royal Commission's final report, which provided for the development of contemporary information architecture.

For either option, there is also value in supporting non-legal advocacy services to ensure that an advocate is available on-call on a 24/7 basis. Unless there is on-call support, then there is an increased risk for consumers who are admitted outside of peak times.

OTHER LEGISLATIVE CHANGES

Outside of the aforementioned change, Orygen considers there are some potential alternatives to improve the proposals around non-legal advocacy.

The engagement paper provides a mandatory requirement that service providers must notify non-legal advocacy services. However, there is no mention of an equivalent requirement that non-legal advocacy services must respond to the consumer. The language used in the engagement paper provides that information will be shared to *allow the non-legal advocate to contact the consumer*. This terminology indicates a potential discretion to the advocate. The risk with this discretion is if there is either an insufficient number of non-legal advocates, or a lack of support for non-legal advocates, this could result in consumers being left without non-legal advocacy support.

To resolve this potential issue, there should be a requirement that a non-legal advocacy service must arrange contact with the consumer within 12 hours of receiving notification from the service provider. If there is a tightening of the initial notification process from service providers (see above), this would help ensure that consumers are provided support from a non-legal advocate in the first 24 hours post assessment order or temporary treatment order.

To further strengthen the role of non-legal advocates, there is also scope to provide an effective 'non-treatment window' in the period between first presentation and the eventual contact from the non-legal advocate. In this window, there could be a limit on certain treatments unless those treatments are necessary to protect life, safety or immediate mental health needs. If a non-treatment window were considered, it would require further discussion with service providers to ensure that consumers are not placed at unnecessary risk.



MAKING NON-LEGAL ADVOCATES ACCESSIBLE TO YOUNG PEOPLE

In Orygen's consultation to support this response, one of the common themes was a lack of awareness of non-legal advocates and their role. This is consistent with commentary by the Royal Commission on page 425 of volume 4, where it was stated that '*matters of accessibility remain*' and '*those with the least understanding [of advocacy services], access it the least.*'

This challenge of accessibility and service engagement is commonly seen for young people. Young people are a cohort that is generally reluctant to seek professional care, and there are many barriers to young people seeking support.⁽³⁾

However, evidence suggests that young people are more likely to engage with services if they are aware of those services, and if the services are accessible and relevant for their needs.⁽⁴⁾ While there is a need for further consideration on how this could occur, Orygen proposes that there are a number of alternatives to help ensure improved engagement by young people with non-legal advocates:

- Introducing and developing youth-specific training programs to educate non-legal advocates on the unique perspectives and needs of young people. Such training programs would be developed in consultation with young people with lived experience
- Promoting opportunities for young people with increased risk of service disengagement to work as a non-legal advocates, such as Aboriginal and Torres Strait Islander young people, young people from culturally and linguistically diverse backgrounds, and LGBTIQ+ young people
- Allowing non-legal advocates to be promptly and easily changed upon request, as young people tend to place an increased value on personal connection in accessing services⁽⁴⁾
- Promoting the roles of non-legal advocates to young people to raise awareness of non-legal advocates and their role

- Using youth peer workers to support non-legal advocates.

While these options are not specifically legislative changes, it is necessary to consider how the proposed MH&W Act can be supported to ensure systemic change in the Victorian mental health system.

SUPPORTED DECISION MAKING

CONSULTATION QUESTIONS

1. Do you think the proposals meet the Royal Commission's recommendations about supported decision making? If not, why?
2. How do you think the proposals about supported decision making could be improved?

ORYGEN RESPONSE

On page 400 of volume 4 of the Royal Commission's final report, four key safeguards are outlined to effect supported decision making principles – statements of rights, advance statements, nominated persons, and second opinions. Orygen recognises the effort to strengthen these principles, yet considers there are further options to ensure more efficient operation of these principles.

STATEMENTS OF RIGHTS

Orygen welcomes an expansion of the circumstances in which people are provided with a statement of rights. It is currently insufficient that people are only provided with a statement of rights when they are subject to a compulsory order. While the proposal in the engagement paper is a forward step, Orygen considers that further changes are required.

The proposed change extends the mandatory provision of a statement of rights beyond compulsory orders, but only to a person voluntarily admitted as an inpatient. As people receiving inpatient care are generally experiencing acute mental ill-health, it is far from ideal that a consumer is only provided a statement of rights at this stage.

For statements of rights to operate effectively, they should be provided at all entry points to the mental health system. This helps ensure that a consumer's rights are part of the language of treatment from the earliest stages and will increase consumer literacy in those rights.

If there is to be a focus on understanding statements of rights and improving consumer literacy, then Orygen's view is that this should start as soon as possible. While not strictly a legislative issue, Orygen would welcome the development of mental health awareness and literacy courses for secondary school students. Such an approach would help decrease the stigma of mental ill-health, in addition to improving awareness of the mental health system.(5)

Communicating the statement of rights

To aid understanding of the statement of rights, Orygen considers that the existing section 13 of the *Mental Health Act 2014* could be further strengthened. Currently, this section states that when a person is provided with a written copy of the statement of rights, an authorised psychiatrist must also provide an oral explanation. For people with limited English or with cognitive or learning disabilities, a written document accompanied by a verbal explanation is not necessarily accessible or understandable.

In this regard, Orygen suggests an amendment in line with section 25 of the *Charter of Human Rights and Responsibilities Act 2006* which provides that (when a person is being charged with a criminal offence), a person is to be informed of the offence '*in a language or, if necessary, a type of communication that he or she speaks or understands.*' Utilising a similar mandatory provision would greatly aid understanding of the statement of rights.

Sharing the statement of rights

In the *Mental Health Act 2014*, when a statement of rights is issued in relation to a compulsory order, the statement of rights may also be provided to a nominated person, guardian, carer or parents (see sections 35, 40, 41, 50, and 59). The engagement paper states that *the new Act will require a*

statement of rights to be given to consumers who are voluntarily admitted as inpatients. Although there is reference to consumers, there is no reference made to who else the statement could be provided to. Due to the importance of support persons in aiding recovery from mental ill-health, Orygen considers that statements of right should be made available to support persons in all circumstances in which a statement is provided.

Form of the statement of rights

Section 12 of the *Mental Health Act 2014* provides that the statement of rights shall be in a form approved by the Secretary of the Department of Health and Human Services. In order to provide greater visibility to the content of the statement of rights, Orygen suggests that this provision be amended to instead provide that the content of the statement of rights be prescribed in regulations. The development of the statement of rights should also occur through consultation with people of lived experience of mental ill-health, including young people.



