Victorian Healthcare Association
Vision • Value • Voice

Submission

29 July 2021

Consultation response: Mental Health and Wellbeing Act

About the Victorian Healthcare Association

The Victorian Healthcare Association (VHA) is the peak body supporting Victoria's public health services to deliver high-quality care. Established in 1938, the VHA represents Victoria's diverse public healthcare sector, including public hospitals, aged care and community health services.

As well as providing a unified voice for the sector, the VHA delivers value for its members by offering tailored professional development programs, networking opportunities, and informative events. The VHA advocates on behalf of its members on sector-critical issues by engaging and influencing key decision-makers involved in policy development and system reform.

Introduction

The VHA is pleased to respond to the consultation to contribute to the development of the new Mental Health and Wellbeing Act. The development of the Act, as envisioned by the Royal Commission into Victoria's Mental Health System (the Royal Commission), is an opportunity to drive the changes required to improve mental health care in the state. While we broadly support many of the elements of the proposed Act set out in the engagement paper, the VHA does have concerns about some missing areas from the Act as it is currently articulated. While this consultation is focused explicitly on the Royal Commission's specific recommendations, the Act needs to learn from the Royal Commission's broader lessons as well as insight from those in the system. For instance, it is vital for the new Act to bind both the sector to behave in a particular way but also require decision-makers to manage and fund the system in line with those expectations.

This submission is based on consultation and discussions with VHA members and partners as part of a broader forum series in collaboration with Mental Health Victoria.

Submission

Objectives and principles of the new Act

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

The proposed objectives and principles of the new Act fail to meet the Royal Commission's recommendations as well as the broader ethos and lessons from the Royal Commission.

Firstly, the Act needs to explicitly include reference to resourcing providers in its objectives and principles. The Act references numerous expectations for providers, yet there is no explicit mention of appropriate resourcing.

The Royal Commission is very clear that a lack of adequate funding is a major reason why the mental health system failed so many people.

Having an explicit sub-objective under the first objective as well as a principle that articulate the need for appropriate resourcing should help to ensure that a situation as captured in the final report does not happen again. Having funding expectations set out in the Act, without prescribing the amount, ensures that providers and consumers can be assured Victorian Government resources will be allocated and that the Act has 'teeth' to support care provision and deliver the reform it intends.

Victorian Healthcare Association
www.vha.org.au
Level 6, 136 Exhibition Street
Melbourne Victoria 3000
T 03 9094 7777 F 03 9094 7788
E vha@vha.org.au

While including references to funding in legislation is not traditional, the proposed Act is intended to do things differently. There is precedent for this; the World Health Organisation in its own mental health policy and service guidance package has a checklist for mental health legislation that has an item around whether it makes provision for the financing of mental health services. Similarly, the Royal Commission in its final report also repeatedly highlighted that the failure of the *Mental Health Act 2014* was partially due to inadequate resourcing; having that expectation set out in the new Act is a useful tool to ensure that it happens. The Royal Commission itself identified that for 'the mental health principles to become embedded in service delivery, it is essential that service providers and decision makers are properly resourced to give effect to these requirements.'

Similar to the above point on funding, the Act needs to explicitly include a reference to the workforce in its objectives and principles.

The workforce is a key enabler to the new mental health system, yet there is no mention across the Act's areas to ensuring that the workforce has the appropriate capability and capacity to deliver the Act's vision. Workforce is a tenet of reforming the mental health system, and that needs to be reflected at the core of this proposed Act. Having a sub-objective and principle that recognise this is important, as it will ensure that there is a requirement for all stakeholders to improve this element; failing to do so risks undermining the broader reform effort. This sub-objective and principle should also reflect the need for a broader mental health workforce, including those providing non-clinical support, to deliver the new Victorian mental health system. The Royal Commission itself, when considering new legislation, repeatedly identified the need to bring the workforce along with the new Act.

An area of the proposed objectives and principles, as well as the broader Act, that could be improved is the use of language. The Act, as currently proposed, is very prescriptive. The future Act should have a greater emphasis on positive and enabling language. While risk management is important, if the key focus is on wellbeing, then the Act should lay out what providers can do to support consumers.

