Australian Nursing & Midwifery Federation
VICTORIAN BRANCH

Response to the Department of Health *Mental Health and Wellbeing Act Update and Engagement Paper*

July 2021

Contents

1. Introduction

1.1 Members' Commitment to Positive Change

The ANMF (Vic Branch) is the peak professional and industrial body for nurses and midwives in Victoria. We represent more than 94,000 members working in Victorian health services, including in public and private specialist mental health services.

Our members are deeply committed to a mental health system that allows all Victorians requiring mental health care to receive best practice, rights-based, person-centred, trauma and recovery-informed care when and where they require it.

As the largest health workforce, our members know they are critical to the delivery of such care, so they are highly engaged in the current change process and the development of the new Mental Health and Wellbeing Act.

Individually, and through the ANMF (Vic Branch), our members provided extensive input into the 2019 Royal Commission into Victoria's Mental Health System (the Royal Commission). After wide consultation with members, the ANMF (Vic Branch) submission recommended the following 10 priority action areas:

1. Fixing the funding shortfall
2. Developing a detailed plan and workforce strategy
3. Continuing to build and develop the nursing workforce
4. Creating safe workplaces
5. Augmenting the acute system to meet current unmet need
6. Investing in community based clinical mental health services
7. Increasing provisions for forensic health
8. Improving health care journeys
9. Developing consistent, best-practice models of care
10. Getting governance right.

Many of these priority action areas were addressed in some way in the recommendations contained in the Royal Commission's Final Report which was delivered in February this year. Since the report's release, the ANMF (Vic Branch) Mental Health Royal Commission Working Group has been meeting regularly to:

- review all recommendations from the interim and final report
- consider how they may impact the mental health nurse workforce
- engage with our members about the recommendations and the implications for their work
- ensure our members have a voice in how the recommendations are implemented.

1.2 This Submission

The *Mental Health and Wellbeing Act update and engagement paper* (the Paper) describes the development of the new Act and proposals on policy issues that the Department of Health considers require more input to meet the Royal Commission's recommendations. The Paper specifically seeks input on the Department's proposals in the following key areas:

- objectives and principles of the new Act
- non-legal advocacy
- supported decision-making
- information collection, use and sharing
- reducing the use and the negative impacts of compulsory assessment and treatment
- reducing the use and the negative impacts of seclusion and restraint and regulation of chemical restraint
- governance and oversight.

In this submission, we address each of these areas, outlining:

- the Royal Commission's recommendations
- our understanding of the proposed legislation
- the proposals we support
- areas of concerns
- improvements and actions we consider are needed to better meet the Royal Commission's recommendations and address our areas of concerns.

Some of these actions go beyond the legislative process. This is in keeping with the Paper which details both the legislative proposals and key processes and developments slated to accompany the legislative process.

In making our submission, we have drawn on:

- our July 2019 submission to the Royal Commission
- input from our Mental Health Royal Commission Working Group
- input from members who attended our Mental Health and Wellbeing Act Workshops in July 2021 to express their views on the Paper
- information gathered from a pulse survey of members which specifically considered the role of nurse practitioners in authorising temporary treatment orders.

Our recommended improvements and actions are summarised in Section 2, with a fuller discussion of the proposals as outlined above in Section 3.

2. Summary of Improvements and Actions Required

1. Principles and objectives

1. Emend Principle 4 to read:

   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 *to themselves.*

2. Expedite the development of the 10-year strategic plan to guide elimination of restrictive interventions recommended by the Royal Commission and include the ANMF (Vic Branch) in the co-production team.

3. Emend Objective 2, bullet point 7 to read:

   … aiming to eliminate the use of restrictive practices within 10 years *and in accordance with the Chief Officer for Mental Health and Wellbeing 10-year elimination strategy.*

2. Non-legal Advocacy

4. Develop:

   - a central and coordinated process for referral to non-legal advocacy services formed in addition to IMHA
   - a simple, efficient and consistent way to document all referrals to this service that does not add to the already complex process of admission.