ADVANCE STATEMENTS AND NOMINATED PERSONS

The primary approach to improving the operation of both advance statements and nominated persons is to ensure that they are accessible to both service practitioners and consumers.

For advance statements and lists of nominated persons to be most accessible for service practitioners, there needs to be a central register of advance statements and nominated persons in line with the Royal Commission's commentary on page 428 of volume 4 of the final report that '*to foster greater understanding of safeguards and supported decision making among consumers and clinicians, the Mental Health Improvement Unit will ... provide for advance statements and nominated persons registers.*' The challenge of fulfilling this in the short term is the range of information-keeping approaches among service providers in Victoria. Accordingly, Orygen suggests that the creation of an advance statement register be a key feature of fulfilling Recommendation 62, providing for the development of contemporary information architecture.

In respect of making advance statements more accessible to consumers, Orygen welcomes the proposals in the engagement paper that advance statements can be provided on a broader range of topics.

We also support expanding the list of people who can witness an advance statement or the nomination of a nominated person. Orygen agrees that the list of authorised witnesses under the *Mental Health Act 2014* is too narrow. However, it is currently unclear how the list of witnesses will be broadened.

One possible proposal is that the witness provisions could be made akin to a will, as both documents exist as a statement of intent for a future action. The *Wills Act 1997* (Vic) provides that a witness can be any competent adult, capable of sight, with no particular qualifications being required. A risk of this option is that advance medical statements and nominated person forms are less accessible than wills

and may require a degree of technical knowledge. Accordingly, a second option is to use the list of people who can witness an affidavit or statutory declaration as outlined in section 19 of the *Oaths and Affirmations Act 2018* (Vic).

Substituted decision making

A key topic within the Royal Commission's final report was the overriding of advance statements, also known as substituted decision making. The Commission provided there would be a reduction of substituted decision making in the medium-term (page 428 of volume 4). While Orygen recognises that this responsibility was allocated to the Mental Health and Wellbeing Commission, it is noted that there is no mention made in the engagement paper of any approaches which will assist in limiting the use of substituted decision making. With respect to compulsory orders, seclusion and restraint, there are proposed approaches (such as quotas) which endeavour to reduce these behaviours. However, there are no equivalent approaches for substituted decision making. This is an issue that requires further consultation with both service providers and consumers.

Orygen agrees that there are circumstances in which clauses in an advance statement of rights need to be substituted. However, there should be clarity for service practitioners on the bases for that substitution, and clarity for consumers on why the substitution occurred. In this respect, there is a need to clarify the terminology 'treatment ordinarily provided by the designated mental health service'.

The risk with this language is that it could lead to equity issues depending upon service availability. If a consumer is in a region with a comparatively lower level of service availability, then there is an increased chance that their needs as specified in the advance statement may not be able to be met. In that situation, the 'treatment ordinarily provided' language would enable substitution, where a consumer in a region with greater access to services would be able to have their needs met. One option is to replace the words 'treatment ordinarily provided by the designated mental health service' with something akin to 'treatment reasonably provided by a designated mental health service.' This would limit issues of service equity and instead become a more objective examination of whether the treatment is ordinarily provided by Victorian service providers.

In terms of clarity for consumers, Orygen welcomes the proposed change that service practitioners must provide written reasons for a decision to override an advance statement. This is a significant improvement over the *Mental Health Act 2014*, which only provided that consumers must be informed that they had a right to written decisions, rather than decisions being put into writing as a matter of course. Orygen would also like to note the commentary on page 429 of volume 4 of the Royal Commission's final report, which provided that '*[d]ata systems should support services to make reporting efficient and practicable.*' Any change which increases reporting requirements on practitioners is likely to have an impact upon practitioner capacity, and these changes should not occur without improvements to reporting systems or additional resourcing to practitioners.

Orygen also welcomes the proposed amendment that written decisions around substitution can be provided to any other person at the consumer's request. In addition to this change, there is value in outlining what can occur if a consumer is unable to nominate another person due to a lack of capacity. In situations where the consumer is deemed to lack capacity, then written reasons for substitution should be provided to any persons listed in an advance statement, and if no advance statement is available, a non-legal advocate.

SECOND OPINIONS

While the Royal Commission's final report identified issues with the length of time it took to access a second opinion, it did not identify the reasons for this beyond a lack of available resources (see page 401 of volume 4).

The engagement paper provides that the MH&W Act will allow more flexibility in how second opinions can be provided. While this is a worthwhile aim, there is insufficient detail to determine whether this

will significantly impact consumer availability to second psychiatric opinions. Orygen recognises that legislative change is not the ideal pathway to effect genuine change on this issue. Ultimately, this is a matter that stems from pipeline issues and resourcing. A future well-resourced and supported mental health sector will also be one where consumers are more easily able to access second psychiatric opinions.

One potential legislative change is to provide an upper time-bound on when requests must be responded to by the second psychiatrist. Due to the often time-specific nature of mental health care, it is vital that any second opinion be accessed promptly. However, there is no current provision in the *Mental Health Act 2014* which provides a time limit on when the second psychiatrist must contact the consumer. If such a change were introduced, it would lessen the time taken to access a second opinion. Such a change should only occur following due consideration of the resourcing needs of the mental health sector. If such a change were bought in without proper resourcing, it would significantly impact currently practising psychiatrists.

INFORMATION SHARING

CONSULTATION QUESTIONS

1. Do you think the proposals meet the Royal Commission's recommendations about information collection, use and sharing? If not, why?
2. How do you think the proposals about information collection, use and sharing could be improved?

ORYGEN RESPONSE

Orygen is supportive of the need for a consumer-driven, consent-focused approach to information sharing. Orygen also recognises the value in expanding the range of circumstances in which families, carers and supporters can access information. The proposals outlined within the engagement paper appear to be broadly consistent with the intent of the Royal Commission, although there are some questions and further opportunities for improvement.

IMPROVED INFORMATION ARCHITECTURE

Any proposals to improve information sharing should not be considered without considering the information architecture that is necessary to improve that information sharing. As outlined on page 90 of volume 5 of the Royal Commission's final report, there are a wide range of approaches to record-keeping and information among mental health service providers. This situation creates potential inequities in how consumers are able to access their own information.

In order to resolve this, the Royal Commission provided in Recommendation 62 for the development and implementation of modern information and communications technology systems for mental health providers. While Orygen recognises that this process is a complex one, improved information architecture is necessary to ensure that the proposed information sharing changes within the MH&W Act can be equitably executed throughout Victoria.