The Royal Commission was very clear that new Act should 'communicate how the intentions behind the legislation should apply in practice'. A clear example of this is around community care. The proposed objectives and principles fail to capture the essence of the Royal Commission's reforms – the Royal Commission is clear that care needs to be enabled to take place in the community, moving away from the current acute model of care. This is not reflected in the objectives or principles, which is an oversight; instead, there is a focus on other elements and telling providers what they should do. This is important as these principles 'will underpin the policies, programs and services of Victoria's mental health service system', yet there is no recognition of arguably the key direction from the Royal Commission.

- **Recommendation: The proposed Act should include a sub-objective and principle that require appropriate funding and resourcing to deliver the wider Act's vision.**
- **Recommendation: The proposed Act should include a sub-objective and principle that require the development of an appropriately trained and sufficiently sized mental health workforce, including those providing non-clinical support, to deliver the wider Act's vision.**
- **Recommendation: The proposed Act's objectives and principles should include an explicit reference to increasing the availability and use of community mental health care.**
- **Recommendation: The proposed Act's objectives and principles should be re-worded to have a greater focus on positive and enabling language.**

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

- *Question 5: Do you think the proposals meet the Royal Commission's recommendations about supported decision making?*
- *Question 6: How do you think the proposals about supported decision making could be improved?*
- *Question 7: Do you think the proposals meet the Royal Commission's recommendations about information collection, use and sharing?*
- *Question 8: How do you think the proposals about information collection, use and sharing could be improved?*

Non-legal advocacy

The VHA supports the proposal relating to non-legal advocacy, but the proposal needs to be strengthened, as mentioned in other aspects of this response, to ensure that decision makers are as responsible as providers to ensure that these measures are delivered.

Any future Act should explicitly include reference to resourcing and funding providers to adhere to the requirements set out in the Act, beyond just being captured as an objective and principle. The Act, when setting out non-legal advocacy, should include a reference to funding non-legal advocacy; it has to do more than just provide guidelines to support Independent Mental Health Advocacy (IMHA), as the engagement paper appears to suggest.

The success of non-legal advocacy is directly tied to the provision of services. Expectations cannot increase on providers without increasing the availability of non-legal advocacy services. Having this requirement for resourcing in the Act will also ensure that the Act has the ability to deliver change in regard to the availability of non-legal advocacy to support consumers. Currently, there is less IMHA available in Victoria compared to other states, with funding a key reason for this – an evaluation of IMHA in Victoria found that IMHA advocates were only present at 15 per cent of Mental Health Tribunal cases in 2016/17, while in New South Wales for the same year that figure was 69.8 per cent.

This mention of funding should also include reference to mental health service providers. The Act's proposed changes, while necessary, will increase the demand on services which needs to be matched by funding if providers are to be able to deliver on these expectations. If funding is not mentioned in the Act, it risks paying lip-service to reform. This should also serve to support the proposed changes in support of supported decision-making, which is enabled by non-legal advocacy. This is supported by the Royal Commission which, in considering further accountability measures, identified that to 'support decision makers in fulfilling these duties, it is essential that the Victorian Government appropriately resource the mental health and wellbeing system and service providers', which should apply to non-legal advocacy and other areas of the proposed Act that will increase the demands on providers.

Supported decision-making

The VHA also largely supports the proposal to enhance supported decision-making. If wellbeing is at the centre of reform, then supported decision-making is required to facilitate that.

The proposals, however, need to have a strengthened element around training. The Act should include an explicit reference to the need for training to be available for clinicians and the non-clinical workforce to ensure they understand and facilitate supported decision-making. Current concerns about the lack of supported decision-making stem from fears about its delivery from health professionals, which means there needs to be a focus on encouraging and growing the non-clinical workforce to fill this gap. This should also serve to support care provision in regional areas where clinical workforce shortages are more common.

Including training in the Act will help to ensure that providers and decision-makers are both held accountable; otherwise, training risks being an issue that is ignored and left to providers, adding to the considerable burden that will be imposed by the necessary changes in this Act. This directly ties in with the need for the workforce to be recognised in the objectives and principles of the proposed Act.

Similar to other areas, the new Act also needs to appropriately reference and strengthen requirements around resourcing for supported decision-making. For instance, the current Mental Health Act mentions and supports

supported decision-making, but it doesn't have any stipulations around having the resourcing required to deliver actual changes in care, with supported decision-making underfunded.

This mention of funding is required as there are multiple components of facilitating supported decision-making, including increasing the availability of training, ensuring greater and quicker availability of second psychiatric opinions, increasing the use and availability of advance statements and the administrative burden that this increased activity places on providers through increased service provision and oversight. If supported decision-making is going to be a core part of the new mental health system, then funding, and the time this should provide, must be available for clinical and non-clinical support people.