5. Support the new Act's non-legal advocacy requirements with accompanying regulations requiring standardised training, licensing, and regulation of non-legal advocates, including a process for ensuring any training requirements and practice standards are met and maintained.

3. Supported decision-making

6. In collaboration with the ANMF (Vic Branch) and other stakeholders, develop statutory guidance about how the supported decision-making provisions in the new Act are to be given effect in practice.

7. Ensure the provisions in the new Act in relation to transparency and accountability for supported decision-making have a clearly defined scope.

8. Consult with the ANMF (Vic Branch) to identify and address the impact on nursing workloads of the proposed provisions that:

   - broaden the application of the statement of rights
   - increase the scope of advanced statements
   - establish and increase new documentation requirements for nursing decisions.

4. Information collection, use and sharing

9. In collaboration with the ANMF (Vic Branch) and other stakeholders, establish clear guidelines and processes around obtaining and maintaining consent, to ensure nurses and midwives have the guidance they need to give effect to the new information sharing provisions without risk to themselves.
10. In collaboration with the ANMF (Vic Branch) and other stakeholders, develop a clear and agreed strategy, implementation plan and timeline for the speedy delivery of the ICT infrastructure needed to support the new provisions.

5. Compulsory assessment and treatment

11. Ensure the provisions around compulsory treatment in the new Act are as objective as possible, and where they are subjective, include clear and unambiguous definitions of the terms used (e.g., 'distress', 'harm', 'serious', 'risk' and 'imminent') to prevent confusion and promote consistent practice.
12. In collaboration with the ANMF (Vic Branch), develop clear practice guidelines to further reduce the capacity for subjective judgements and inconsistent practice.
13. Consult further with the ANMF (Vic Branch) about the proposal to extend the power to make a temporary treatment order to nurse practitioners.

6. Seclusion and restraint

14. Complete the roll out of Safewards to all programs by 2023.
15. In collaboration with the ANMF (Vic Branch), review and adopt the recommendations from our submission to the Royal Commission in relation to creating safe workplaces, including the following:
    - embed trauma-informed care to increase safety for people with lived experience and clinicians
    - enforce the state-wide implementation of the ANMF (Vic Branch) 10-point plan to reduce occupational violence and aggression across all adult mental health services and in Forensicare
    - consider implementing more targeted and effective incident reporting, inspection, investigation, accreditation mechanisms and accountabilities
    - deliver resilience training programs for nurses working in adult mental health as a protective measure
    - continue to invest in and support the highly successful Nursing and Midwifery Health Program Victoria (NMHPV)
    - standardise all occupational violence and aggression and de-escalation training offered to staff working in mental health units.

16. Embed an occupational health and safety committee into the new Act to provide oversight and monitor compliance with both the new Act and the OHS Act and support continuous improvement and best practice by:
    - considering workplace safety during the implementation of the new Act, and ensuring potential health and safety impacts on staff are identified and eliminated or mitigated
    - considering workload management during the implementation of the new Act, and making recommendations to rectify impacts
    - monitoring and making recommendations to improve workplace safety across the lifespan of the new Act
    - participating directly in the review of the new Act at years five and seven
    - supporting ongoing research into workplace safety in mental health settings.
17. Consult further with the ANMF (Vic Branch) about the definition of chemical restraint to be used in the new Act when the Department has a definition to propose.

7. Governance and oversight

18. In consultation with the ANMF (Vic Branch), amend the *Safe Patient Care Act 2015* to include safe staffing levels for all mental health services that fall under the expanded remit of the Mental Health and Wellbeing Commission and the Chief Psychiatrist, and require:
    - all public services included in this remit to be subject to agreed safe staffing levels prescribed under the Safe Patient Care Act
    - all non-government services included in this remit to meet the same relevant safe staffing levels as part of their funding agreements
19. Require the Mental Health and Wellbeing Commission to work with AHPRA to develop and publish a clear decision-making protocol for determining who will investigate complaints about registered practitioners.
20. Expedite the Royal Commission's recommendations in relation to correctional mental health services [recommendations 37 and 38] so that models of care that comply with the Chief Psychiatrist's standards are in place as soon as possible, and:
    - consult with the ANMF (Vic Branch) to determine appropriate staffing levels for the new beds and additional workforce development measures to ensure adequate numbers of qualified nurses are available to achieve these levels.