WHO INFORMATION IS PROVIDED TO

The engagement paper provides that the MH&W Act *'will create a duty for mental health service providers to share information with families, carers or supporters ... with the consumer's consent.'*

The wording used above indicates that information can only be provided to families, carers or supporters. Orygen wishes to clarify whether this list is intended to be exhaustive and, if so, who it is intended to apply to. There is not currently a definition of 'supporter' within Victorian legislation and Orygen's primary concern is that the term is defined narrowly, which may limit the range of people who can aid the consumer. However, if the term is defined broadly, as any individual or group of individuals who provide help or support to people experiencing mental ill-health, then we consider that this provides sufficient definitional flexibility.

Orygen also wishes to clarify how consent operates within these proposed provisions. Generally, consent is perceived as conferring additional access – as in the consumer consents to a broader range of people to access the information. However, feedback from Orygen's consultation has expressed interest in whether consent can be utilised to reduce access – in that the consumer can prevent others from information. Mental health information can be very sensitive and there is a heightened risk of sensitivity for young people. There may be situations in which a young person wishes to prevent a family member, carer or supporter from being able to access information.

If all information sharing in the MH&W Act is dependent upon consumer consent, then the abovementioned concerns are not necessarily an issue, as the consumer will simply be able to outline who they want information to be provided to. However, there are provisions in the existing *Mental Health Act 2014* which provide for mandatory provision of information in potentially sensitive

circumstances. As one example, section 32 provides that information regarding an assessment order can be provided to a carer if assessing the person will directly affect the carer and the care relationship. Under this provision, there is a risk that sensitive information about a young person may be provided contrary to their wishes. Orygen wishes to confirm whether information sharing may be able to be limited in these circumstances if the young person considers that certain people should not get access to information.

Orygen recognises that the aforementioned paragraphs are not universal for all young people. There are a range of information provisions within the *Mental Health Act 2014* that provide for mandatory notification of certain information to a parent or a carer if a person is under the age of 16 years. In this respect, we ask that there be consideration as to how young people between 12 to 16 years can be involved in the decision making of sharing their personal information.

WHEN INFORMATION IS PROVIDED

The engagement paper provides that information will be able to be shared at 'defined points' during a consumer's care or treatment. While Orygen is generally supportive of this intent to improve information sharing, there are concerns that being overly prescriptive on defined points could lead to an inflexible approach.

Instead of a purely milestone-based approach, Orygen suggests that there could be a general provision which provides that information is to be shared across the course of treatment to ensure that consumers, families, carers and supporters are able to make decisions in relation to treatment. The language within this general provision is akin to that within the proposed principles five and six of the MH&W Act. This general provision could then be bolstered with indicative (rather than prescribed) milestones at which information should be provided.

An example of how a general provision around information can be combined with indicative examples is seen with section 53 of the *Service Victoria Act 2018*. This section provides a general reporting power in subsections (1) and (2), but subsection (3) then provides a list of potential inclusions within that report.

Regardless of the approach taken to such a provision, Orygen would like to see further consultation on what these defined points of information sharing could be.

CAPACITY TO CONSENT

In a consent-driven information sharing system, there needs to be consideration of what occurs when a person does not have the capacity to consent. However, there is no mention within the engagement paper of what is to occur if consent cannot be provided.

One option is to use the existing regime for decision-making and apply it to information sharing. Section 75 of the *Mental Health Act 2014* provides who may consent to give medical treatment if a person is unable to provide informed consent. This section provides for a relatively narrow list of persons and Orygen considers there is an opportunity to use this list as a base for information sharing. In addition to the parties listed in section 75, consent may be provided by a person who is listed in a statement of rights or a nominated person. Including a reference to these parties further enshrines a consumer's ability to have a choice in who can act on their behalf.

CONSUMER STATEMENTS

The engagement paper provides for a new provision that allows consumers to include a statement on their record if they disagree with any information in that record. During Orygen's consultation, one of the concerns raised by young people with lived experience was the perception that making such a note of correction could bias ongoing treatment. To give one potential example, if a person has been diagnosed with a mental disorder which impacts external perception (i.e. psychosis), and that person

disagrees with a statement on their record, there is a potential risk that the disagreement could be considered as a symptomatic demonstration of the mental disorder, even if the person is well.

Orygen recognises that these inconsistencies in opinion will occur and consider that the legislation should provide a regime in which the consumer and the service practitioner can discuss the inconsistency. Accordingly, Orygen proposes that if a consumer attaches a statement to their record indicating disagreement, then the practitioner or the service provider must make all reasonable attempts to discuss the inconsistency with the consumer. If the inconsistency is not able to be resolved, then it is worth including a provision which prevents the use of a consumer's notes as evidence of the symptoms of mental ill-health.

CLARIFYING CERTAIN TERMS FOR INFORMATION SHARING BETWEEN SERVICES

While Orygen supports the general approach to simplify information sharing, there is concern with the proposal that '*consent for sharing basic information with the broader social service system will not be required.*' There are two concepts in particular which require clarification:

- **Basic information.** Basic information can be quite narrow (i.e. name and age), yet can also be defined more broadly to include information used to help identify and contact a person (i.e. addresses, contact details, employment information). If 'basic information' is defined more broadly (especially if information is provided around a person's diagnosis), then there is the concern from young people that this information is provided widely among social service system.

Existing practice in health seems to indicate that 'information' is generally viewed quite broadly. The *Health Records Act 2001* defines 'health information' to include information on a person's diagnosis as well as personal information sufficient to enable reasonable identification of that person. If a similar definition is used for 'basic information' under the MH&W Act, this would be of some concern.

While Orygen recognises that a consumer could request that information not be shared, this relies upon a universal awareness that such an option is available. For young people who may be inexperienced in navigating the service system, there is a heightened risk that they will be unaware of such an option.

- **Broader social service system.** If this term is defined broadly, it may include any services which exist for the benefit of the community, such as education providers, housing providers, and police and justice. There is likely to be concern if information can readily be provided to some of these non-health service providers. Different social service providers are very distinct in their operation and often have different objectives, accountabilities, legislative functions, and requirements around privacy and information.

To give just one example of the potential impact of this change, if it is known that a person with lived experience of mental ill-health has more difficulty in accessing housing due to the stigma that they are more difficult tenants.⁽⁶⁾ As such, young people are likely to be uncomfortable if basic information about their mental health and wellbeing could be provided to housing providers.