Information sharing

While the VHA largely agrees with the proposed principles and ideas for information sharing, there are missing aspects to the proposal.

The engagement paper is clear around consumer control and direction, but it is vital that this is reflected in the details of the proposed Act. There should be further opportunities to consult on information sharing, beyond those future consultation opportunities identified in the engagement paper, to ensure that the future mental health system delivers on its promise.

The Act should articulate key elements of the future system sharing model, including how and when information should be shared with carers and families, as well as what 'basic' information can be shared with other providers. This clarification around information sharing should take place as soon as possible to support the development of an information sharing system. For information sharing to be successful, it is critical that the system has the consumer and their interests at the centre of it, especially as it will often require collaboration other service providers and external agencies.

There are areas to the proposed principles for information sharing that are missing that need to be rectified.

The future Act needs to ensure that there is no duplication in information sharing, with a principle to ensure that consumers and providers are not burdened by having to move information across different system. This is especially important with the development of other information sharing systems, including in healthcare. If these systems are separate, it risks undermining consumer confidence and the efficacy of these system.

Due to the interactions between different elements of care, including health, mental health, alcohol and other drugs and social determinants of health, information sharing must be broader than just mental health. There cannot be siloes. The information that should be shared has to be connected to the risk of the patient.

There also needs to be a principle about supporting providers to ensure that they can deliver an information sharing system that meets consumers' needs. Consumer sentiment and concern about information sharing has been identified as an issue that has inhibited progress in this area. While the current principles prioritise the consumer, these will be in vain if consumer trust is not maintained.

This principle is important to ensure that services are capable of adjusting to the new system. One service, through this consultation, has identified that clinicians need training to write for consumers if information is to be made available; this is a system issue that affects more than one provider. Cultural change is an important component to delivering appropriate information sharing – there has to be a mechanism for culture change, or it risks undermining this reform.

- **Recommendation: The proposed Act should include specific reference to appropriately funding the increased use of non-legal advocacy, including funding the increased provision of Independent Mental Health Advocacy and funding providers to adhere to the proposed requirements.**
- **Recommendation: The proposed Act should include specific reference to appropriate funding and training to increase the provision of supported decision-making in the mental health system, utilising both the clinical and non-clinical workforce.**

- **Recommendation: There should be further consultation to support the requirements around information sharing in the proposed Act, which should be finalised before the final draft of the Act is proposed.**
- **Recommendation: The proposed Act should include a principle around information sharing that limits duplication, aligns information sharing with broader information sharing initiatives and does not increase the burden on consumers and providers.**
- **Recommendation: The proposed Act should include a principle around information sharing that specifically references the need to appropriately fund providers to ensure that they can meet the broader information sharing principles of the Act.**

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?*
- *Question 10: How do you think the proposals about compulsory treatment and assessment could be improved?*
- *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?*
- *Question 12: How do you think the proposals about seclusion and restraint could be improved?*

Compulsory assessment and treatment

While the proposed changes around compulsory treatment and assessments will lead to some improved aspects of care, the focus of the engagement report suggests there are some missing areas that will lead to unintended consequences.

In regard to the objectives and principles, the language used needs to be further clarified and defined, with an expansion of the principles related to compulsory assessment and treatment. For instance, with the use of 'last resort', the language is broad, which hinders providers and consumers as it allows ambiguity. It is important that this legislation provides clear direction, and that the sector is involved in understanding and defining this term. It is also important the objectives and principles reflect that there should be an attempt to understand how a situation of 'last resort' happens and look to avoid it. Consumers need to have all the options available to them.

A focus on safety and safe care can also be made more explicit in the principles and objectives of the Act. While there is recognition of the 'least possible restrictions on people's rights', there is no specific mention of ensuring that safe care is taking place. Furthermore, the principles should reflect the value of assessment – if appropriate assessment takes place, it should reduce the likelihood of acute and compulsory care. The language, similar to an earlier point, should also be more positive; the language is very clinical when this is meant to be an Act that is focused on wellbeing. As the system is meant to be transitioning away from focusing on crisis, the use of 'last resort' makes it sound like it is still operating in crisis. These objectives and principles could better reflect that earlier and safer care is the goal.

In terms of authorisation of compulsory treatments, the VHA supports the overall direction signalled in the engagement paper.