3. Review of DoH proposals

2.1 Objectives and principles

Royal Commission recommendations

The Royal Commission recommended that the Victorian Government:

- ensure the new Mental Health and Wellbeing Act (the new Act) include new objectives and mental health principles, with the primary objective being to achieve the highest attainable standard of mental health and wellbeing for the people of Victoria by:
  - promoting conditions in which people can experience good mental health and wellbeing
  - reducing inequities in access to, and in the delivery of, mental health and wellbeing services
  - providing a diverse range of comprehensive, safe and high-quality mental health and wellbeing services [Recommendation 42(2)(a)]
- promote, protect and ensure the right of people living with mental illness or psychological distress to the enjoyment of the highest attainable standard of mental health and wellbeing without discrimination [Recommendation 56(1)].

Legislative proposals

To meet these recommendations, the Department of Health is proposing that the new Act has the following broad objectives:

1. to achieve the highest attainable standard of mental health and wellbeing for people of Victoria
2. to protect and promote the rights and dignity of people living with mental illness or psychological distress
3. to recognise and promote the role of families, carers and supporters in the care, support and recovery of people living with mental illness or psychological distress.

It also proposes the new Act include 13 rights-based principles that will underpin all mental health policies, programs and services (see Appendix 1).

Support for proposals

The ANMF (Vic Branch) recognises the current inequities in access to, and delivery of, mental health services. We welcome this human-rights based approach and the commitment to:

- providing a diverse range of comprehensive and recovery-focussed services
- promoting ongoing continuous improvements in the quality and safety of mental health and wellbeing services
- ensuring the lived experience of people living with mental illness or psychological distress, carers, families and supporters is at the centre of practice change and system design.

We commend recognising the diversity related needs and experiences of all people needing care; our members know that people receiving services are much more than a UR number. We consider all treatment for mental and physical illness should be integrated and respectful of

cultural identity and welcome all efforts to build cultural awareness and cultural safety among mental health practitioners. We commend the commitment to:

- ensure mental health and wellbeing services, including Aboriginal social and emotional wellbeing services, are culturally safe and responsive to Aboriginal and Torres Strait Islander peoples' identity, connection to culture, family, community and Country
- respect Aboriginal and Torres Strait Islander peoples' right to practise self-determination and exercise their decision-making power, including their right to free, prior and informed consent and individual choice.

We note that these commitments, as expressed in the proposed objectives and principles, are consistent with the views we expressed in our submission to the Royal Commission. This submission called on the Victorian Government to:

- improve health care journeys, with the system designed for people not providers, with clear, seamless, readily accessible pathways [Priority 8]
- recognise medical and other health needs and improve care journeys, so people receiving mental health care can access holistic care across their life span as needed [Priority 8]
- promote recovery and embed trauma-informed care to increase safety for people with lived experience and clinicians [Priority 8]
- reduce restrictive interventions to reduce trauma for people with lived experience and clinicians [Priority 8]
- develop and implement a mental health funding model whereby services, no matter where they are accessed, can integrate and adjust, removing service fragmentation for consumers/clients [Recommendation 3]
- recognise the importance of including culturally appropriate perinatal mental health screening as a key service and take steps to ensure it is funded and built into the service provision [Recommendation 40]
- introduce mechanisms to encourage, where possible, participation from family members to support their loved one as they go through treatment [Recommendation 50].