Due to the potential impact of these concepts upon consumers, Orygen requests further information on what is intended through this proposed change and if/how the abovementioned terms are going to be defined in the MH&W Act.

INTERACTION WITH FOI LAWS

The engagement paper notes that the MH&W Act will enhance consumer access to their own information. Orygen is very supportive of this intent, yet we would like to clarify whether this will be impacted by the operation of the *Freedom of Information Act 1982*. Section 6A of that Act provides that the operation of that Act does not affect the operation of another Act, but Orygen would like to ensure that there are no potential impacts due to the interrelationship between the two pieces of legislation.

COMPULSORY ASSESSMENT AND TREATMENT

CONSULTATION QUESTIONS

1. Do you think the proposals meet the Royal Commission's recommendations about reducing the use and negative impacts of compulsory assessment and treatment? If not, why?
2. How do you think the proposals about compulsory treatment and assessment could be improved?

ORYGEN RESPONSE

Orygen's consultation on compulsory treatment and assessment has noted that there are strong competing views regarding this issue.

There is the perception from consumers that the use of compulsory treatment and assessment orders is an unduly invasive approach that limits an individual consumer's rights to have a voice in their own treatment.

From clinicians and service providers, Orygen has heard that compulsory treatment and assessment orders remain a necessary response depending upon circumstances and are mindful of any legislative changes that may lead to an increased risk being faced by mental health staff.

There are complex attitudes that exist around compulsory treatment and there are divergent perspectives on the impact of compulsory orders. A 2010 qualitative analysis of patient experiences under mental health legislation found that involuntary inpatient care is often frightening and distressing, but there was also a recognition that involuntary care had kept people safe at a time when the severity of the mental ill-health could not be identified.⁽⁷⁾ An Australian study on inpatient mental healthcare noted the complexity of experiences of care, including how involuntary care endeavours to facilitate clinical recovery while not being recovery-oriented.⁽⁸⁾ A recent study of binding directives for people with bipolar disorder found a majority of the participants endorsed binding directives as a means of shifting distorted thinking and decision making when unwell.⁽⁹⁾

Compulsory orders also have an impact on families and carers. In some cases, families and carers have expressed concern about the powerlessness that can occur when a person is under a compulsory order and there may be different attitudes on the need for hospitalisation. However, there is often a recognition that these orders can provide assistance that the family or carer may not be able to provide.^(10, 11)

From Orygen's consultation and a review of the available evidence, there is unlikely to be a simple response to the future of compulsory orders. The range of views around compulsory assessment and treatments means that this is an issue which requires deep consideration. If changes are made without due consultation, then there is a risk of either a loss of trust by consumers or an increased burden upon service providers. It is vital that any response to this issue involve extensive consultation with a wide range of voices within the Victorian mental health system.

The in-depth consultation needed to progress this issue will not be able to occur under the proposed timelines presented in the engagement paper. Accordingly, Orygen proposes that provisions relating to compulsory assessment and treatment be delayed. Such a period of delay was proposed in the Royal Commission's final report which stated that '*while some provisions could start upon attaining Royal Assent, other amendments may need a longer lead-in time before starting. This would give the Victorian Government, the mental health workforce and service providers enough time to properly lay the groundwork for major change*' (See page 38 of volume 4).

Orygen notes that the Royal Commission also stated on page 38 of volume 4 that '*provisions relating to compulsory assessment and treatment should no longer be the defining feature of Victoria's mental health laws, and provisions that are brought across from the Mental Health Act should be simplified.*' We agree that compulsory orders should not define mental health treatment in Victoria, but for this to

occur, there is a need for a system that is enabled to provide effective early intervention of mental ill-health to limit the number of people who experience acute mental ill-health and are accordingly at increased risk of experiencing more invasive treatments.

The Royal Commission's final report recognises this need in chapter 32.2.2. The Commission states that '*[s]carce resources have meant that public mental health services have had little choice but to concentrate the delivery of services on crisis responses and acute inpatient services. This has made it difficult to focus on early intervention and recovery through community-based mental health services, which are approaches that would help to avoid crisis and reduce compulsory treatment use*' (page 386 of volume 4).

In chapter 32.2.2, the Commission states in summary that '*under-investment in the current system does not allow consumers to receive treatment, care and support when it would make the most difference nor enable the workforce to provide services in a way that would reduce the use of compulsory treatment*' (page 387 of volume 4).

In this regard, Orygen considers that the major step needed is the promotion and resourcing of early intervention and prevention approaches. This will help lead towards a future Victorian mental health care system that limits the use of compulsory orders while not being overly burdensome on service providers. While legislative change is needed, it is not a change that should occur with excessive haste due to the impact that it could potentially have upon consumers and service providers.

While Orygen's recommendation is that there is additional consultation on the reduction of compulsory orders, we can provide the following feedback in the event that the proposals in the engagement paper are put into effect.

SHORTENING THE AUTHORISATION PERIOD

The *Mental Health Act 2014* provides that a treatment order can be in place for 28 days prior to a hearing by the Mental Health Tribunal. Section 61 of the *Mental Health Act* does provide a power for an authorised psychiatrist to revoke an order prior to the 28-day expiry date. However, anecdotal evidence suggests that this power is less likely to be used as opposed to psychiatrists simply letting the order lapse.

Ultimately, Orygen considers that this 28-day period of review is too long due to the potentially significant impacts to a consumer if they are left under an ill-considered, hastily provided or misapplied compulsory order for such a length of time.

There are examples in interstate legislation of shorter review periods for compulsory orders. In the *Mental Health Act 2007* (NSW), a review of a community treatment order can be heard in a minimum of three days if the person is detained in a mental health facility, and a minimum of 14 days if they are not detained in a mental health facility.

Under the *Mental Health Act 2013* (Tas), an initial compulsory assessment order (which has effect for 24 hours) can only be extended for a maximum of four days prior to the Tasmanian Mental Health Tribunal considering whether a treatment order should be issued.

Orygen does not consider that a review period of less than seven days is necessarily viable as it can take this long to examine and review the impacts of treatment. Instead, we propose that the assessment period in the *Mental Health Act 2014* be lowered to somewhere between seven to 14 days. This time period balances the risk of harm to a compulsory order being in place too long while providing sufficient time to understand the impact of a compulsory order.