There should be an expansion of the workforce involved in temporary treatment orders. Workforce shortages impact the wider health workforce, particularly in regional areas, so, with appropriate oversight and training, this should improve the availability and equity of care. The VHA has previously supported the expansion of nursing roles to the full extent of their capabilities, including nurse practitioners and Rural and Isolated Practice Endorsed Registered Nurses (RIPERN), who are well placed to take this role. However, it is also important that those who are given this responsibility are also enabled to take consumers off compulsory treatment orders. This would help ensure that consumers are not under these orders any longer than they need to be.

The VHA agrees with the engagement paper on the need for further consultation on these changes. We would urge that the expectation be that if people have the right accreditation, then they are enabled do it. This already happens

in Queensland, where it is possible for personnel to become an Authorised Mental Health Practitioner, after successfully completing the four mandatory course units and a competent Practice Portfolio, to be enabled to make a Treatment Authority to authorise involuntary treatment.

A key issue, however, around compulsory treatment is the proposed criteria. While we support the aim of the changes, and the majority of the language, there are concerns around the potential for unintended consequences.

There should be further clarification around the meaning of the language in the criteria and what it means for providers and their workforce. In particular, the use of the word 'imminent' needs to be defined, as it could limit the ability of the workforce to use compulsory treatment orders to protect the consumer, the community and their colleagues.

While the engagement paper highlights the value of dignity of risk for consumers, which is important, this dignity needs to be extended to the wider mental health workforce and the community; not appropriately treating a consumer, who quickly goes on to cause harm to themselves or others, because the risk was not deemed 'imminent' fails to do this. The word 'imminent' should either be removed, or the statutory guidance needs to provide appropriate direction beyond just clarifying harms that should be prevented to consumers, allowing providers and the mental health workforce to have sufficient nuance with the term to protect themselves, the consumer and others. The proposed statutory guidance should provide clear direction for providers while also not burdening them with unnecessary administration. If the guidance is too prescriptive and onerous, it risks complicating the care for at-risk consumers, potentially putting them or others at harm.

Seclusion and restraint

The VHA broadly agrees with the approach around seclusion and restraint as set out in the engagement paper, but there are issues, potentially, about how these ideas will be delivered. The eventual elimination of restraints, as set out by the Royal Commission, is a noble goal, while it is proposed that the Act will acknowledge their harm and require clinicians to consider alternatives and document the reason restraints were used. We are not opposed to this proposition, and support causing as little harm as possible, but do have concerns about the practical implementation.

The use of seclusion and restraint is required at times to protect consumers, the community and the mental health workforce. There are sometimes no alternatives. If the mental health system is to work towards eliminating the use of restraint, then the new Act needs to explicitly encourage and grow the support that can mitigate people ever reaching a state where restraints are required.

We need to focus on why people are getting restraints, and deal with those underlying reasons. This is a key theme of the Royal Commission's vision, yet it is not currently reflected in the information provided in the engagement paper, which only focuses on provider accountability. We need ensure that the system changes to keep up with the legislative reform, or this change risks hurting consumers and the mental health workforce. To help achieve this there should be a focus on positive and enabling language. For instance, it is important to not increase distress, while there should be a specific focus on prevention and holistic treatment.

For this to happen, changes are required to the Act which are similar to the feedback provided earlier. The VHA supports the increased oversight measures set out in the engagement paper, but the future Act needs to reflect the factors that have driven the use of seclusion and restraint.

The Act should ensure that appropriate resourcing and workforce training are specifically highlighted so services can provide the care consumers need and meet the new requirements around accountability and measurement. The sector and its workforce want to achieve minimisation and elimination of seclusion and restraint, but have been hampered by funding shortfalls and workforce shortages in capability and capacity. The Act needs to have requirements around supporting the training of the workforce. Only through having an appropriately trained workforce is it possible to reduce the need for seclusion and restraint, as well as broader restrictive practices, as they can better manage acute circumstances and give the therapeutic care required before seclusion and restraint are necessary.

It has been highlighted that the workforce, largely, does not have this training. Practitioners are considered appropriately trained even with only a few units of study directly focused on mental healthcare. We are losing that expertise in the workforce, so people don't have the skills to minimise restriction and trauma. Having these funding and training elements recognised in the future Act will help provide direction to decision-makers and the sector on what is required to achieve that long-term goal of eliminating seclusion and restraint, if that is to ever be possible.

There also needs to be clarification around compliance and who is impacted by these changes.