Areas of concerns

Risk

We note that Principle 4 requires respect for the views, preferences and decisions of people receiving mental health and wellbeing services, including when those decisions involve a degree of risk. As discussed in our submission to the Royal Commission, as well as risk to the person receiving services, risk in mental health care settings can include:

- risk to other people receiving services
- risk to families, carers and support people
- risk to people providing services.

We discuss the risk to nursing staff at length in 2.6. Here, we note the current wording leaves it open for the person receiving mental health and wellbeing services to make, and be supported in, decisions that involve risk to others. This should be remedied.

Support and guidance

We note that the Paper states that the new objectives and principles will mean people working in the mental health and wellbeing service system will:

- be supported, through statutory guidance and the work of new entities, to act in ways and make decisions that are consistent with the principles of the new Act
- have access to statutory guidance about how the principles of the new Act must be given effect in compulsory treatment decisions
- be able to work and collaborate with a more diverse range of comprehensive and coordinated services to help people living with mental illness or psychological distress, including comprehensive local services (page 8).

Principle 3 requires that compulsory treatment and restrictive practices are only used as a last resort and Objective 2 requires that compulsory treatment and coercive and restrictive practices are reduced, with restrictive practices to be eliminated within 10 years.

Achieving this goal will require significant guidance and support along with substantial system reform. We note that the Royal Commission recommended the Chief Officer for Mental Health and Wellbeing develop a 10-year strategy to eliminate restrictive practices. The development of this strategy should be expedited. Objective 2 should also be emended to refer to the strategy to ensure consumer expectations align with it. Given the implications of this strategy for nursing practice, it is also essential that the ANMF (Vic Branch) is included in the coproduction team.

Improvements and actions required

1. Emend Principle 4 to read:

   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 *to themselves.*

2. Expedite the development of the 10-year strategic plan to guide the elimination of restrictive interventions recommended by the Royal Commission and include the ANMF (Vic Branch) in the coproduction team.

3. Emend Objective 2, bullet point 7 to read:

   … aiming to eliminate the use of restrictive practices within 10 years *and in accordance with the Chief Officer for Mental Health and Wellbeing 10-year elimination strategy.*

2.2 Non-legal advocacy

Royal Commission recommendations

The Royal Commission recommended that the Victorian Government:

- include a legislative provision in the new Act enabling an opt-out model of access to non-legal advocacy services for consumers who are subject to or at risk of compulsory treatment [Recommendation 56(2)].

Legislative proposals

To meet this recommendation, the Department of Health is proposing that the new Act require:

- mental health and wellbeing service providers to notify non-legal advocacy services as soon as practicable, within 24 hours, after making an assessment order or a temporary treatment order
- necessary information to be shared to allow the non-legal advocate to contact the consumer
- consumers to have the right to opt out of this service if they so choose.

The new Act will also include protections to ensure advocates can connect with consumers, such as:

- rights for advocates to access inpatient services
- no restrictions on a consumer's right to communicate with an advocate
- rights for advocates, with the person's consent, to access a person's records, meet with the person or attend any meeting or consultation with the person
- obligations on service providers to give reasonable assistance to advocates in performing their functions, including responding to any requests for information within a maximum of three days
- obligations on service providers to notify a person's advocate in certain circumstances, including when a person is subject to seclusion or restraint.

The new Act will support the Chief Officer for Mental Health and Wellbeing to issue operating guidelines for non-legal advocacy services that clarify and give effect to the obligations of mental health service providers to engage with non-legal advocacy services.

Support for proposals

The ANMF (Vic Branch) supports an opt-out model of access to non-legal advocacy services for consumers who are subject to, or at risk of, compulsory treatment. We recognise non-legal advocates can support care by helping users:

- understand their care plans
- raise questions about their care and medication
- prepare for care discussions with their health team.

Areas of concerns

Consistency and efficiency

The current system enables consumers who are subject to, or at risk of compulsory treatment, to access non-legal advocacy services through the Independent Mental Health Advocacy (IMHA) service at any time by choice. These non-legal advocacy services are currently not routinely offered on admission; however, they are referred to in the *Statement of Rights* which must be provided to consumers when they are subject to compulsory treatment. The proposed changes will require a clear and efficient process for making and documenting all referrals to non-legal advocacy services formed in addition to IMHA.