Orygen is mindful of the impacts of such a proposed change and suggests that there would need to be extensive consultation to understand the impacts of shortening the review period. One notable impact would be an increased administrative burden upon service providers and clinical staff who would have a limited time to submit notification of compulsory orders to the tribunal. This could then impinge on

the amount of time that practitioners are able to dedicate to treatment and potentially impact upon the quality of care. Orygen considers that there are two potential options to alleviate the practitioner burden:

1. Provide funding to eligible mental health care providers to employ clinical staff to support reporting, as well as administrative staff to support record-keeping and reporting.
2. Simplifying the current reporting requirements. As we previously proposed with non-legal advocates, there should be the ability for service providers to send push notifications via their browser to the Mental Health Tribunal.

Lowering the review times may increase the burden upon the Mental Health Tribunal. However, if there is a shorter timeframe then this will be balanced by a lower need for conferences to be held, as proposed in the engagement paper

Lived experience and the Mental Health Tribunal

In the event that the MH&W Act provides for a shorter review period, it is likely that this will increase the burden on the Tribunal itself. Orygen considers that this is an opportunity to provide for a greater number of people with lived experience on the Tribunal.

Sections 159 and 163 of the *Mental Health Act 2014* provide that community members with an interest/experience in mental illness can be appointed as a senior member of the Tribunal. Section 179 further provides that a community member must be appointed to both general and special proceedings of the Tribunal. Orygen supports these provisions, but there is an opportunity to consider whether sections 179(2)(c) and 179(3)(c) can be amended to support young people becoming members of the tribunal. There is an option to provide for something akin to a community member with reasonably comparable lived experience to the relevant consumer (if available). For young people, there would be greater trust in the tribunal system if it were staffed by other young people with a similar lived experience.

THE CRITERIA FOR COMPULSORY TREATMENT

Within the engagement paper, it is proposed to change the criteria under which a compulsory treatment order can be made. This may be a viable approach, but Orygen has concerns with the proposed new criteria.

Serious distress

The proposed criterion of 'serious distress' could be challenging to define and apply within a clinical setting. Currently, the criteria for a compulsory order, as outlined in section 5 of the *Mental Health Act 2014*, provides that a person must have a mental illness, and because they have a mental illness, the person needs immediate treatment to prevent 'serious deterioration in the person's mental or physical health'. The Act ensures the need for a causative link between the mental illness and the serious deterioration.

If the language 'because the person has a mental illness' remains in the MH&W Act, there is likely to be an increased difficulty in proving a causative link between the mental illness and the experience of distress, because distress can arise from a wide-range of situations. This is a particular issue for acute settings, as distress is too often an inherent part of acute treatment. For example, if a young person is presenting at an emergency department, the environment, the interactions and the uncertainty could all lead to the young person experiencing distress, which is not necessarily linked to any underlying mental ill-health.

If there is confusion in determining whether or not the distress was caused by the mental illness, then the service practitioner will find it unduly difficult to determine whether or not a person meets the criteria for a compulsory treatment order. While this could result in a reduction in compulsory treatment orders, there is a risk that it will lead to an increase in compulsory orders.

For example, if a young person presents at an emergency department under police supervision and in distress, their distress may be perceived as being linked to a mental illness and to put the person under a compulsory treatment order. However, in this scenario, the young person in question had little experience with either police or emergency wards and was distressed due to the unfamiliarity and difficulty of these experiences, and would not have been distressed in other settings. For situations similar to the scenario outlined above, the proposed new criteria may lead to a potentially increased risk of compulsory treatment orders.

The solution is not to remove the language 'because the person has a mental illness', as this will almost certainly increase compulsory treatment orders. If that language is removed, then the criterion will become "the person needs immediate treatment to prevent serious distress". As outlined above, distress can be a response to the acute treatment process, especially for young people with limited service experience. In those scenarios, any distress, even if caused by the situation or environment, will be enough to satisfy this particular criterion for a compulsory treatment order.

A further issue with the change to 'serious distress' is that not all mental illnesses lead to experiences of distress. People experiencing certain mental disorders might not present with any visible distress. For example, people with eating disorders, or who are in a delusional state, can often lack visible distress due to their beliefs about themselves and their surrounding circumstances. Under the *Mental Health Act 2014*, the lack of distress would not prevent the imposition of a compulsory order as the aforementioned disorders would still satisfy the requirement of being a 'serious deterioration in the person's physical or mental health'. If there is no reference to 'serious deterioration' or 'serious harm' in the MH&W Act, then there is the risk that people with serious presentations of certain disorders may not access care.

For these reasons, Orygen does not support the use of 'serious distress' within the MH&W Act. Due to the complexities of any criteria that are used, this is a matter that must be examined more broadly in consultation with the mental health workforce and people with lived experience of mental ill-health.

Serious and imminent

The second listed criterion in the engagement paper provides that the harm being prevented must be both 'serious and imminent'. This language is currently used in the *Mental Health Act 2014* for the criteria for whether seclusion and restraint. The terminology of imminent risk applies to seclusion and restraint as seclusion/restraint are immediate responses to a severe, imminent risk.

However, using the word 'imminent' for compulsory treatment orders is less appropriate because treatment orders do not necessarily provide for immediate, short-term responses. To give an example, if a person presents with an eating disorder, their underlying physical symptoms may not suggest an imminent risk to the person's health, but they are at risk of serious, long-term harm.

Under the language of the *Mental Health Act 2014*, this scenario would meet the criteria for a compulsory treatment order, but would not meet the proposed criteria in the MH&W Act. Accordingly, using the criterion 'serious and imminent' presents a danger that people at risk of significant harm, may not access necessary care.

A further challenge faced by the use of 'imminent' is that for most of the impacts of mental ill-health, there are few tools to determine whether or not a risk is imminent. One exception to this is for aggression and violence, where there are a range of diagnostic tools to assist in determining whether aggression or violence is imminent.⁽¹²⁾

However, even where risk prediction tools are available, these tools take time and involve a high level of expertise. Accordingly, risk prediction tools are often not practicable in situations requiring an immediate determination – particularly in emergency wards.

A further challenge is that attempts to define the probability of a mental ill-health event occurring have not been very successful. To provide a notable example, there has been a range of research

endeavouring to determine what risk factors lead towards a person being identified as a 'high-risk' or a 'low-risk' of suicide. Dr Matthew Large, the Clinical Director of Mental Health in the Eastern Suburbs Mental Health Service, NSW, has done a significant amount of research on risk assessment and suicide. He has stated that *'risk categorisation of individual patients has no role to play in preventing the suicide of psychiatric inpatients'* and that diagnostic tools for risk of suicide have *'limited validity because they contain factors that were in all likelihood chance findings.'*(13, 14) Accordingly, even where risk tools are in place to determine if something is imminent, there is no guarantee that predictive tools will be more effective than chance.