The VHA supports the regulation of restrictive practices in all settings that provide care to those suffering from poor mental health episodes, as it cannot stop at just mental health services. However, while we support the need for greater oversight, it is important that the statutory guidance and monitoring of this issue does not take the focus away from providing care.

Increased reporting does not mean increased compliance, and increased compliance does not mean better outcomes. With the engagement paper proposing that two different bodies will be conducting oversight, it is vital that the Act reflects that there should not be duplication of reporting, in line with earlier recommendations around information sharing.

The future Act should also be emphatic that the focus should be on consumer outcomes rather than just increasing compliance in lieu of that. Greater transparency is important, but it should not come at the expense of care. This is similar to the considerations around the use of chemical restraint; while oversight is necessary, it should not inhibit the use of medications, as needed, to support the wellbeing of consumers in all settings.

- **Recommendation: The proposed objectives and principles relating to compulsory treatment should be further defined, while also being re-worded to better reflect the wellbeing element of the new mental health system.**
- **Recommendation: Authorisation of temporary compulsory treatment orders should be expanded, including the ability to take consumers off the same orders, with further consultation required to explore increasing the scope of nursing and implementing a model similar to that delivered in Queensland.**
- **Recommendation: The proposed Act should include specific reference to ensuring that the changes to the compulsory treatment criteria do not come at the expense of consumer, staff and community safety.**
- **Recommendation: The proposed Act should include specific reference to increasing the use and availability of alternative treatments that encourage early intervention and prevention to support the effort to eliminate the use of restrictive interventions.**
- **Recommendation: The proposed Act should include specific reference to appropriately funding providers and training the workforce to support the elimination of restrictive practices.**
- **Recommendation: The proposed Act should include specific reference to ensuring that the compliance around seclusion and restraint should not come at the expense of consumer outcomes and safety.**

Governance and oversight

- *Question 13: Do you think the proposals meet the Royal Commission's recommendations about governance and oversight?*
- *Question 14: How do you think the proposals about governance and oversight could be improved?*

The VHA largely supports the proposed governance and oversight as set out in the engagement paper. However, this is because there is limited new detail beyond what was set out by the Royal Commission. The VHA has already welcomed the Royal Commission's vision for a new mental health system. It is hard to provide feedback when there is limited information, which impacts the value of this process to reforming the mental health system. This means that further detail and consultation is required on the new governance of the system.

However, it is vital that the future Act ensures that there is no duplication across governance, leading to the potential risk of services dealing with multiple governance and oversight bodies. While governance and oversight are important,

and should be strengthened, excessive administrative burden with confusing reporting lines will not lead to better outcomes with patients. This is in line with earlier recommendations on the future Act.

An area of concern for the VHA is around the Regional Mental Health and Wellbeing Boards. While the Royal Commission explicitly sees them as commissioners, as set out in the recommendations, the proposed Act diminishes their power and has no mention of commissioning; instead, they will just support integration and planning, while the Department will keep a role as a 'strategic commissioner'. This does not meet the vision of the Royal Commission. If the Boards are to be used like this, it brings into question why they are being created, as it will add to an already convoluted governance landscape.

- **Recommendation: There should be further consultation, and information relating to the governance and oversight mechanisms of the new mental health system, with a focus on limiting duplication and unnecessary administrative burden. Further information should be provided on why the Royal Commission's recommendation on Regional Mental Health and Wellbeing Boards is not being implemented as intended.**

Other

This consultation should be a learning experience to inform future engagement as the Royal Commission's vision is implemented over the coming decade.

The consultation process for future sector engagement needs to be improved. Services need longer timeframes than what was initially set out for the consultation, especially with current demands on the health system, while there should be further opportunities to inform and direct the future Act.

For instance, in regards to the reforms in the 'Treatment, care and support' section, these are complex issues requiring further consideration. In line with the Royal Commission's commentary, this is an issue that should commence at a later date and be consulted on further.

There should also be consideration of how proactive consultation takes place. The VHA has previously developed a proposal to the Department of Health to support ongoing engagement with the Victorian health sector, and we remain willing to support further sector engagement.

- **Recommendation: Future consultation on the Act and broader mental health reform must have longer timeframes recognising pressures on the health system and utilise key stakeholders, including the VHA, to support and inform engagement.**

For further information contact

Ben Rogers
Senior Advisor, Policy and Advocacy
ben.rogers@vha.org.au
03 9094 7777