We note that the Paper states that the new non-legal advocacy arrangements will mean people working in the mental health and wellbeing service system will have access to statutory guidance about how the principles of the new Act must be given effect and how to better provide for supported decision making (page 13).

Clearly such guidance will have a direct impact on the work of our members, making it essential that the ANMF (Vic Branch) is directly involved in the forming of the statutory guidance for non-legal advocacy.

Regulation and training to ensure safe and appropriate practice

We note that other jurisdictions providing non-legal advocacy regulate the role of a non-legal advocate. For example, the *Mental Health Act 1983 (Independent Mental Health Advocates) (England) Regulations 2008* impose the following conditions:

(1) A person may not act as an Independent Mental Health Advocate unless the conditions specified in paragraph (2) are satisfied.

(2) Those conditions are that the person referred to in paragraph (1)—

a) has appropriate experience or training or an appropriate combination of experience and training

b) is a person of integrity and good character

c) is able to act independently of any person who is professionally concerned with the qualifying patient's medical treatment, and

d) is able to act independently of any person who requests that person to visit or interview the qualifying patient.

To ensure safe and appropriate practice, we consider similar arrangements are needed here. These arrangements would provide a sound ethical and practice framework that includes standardised training, licensing, and regulation of non-legal advocates, as well as a process for ensuring any training requirements and practice standards are met and maintained.

Improvements and actions required

4. Develop:
    - a central and coordinated process for referral to non-legal advocacy services formed in addition to IMHA
    - a simple, efficient and consistent way to document all referrals to this service that does not add to the already complex process of admission.
5. Support the new Act's non-legal advocacy requirements by developing accompanying regulations requiring standardised training, licensing, and regulation of non-legal advocates, including a process for ensuring any training requirements and practice standards are met and maintained.

2.3 Supported decision making

Royal Commission recommendations

The Royal Commission recommended that the Victorian Government:

- align mental health laws over time with other decision-making laws with a view to promoting supported decision-making principles and practices [Recommendation 56(4)].

Legislative proposals

To meet this recommendation, the Department of Health is proposing that the new Act will:

- include stronger language about the obligation on decision-makers to consider the views and preferences of the consumer, their nominated person and other relevant people who must be consulted under the new Act
- promote supported decision making for all consumers, not just those on compulsory orders, throughout all aspects of a person's assessment, treatment and recovery
- increase transparency and accountability of supported decision making by requiring a formal record of how a person's preferences were considered and where they were overridden during treatment, including:
  - discussions about informed consent for treatment or assessments that show a person could not provide informed consent
  - efforts to support a consumer to make a decision
  - decisions to act against a person's views and preferences and how they were reached
- promote tools to enable supported decision making, including statements of rights, advance statements, nominated persons and second psychiatric opinions.

Statement of rights

Under the proposed changes, a statement of rights must be given to:

- a person who is subject to compulsory assessment or treatment orders
- consumers who are voluntarily admitted as inpatients.

They must have the statement explained to them and be allowed to ask questions and have them answered. The person providing the statement must ensure the person understands their rights through initial and ongoing conversations about their rights and supports.

Advance statements

The new Act will enable advance statements to include preferences on a broader range of matters such as culturally appropriate foods or mealtimes and a broader range of people will be able to witness them. It will also increase transparency around overriding advance statements by requiring that:

- the consumer be given written reasons for a decision to override their treatment preferences
- these reasons be provided to any other person at the consumer's request.

Nominated persons

Under the new Act, when a nominated person is appointed to support a person on a compulsory assessment or treatment order, they will be required to agree to support the person to make their own decisions and to represent their views and preferences, including those set out in an advance statement.