For each of these reasons, if the criterion of serious and imminent is introduced, then it will place a heightened burden on the workforce and service providers to make decisions on a criterion that is challenging to operationalise. This therefore increases the likelihood of improper application of the criteria for compulsory treatment and an according risk to the provision of mental health care. As such, this criterion must be examined more broadly in consultation with the mental health workforce and young people with lived experience of mental ill-health.

Eliminating all other treatment options

The third proposed criterion in the engagement paper provides that all other treatment and support options must have been considered and eliminated. Orygen is generally supportive of this criteria, although for this criteria to be effective in reducing compulsory orders, there must be the equitable funding and provision of genuine service alternatives. This was outlined clearly in chapter 32.2.2 of the Royal Commission's final report (for further commentary on this chapter, see page 13 to 14 above).

Alternative criteria

On page 385 of volume 4 of the Royal Commission's final report, they outlined that Western Australia had the lowest number of people subject to compulsory treatment orders and the lowest proportion of acute separations for hospital stays. While every state and territories' mental health scheme is different, there is value in examining the Western Australian approach to compulsory orders.

Section 25 of the *Mental Health Act 2014 (WA)* provides five criteria before an involuntary treatment order can be considered:

1. that the person has a mental illness for which the person is in need of treatment;
2. that, because of the mental illness, there is
 - a. a significant risk to the health or safety of the person or to the safety of another person; or
 - b. a significant risk of serious harm to the person or to another person;
3. that the person does not demonstrate the capacity required by section 18 to make a treatment decision about the provision of the treatment to himself or herself;
4. that treatment in the community cannot reasonably be provided to the person;
5. that the person cannot be adequately provided with treatment in a way that would involve less restriction on the person's freedom of choice and movement than making an inpatient treatment order.

The first, second, fourth, and fifth criterion are reasonably similar to what is currently provided in section 5 of the *Mental Health Act 2014 (Vic)*. What is significantly different is the third criterion, which has the effect of providing that if a person can effectively understand and communicate their treatment, then they have the capacity to make treatment decisions. Section 18 of the *Mental Health Act 2014 (WA)* provides that a person performing a function under that Act is responsible for determining whether the patient has this capacity.

This third criterion is a demonstration of the idea of 'dignity of risk', which involves respecting consumers' ability to make decisions for their own needs. The proposed objectives and principles of the MH&W Act recognise the importance of dignity of risk through the words of principle four – *'involve people receiving mental health and wellbeing services in all decisions about their assessment,*

treatment and recovery and ensure they are supported to make, or participate in, those decisions, and respect their views and preferences, including when those decisions involve a degree of risk.' In this respect, the concept of dignity of risk emphasises consumer choice, but would also see a shift of risk towards consumers and away from the workforce.

Orygen is not recommending that the MH&W Act include the introduction of a similar criterion, but instead considers that this is an approach that warrants further review. It remains to be seen whether the West Australian criteria for compulsory orders have a meaningful effect in their reduced rates of compulsory treatment or if it is due to other aspects of their system.

Operationalising criteria change

If the MH&W Act is to change the criteria for compulsory orders, then the new criteria will need to be operationalised and clarified through practice guidelines and procedures that are both publicly available and informed by the perspectives of service providers, the workforce and people with lived experience.

These supporting documents should be considered and developed prior to the commencement of the operational provisions of the MH&W Act. This will help ensure a shared understanding of how the proposed criteria are to operate in practice.

EFFECTING BEHAVIOURAL CHANGE

In chapter 32.2.3 of Volume 4 of the Royal Commission's final report, the Commission provides commentary noting that the mental health workforce is placed in a difficult position where they are responsible for the risks of not effecting treatment, which has led to a relatively risk-averse mindset that, in-turn, contributes to increased rates of compulsory treatment in Victoria.

The engagement paper notes a need for a cultural shift, yet little indication is provided in the paper on how this shift could occur. One approach that is mentioned is the provision of system-wide targets. Orygen has three concerns with the use of targets. Firstly, there is no mention of how the target figures are to be developed. If targets are to be equitable, then they should be proportional rather than on raw numbers, but those proportional targets also have to consider the demographic differences in service settings.

Secondly, if targets are to be used, then it is worth considering what would occur if those targets are not met. There is a fine line between an overly punitive response and an ineffectual response. Finally, it is unclear whether targets can actually effect behavioural change. The use of policy targets can lead to arbitrary bases for decisions and do not necessarily promote an examination of the deeper issues leading to an unwanted behaviour.(15)

Instead of, or in addition to, system-wide targets, Orygen suggests that the MH&W Act could mandate professional development or training programs that emphasise alternative approaches to compulsory assessment and treatment orders.

COMPULSORY ORDERS AND COERCION

Orygen's consultation on the proposed MH&W Act found that a key concern was that the threat of compulsory orders is sometimes used as a coercive tool to effect change. To prevent this from occurring, there should be a mechanism to prevent any misuse of the MH&W Act whereby consumers are threatened with a compulsory order to gain adherence to a treatment plan, without being given any of the protections of the Act.

To strengthen this provision, there also needs to be a provision requiring that consumers are made aware of their treatment options prior to a compulsory order being made, without it being understood as a threat or intimidation.

Such a change should occur in concert with the Royal Commission's recommendation 55(4)(c), providing that the Mental Health Improvement Unit work with services to '*make available workforce training on non-coercive options for treatment that is underpinned by human rights and supported decision-making principles.*'

SECLUSION AND RESTRAINT

CONSULTATION QUESTIONS

1. 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? If not, why?
2. How do you think the proposals about seclusion and restraint could be improved?

ORYGEN RESPONSE

Orygen supports the Royal Commission's aim, as stated in recommendation 54, of reducing the practice of seclusion and restraint with a view towards eventual elimination.

While the focus of the engagement paper is on legislative change, Orygen wishes to note that the eventual elimination of seclusion and restraint will require a broad response across a range of domains. In chapter 31.4 of their final report, the Royal Commission outlined a series of factors contributing to the use of seclusion and restraint, including an under-resourced mental health system, outdated infrastructure and a need for further workforce support (see pages 320 to 326 of volume 4).