Second psychiatric opinions

The new Act will:

- with the consumer's consent, allow more flexibility in how second opinions can be provided to support the timely provision of second opinions
- require that an authorised psychiatrist documents their reasons for not accepting the opinion of the second psychiatrist and provide a copy of these reasons to the consumer and any other person requested by the consumer.

Support for proposals

The ANMF (Vic Branch) supports the proposed changes in principle. We note that while advanced statements and nominated persons are already allowed under the current Act, neither is used optimally. Advanced statements are underused and nominated persons are often the person's next of kin and are unclear about their nominated person role. The enhanced nominated person role and agreement process will provide greater clarity to the person and undertaking this role and greater support to consumers in their decision making. This could enhance the person's treatment, care, support and recovery.

Areas of concerns

Scope and workloads

The ANMF (Vic Branch) is concerned about how the changes will affect our members in practice. Members already report heavy workloads and are likely to be significantly affected by:

- the increased application of the statement of rights and the onus on the practitioner to ensure it is understood
- the increased transparency and accountability around supported decision making with a formal record of how preferences were considered and where and why they were overridden being required
- the increased scope and accountability requirements for advanced statements, with non-clinical preferences such as meal contents and times now included and written reasons for a decision to override preferences required.

These changes mean nurses are likely to be providing the statement of rights to more people and will require more time when they do – and in follow-up interactions – to ensure the person understands it.

If transparency and accountability arrangements around supported decision making extend beyond medical treatment to nursing and support care – and it is unclear whether they do – they will include a range of routine decisions currently made by nurses. For example, they would apply when the nurse in charge of a Mental Health Inpatient Unit decides a patient is not safe in

a low dependency area and needs to be moved to a higher acuity area, and the consumer did not agree with the decision. The nurse would then be required to meet the new documentation requirements which would require additional time and add to an already heavy workload.

With non-clinical areas now covered in advanced statements (e.g., food and mealtimes), it is also unclear whether the documentation obligations will apply when these preferences cannot be met, and if so, who will be required to fulfil these obligations. Our members are already concerned about their current documentation obligations which are often duplicated and time consuming, and already reduce the amount of time they are available to consumers.

For these obligations to work in practice, greater clarity around the intended scope of the new provisions is needed, with the legislation written in a way that clearly defines the scope so there is no confusion at service or ward level.

If the scope is to include nursing decisions, we will need further collaboration with the Department of Health about when and how they will apply to nurses and the decisions they make. The ensuing workload issue will need to be addressed.

Improvements and actions required

6. In collaboration with the ANMF (Vic Branch) and other stakeholders, develop statutory guidance about how the supported decision-making provisions in the new Act are to be given effect in practice.
7. Ensure the provisions in the new Act in relation to transparency and accountability for supported decision making have a clearly defined scope.
8. Consult with the ANMF (Vic Branch) to identify and address the impact on nursing workloads of the proposed provisions that:
    - broaden the application of the statement of rights
    - increase the scope of advanced statements
    - establish and increase new documentation requirements for nursing decisions.

2.4 Information collection, use and sharing

Royal Commission recommendations

The Royal Commission recommended that the Victorian Government:

- ensure the new Act specifies the ways in which information about mental health and wellbeing may be collected and used [Recommendation 42(2)(g)]
- develop policies, standards and protocols to enable the effective, safe and efficient collection and sharing of such information, including standards to guide the sharing of information with families, carers and supporters [Recommendation 30(4)]
- set expectations that mental health and wellbeing services will provide opportunities for consumers to contribute to the information held about them and gain easy access to it [Recommendation 61]
- collaborate with consumers to introduce a consent-driven approach to information sharing with mental health and wellbeing services and individuals outside the mental health and wellbeing system [Recommendation 61]
- develop, fund and implement modern information and communications technology (ICT) infrastructure, including:
  - a new, state-wide, electronic Mental Health and Wellbeing Record to replace CMI/ODS
  - a review of current data items that sees unused items removed and new useful items added to accurately collect mental health service activity and consumer outcomes
  - a new Mental Health Information and Data Exchange that allows real time information sharing within and across services and sectors and includes a user-friendly online consumer portal for consumers to view their key information and authorise its sharing, and a comprehensive data repository with clinical registries to support mental health outcome measurement, service planning, continuous improvement and research [Recommendation 62(1)].

Legislative proposals

To meet these recommendations, the Department of Health is proposing that the new Act include simpler and clearer information collection, use and sharing provisions that build on the current provisions. These provisions will be guided by the following principles:

- consumer access to their own information as soon as practicable after a request
- respect and dignity when recording consumer information
- respect for consumers' diverse backgrounds and needs
- accountability for high-quality information collection and use
- improving consumer experiences
- consumer consent and privacy
- providing safe, high-quality treatment and care
- supporting transitions between services or care levels, and integrated services
- the important role of families, carers and supporters and their need to access appropriate information

- the importance of information sharing to promote and maintain physical, emotional, cultural and psychological safety
- the right of Aboriginal and Torres Strait Islander people to self-determination and to have their information shared in a way that is culturally sensitive and appropriate
- transparency between service providers and consumers in relation to information sharing.

The new Act will give consumers greater access to their own information by enabling the Health Complaints Commissioner to issue guidelines to mental health and wellbeing providers on consumer access to information. Consumers will also be able to ask for a statement to be included on their record if they disagree with the information in the record.

The new Act will create a duty for mental health service providers, with the consumer's consent, to share information with families, carers or supporters at defined points during care or treatment, such as admission and discharge.

It will also provide for information sharing in and beyond mental health and wellbeing services, including with Ambulance Victoria in its first responder role and with other services such as housing, alcohol and drug services, so consumers have a more seamless experience when using multiple services.

New provisions will allow some basic information to be shared across the broader social service system without consent, but consumers will also have the right to request that this information not be shared. Consent will be required for more detailed information and consumers will be able to provide further instructions about information sharing through an advance statement.

The training, professional guidelines, standards and cultural change to support these new provisions and practice changes, as well as design of the new information-sharing infrastructure, will be determined in a separate process, in collaboration with interested stakeholders.

Support for proposals

The ANMF (Vic Branch) recognises that information sharing, with the consumer's consent, can improve consumer care journeys by building links between services and enabling consumers to access clear, seamless, pathways to tailored, holistic care. It can also reduce trauma for the person receiving care by reducing the need to retell their story before accessing treatment. The proposal is therefore consistent with Priority 8 – Improving care journeys – in our submission to the Royal Commission.

Areas of concern

Practice guidance

ANMF (Vic Branch) members have always taken very seriously their obligation to protect and uphold the privacy and confidentiality of consumer information. They are aware that consent can be given and removed throughout a care episode and that in health settings, including mental health, obtaining consent may not always be straightforward. As members stated:

> When a patient is receiving treatment for mental illness, how do you define consent? How do you say to someone who is receiving medication for their mental illness, when that medication may be affecting their cognition: "Is it ok if I tell your mum that you are an inpatient here?" We don't know their relationship with their mum. I feel

uncomfortable sharing anybody's information. If they give me consent, I need them to be in the room with me, and I need clear notes about it.'

'We need to be clear about what can be shared with and without consent because when we are putting that into practice, we need to be supported to get appropriate consent and with what information we are able to disclose. If it is just a blanket statement without clear guidance, then people may assume and share information that is not appropriate.'

Legislation preceding ICT infrastructure

Members are also aware that while their documentation is of a high standard, services will need to improve their systems if they are to provide their information without delay.

We note that the new ICT infrastructure will be determined through a separate process, as will the training, professional guidelines, standards and cultural change needed to support the requisite practice change. This process, particularly for developing ICT, is likely to follow the enactment of the Act, making it difficult for staff and services to meet the new obligations at the outset.

Given the impact of these changes on our members, it is essential that the ANMF (Vic Branch) is involved in these additional processes to ensure members have the guidance they need to give effect to the new provisions without risk to themselves.