The need for further resourcing is particularly important. If seclusion and restraint is truly to be an option of last-resort (even in the short-term), its use is unlikely to be reduced unless service providers feel they have a viable series of alternatives without having to be placed at undue risk or having to turn vulnerable young people away from treatment.

With respect to the legislative changes outlined in the engagement paper, these are supported save for the following opportunities for change.

CHEMICAL RESTRAINT

The engagement paper notes that the '*Royal Commission has recommended that the new Act introduce similar requirements as the Tasmanian model for regulating chemical restraint*' (page 30). It is Orygen's view that the Commission was not recommending similar requirements, but instead a similar regulatory approach (see page 344 of Volume 4).

Tasmania's regulatory approach is to define chemical restraint as a means of excluding it as a valid treatment. This is a valid regulatory approach, but for such an approach to work, it is vital that chemical restraint is defined in such a way that meets the intent of the Royal Commission.

Orygen is unsure whether the definition of chemical restraint, as provided in the *Mental Health Act 2013* (Tas), will meet the Royal Commission's intent of reducing seclusion and restraint. The key issue within the Tasmanian definition is the use of the language '*medication given primarily to control a person's behaviour.*' This language requires an understanding of the subjective intent of the person administering the medication.

Comprehending a person's subjective intent is challenging for a momentary decision such as administering medication. Unless there are contemporary records that include the reasons for the seclusion and restraint, there is a need to rely upon a person's memory of the event. This memory can be unreliable and it is unlikely that a person will freely want to recall their actions in such a way that readily admits to providing medication to control another person. To ensure that there is contemporaneous record-keeping, there could be a mandatory provision in the MH&W Act providing a requirement to prepare a written report, while also indicating that the report must include the reasons why the seclusion and restraint occurred. The operation of this provision could be similar to section 84 of the *Mental Health Act 2014*, which provides for mandatory reporting of second opinions, as well as outlining some mandatory inclusions within that report.

A second issue with the Tasmanian definition is the word 'control'. With respect to the use of medications, control can definitely be used in a negative sense, if the medication is used simply to govern behaviour with no therapeutic benefit. However, control can also refer to the limiting of harmful behaviour. For example, a person may present with a behavioural disorder which is manifesting in a way that endangers themselves or others. In this circumstance, medication can still be provided in a therapeutic manner that manages behavioural symptoms while allowing the person to maintain normal functioning. In both scenarios, medication has been given to control behaviour, but what differed was whether there was therapeutic intent. By using language such as 'control', there is concern from service practitioners that this will lead to a conflation between a therapeutic use of medication and chemical restraint.

For the reasons outlined above, it is Orygen's view that there needs to be further consideration of how chemical restraint should be defined and the impacts of defining it in a particular manner. In particular, whether the definition serves to assist in lowering the prevalence of restraint while not preventing the use of medication in a therapeutic manner.

An alternative approach is provided in the *Mental Health Act 2016* (Qld), which instead defines medication to include the following statement – '*A person must not administer medication to a patient unless the medication is clinically necessary for the patient's treatment and care for a medical condition.*' Such a definition is objective rather than subjective, and clearly outlines that medication must be provided for a therapeutic purpose. The issue with this definition is that it does not make reference to chemical restraint.

TARGETS AND BEHAVIOURAL CHANGE

In a similar vein to the response on compulsory orders, Orygen does not consider that targets are necessarily the best alternative in order to effect a reduction in seclusion and restraint. As with compulsory orders, Orygen has three concerns with the use of targets for seclusion and restraint. Firstly, there is no mention of how the target figures are to be developed. If targets are to be equitable, then they should be proportional rather than on raw numbers, but those proportional targets also have to take into account the demographic differences in service settings.

Secondly, if targets are to be used, then it is worth considering what would occur if those targets are not met. There is a fine line between an overly punitive response and an ineffectual response. The last concern with targets, is that it is unclear whether targets can actually effect behavioural change. The use of policy targets can lead to arbitrary bases for decisions and do not necessarily promote an examination of the deeper issues leading to an unwanted behaviour.(15)

Instead of, or in addition to, system-wide targets, Orygen suggests that the MH&W Act could mandate professional development or training programs that emphasise alternative approaches to seclusion and restraint. In general there will need to be a wide range of supports to eliminate seclusion and restraint. This need for support is heightened for mental health nurses, who are often in a position of determining the use of seclusion and restraint. There is also evidence that Australian nurses do not necessarily believe that seclusion and restraint could, or should, be eliminated.(16)

A further vehicle to help effect change may be real-time reporting on the use of seclusion and restraint to enable a prompt response to any concerns around its use. Section 107 of the *Mental Health Act 2014* already provides a mandatory requirement for reporting of seclusion and restraint as soon as is practicable. This is an important provision, but with regards to the MH&W Act, it should include the Mental Health and Wellbeing Commission as one of the notified parties.

OTHER INTERVENTIONS

The engagement paper provides that services and clinicians will only be able to use seclusion and restraint practices if they have documented the use of other interventions which have been tried unsuccessfully or have been deemed inappropriate or unsuitable. As with compulsory orders, there

must be the equitable funding and provision of genuine service alternatives for such a criterion to be meaningful (for further commentary on this issue, see page 13 to 14 above).

It is also vital that these service alternatives are designed in such a way (i.e. appropriate environmental settings, resources and facilities) that reduce the need for seclusion and restraint. The need for a built environment that helps minimise seclusion and restraint is particularly important within hospital emergency departments. Orygen’s consultation has found that emergency wards are environments that are more likely to support the operation of seclusion and restraint.



GOVERNANCE AND OVERSIGHT

CONSULTATION QUESTIONS

1. Do you think the proposals meet the Royal Commission's recommendations about governance and oversight? If not, why?
2. How do you think the proposals about governance and oversight could be improved?

ORYGEN RESPONSE

Orygen welcomes the broad governance changes proposed in the Royal Commission's final report and support the new provisions in the engagement paper designed to effect those broad changes. There are some isolated opportunities for improvement, but the changes are broadly supported.

YOUTH REPRESENTATION

Orygen supports the statement in the engagement paper that the Regional Mental Health and Wellbeing Boards will be inclusive of people with lived experience. In line with the intent of the Royal Commission, we agree that lived experience voices need to be involved at all levels of the new governance framework. However, it is also important to recognise the value in including representation of different lived experience backgrounds and experiences.

To ensure that young people's voices are heard, Orygen would like to see mandatory inclusion of at least one young person with lived experience of mental ill-health on all Regional Mental Health and Wellbeing Boards, and one person representing a youth-focused service on Statewide and Regional Multiagency Panels.

In general, there is value in using the MH&W Act to outline the proposed membership of the boards and panels. It is common to use legislation to outline the membership of legislative bodies, and one example can be seen in the formation of the Building Regulations Advisory Committee and Plumbing Advisory Council in the *Building Act 1993*. In a similar vein to the language in section 211(2)(a) of that Act, there could be provision in the MH&W Act that two of the members of the Regional Mental Health and Wellbeing Boards must be a young person (aged under 26 years) with experiences of mental ill-health. A similar provision can be used to have someone representing a youth-focused service on Statewide and Regional Multiagency Panels.

Outside of the Regional Mental Health and Wellbeing Boards and Statewide and Regional Multiagency Panels, it is recommended that young people's voices are enshrined at all levels of the new mental health governance system. Young people are a cohort that is uniquely impacted by mental ill-health. The onset of mental ill-health generally occurs in young people, with 50 per cent of mental ill-health onset occurring before the age of 15 years and 75 per cent by the age of 24 years.⁽¹⁷⁾

SUPPORT FOR THE NEWLY-ESTABLISHED ENTITIES

Although this is not strictly a legislative issue, it is clear that the effective functioning of these bodies stems not only from their legislative functions, but also from how they are supported and managed. The proposed legislative provisions will need to be supported by regulation, policies and procedures. This includes, but is not limited to:

- training and education of board and panel members
- revolving term limits for members, and
- secretariat support.

CLARIFYING THE INTERACTION BETWEEN OVERSIGHT AND SERVICE DELIVERY

The engagement paper mentions that the Mental Health and Wellbeing Commission will have *'responsibility for system-wide oversight of the quality and safety of mental health service delivery.'* Orygen recognises that this language is akin to that used within the Royal Commission's final report, but wishes to ensure that this language does not provide for future scope creep.

In general, the responsibility for service delivery should reside with the parties who are responsible for funding. The entity with oversight responsibility should be free of these concerns to enable both actual and perceived independence. While Orygen recognises that the intent of the aforementioned words in the engagement paper is that the Commission is simply overseeing whether services are operating in line with the MH&W Act, we wish to ensure that the Act clearly delineates oversight, funding and service delivery to ensure there is no ambiguity in the responsibilities for the newly introduced entities.

STATUTORY GUIDELINES AND TRANSITIONAL PROVISIONS

The *Mental Health Act 2014* provides the Chief Psychiatrist with powers to issue standards, guidelines or practice directions (see sections 121, 133, and 139 of the Act). Feedback from Orygen's consultation process has noted the benefits of these guidelines and wants to ensure that they will continue under the MH&W Act. In this respect, we would like to see transitional provisions in the MH&W Act retaining the current guidelines issued under the *Mental Health Act 2014*.

REFERENCES

1. World Health Organization. Violence against women prevalence estimates, 2018: global, regional and national prevalence estimates for intimate partner violence against women and global and regional prevalence estimates for non-partner sexual violence against women. 2021.
2. Cox P. Violence against women in Australia: Additional analysis of the Australian Bureau of Statistics' Personal Safety Survey, 2012: Australia's National Research Organisation for Women's Safety; 2015.
3. Rickwood DJ, Mazzer KR, Telford NR. Social influences on seeking help from mental health services, in-person and online, during adolescence and young adulthood. *BMC psychiatry*. 2015;15(1):1-9.
4. Brown A, Rice SM, Rickwood DJ, Parker AG. Systematic review of barriers and facilitators to accessing and engaging with mental health care among at-risk young people. *Asia-Pacific Psychiatry*. 2016;8(1):3-22.
5. Hampson ME, Watt BD, Hicks RE, Bode A, Hampson EJ. Changing hearts and minds: The importance of formal education in reducing stigma associated with mental health conditions. *Health Education Journal*. 2018;77(2):198-211.
6. Mejia-Lancheros C, Lachaud J, Woodhall-Melnik J, O'Campo P, Hwang SW, Stergiopoulos V. Longitudinal interrelationships of mental health discrimination and stigma with housing and well-being outcomes in adults with mental illness and recent experience of homelessness. *Social Science & Medicine*. 2021;268:113463.
7. Priebe S, Katsakou C, Glöckner M, Dembinskas A, Fiorillo A, Karastergiou A, et al. Patients' views of involuntary hospital admission after 1 and 3 months: prospective study in 11 European countries. *The British Journal of Psychiatry*. 2010;196(3):179-85.
8. Isobel S. 'In some ways it all helps but in some ways it doesn't': The complexities of service users' experiences of inpatient mental health care in Australia. *International journal of mental health nursing*. 2019;28(1):105-16.
9. Gergel T, Das P, Owen G, Stephenson L, Rifkin L, Hindley G, et al. Reasons for endorsing or rejecting self-binding directives in bipolar disorder: a qualitative study of survey responses from UK service users. *The Lancet Psychiatry*. 2021;8(7):599-609.
10. Canvin K, Rugkåsa J, Sinclair J, Burns T. Patient, psychiatrist and family carer experiences of community treatment orders: qualitative study. *Social psychiatry and psychiatric epidemiology*. 2014;49(12):1873-82.
11. Gault I. Service-user and carer perspectives on compliance and compulsory treatment in community mental health services. *Health & social care in the community*. 2009;17(5):504-13.
12. Dickens GL, O'Shea LE, Christensen M. Structured assessments for imminent aggression in mental health and correctional settings: Systematic review and meta-analysis. *International journal of nursing studies*. 2020;104:103526.
13. Large M, Galletly C, Myles N, Ryan CJ, Myles H. Known unknowns and unknown unknowns in suicide risk assessment: evidence from meta-analyses of aleatory and epistemic uncertainty. *BJPsych bulletin*. 2017;41(3):160-3.
14. Large M, Ryan C, Nielszen O. The validity and utility of risk assessment for inpatient suicide. *Australasian Psychiatry*. 2011;19(6):507-12.
15. Howlett M. Behavioural considerations in public policy: matching policy tools and their targets. *Handbook of Behavioural Change and Public Policy*: Edward Elgar Publishing; 2019.
16. Barr L, Wynaden D, Heslop K. Nurses' attitudes towards the use of PRN psychotropic medications in acute and forensic mental health settings. *International journal of mental health nursing*. 2018;27(1):168-77.
17. Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of general psychiatry*. 2005;62(6):593-602.