Improvements and actions required

9. In collaboration with the ANMF (Vic Branch) and other stakeholders, establish clear guidelines and processes around obtaining and maintaining consent, to ensure nurses and midwives have the guidance they need to give effect to the new information sharing provisions without risk to themselves.
10. In collaboration with the ANMF (Vic Branch) and other stakeholders, develop a clear and agreed strategy, implementation plan and timeline for the speedy delivery of the ICT infrastructure needed to support the new provisions.

2.5 Reducing the use and the negative impacts of compulsory assessment and treatment

Royal Commission recommendations

The Royal Commission recommended that the Victorian Government:

- ensure the Mental Health and Wellbeing Act:
  - specifies measures to reduce rates and negative impacts of compulsory assessment and treatment, seclusion and restraint
  - simplifies and clarifies the statutory provisions relating to compulsory assessment and treatment so they are no longer the defining feature of Victoria's mental health laws [Recommendation 42(2)(e-f)]
- facilitate the Mental Health and Wellbeing Commission to monitor the use of compulsory treatment [Recommendation 53(2)(b)]
- act immediately to ensure the use of compulsory treatment is only as a last resort
- set targets to reduce the use and duration of compulsory treatment on a year-by-year basis and gather and publish service-level and system-wide data in this regard [Recommendation 55(1-2)].

Legislative proposals

To meet these recommendations, the Department of Health is proposing a raft of legislative changes as well as new additional regulations and system and service provision changes.

Legislative changes

The Department of Health is proposing that the new act will:

- strengthen principles and accountability around compulsory treatment by:
  - setting clear expectations that compulsory treatment is to be used only as a last resort and that treatment, care and support should always be provided with the least possible restrictions on people's rights
  - including principles relating specifically to the use of compulsory treatment that require decision-makers to consider the impact of such treatment on the person receiving it, including any distress and harm that may be caused by the treatment itself
  - requiring that a compulsory treatment order is made with the aim of supporting recovery and moving towards non-coercive approaches to treatment and support
- strengthen regulation and oversight of the use of compulsory treatment by:
  - empowering the Mental Health and Wellbeing Commission to issue statutory guidelines on how to apply the principles when making compulsory assessment and treatment orders and to investigate and monitor the use of compulsory treatment
  - empowering the Chief Officer for Mental Health and Wellbeing to set system-wide targets for reducing the use and duration of compulsory treatment

  - establishing formal reporting requirements on the use and duration of compulsory treatment, with the Department of Health to publish service-level and system-wide data
- strengthen the criteria for compulsory treatment by:
  - replacing 'preventing serious deterioration in the person's mental or physical health' with 'preventing the person experiencing serious distress'
  - requiring that the harm being prevented be both 'serious and imminent' and all other treatment and support options have been considered and eliminated
- strengthen the authorisation arrangements for compulsory treatment by:
  - empowering the Mental Health Tribunal to require a conference be held ahead of considering a treatment order extension to facilitate more diverse input, shared decision making and enhanced understanding
  - enabling consumers to request or object to a conference, with the conference not held if the consumer objects.

Regulation and other changes

As well as these legislative changes, the Department of Health foreshadows:

- further significant changes to the Mental Health Tribunal following an independent review of its role
- the use of regulation to enable further changes, such as:
  - permitting a broader range of professionals, such as nurse practitioners and social workers, to authorise temporary treatment orders
  - including measures to provide confidence to decision-makers who make treatment and care decisions that are consistent with the principles, the broader vision for Victoria's mental health and wellbeing system and allow for dignity of risk.

System and service provision changes

The Department of Health says the redesigned mental health and wellbeing system will move from a crisis-driven model to a system built around community-based services. The Department will put in place system reforms that enhance voluntary treatment, care and support methods. This will include:

- introducing a more diverse mix of treatment, care and support to meet people's needs and preferences
- driving practice change and workforce initiatives led by the new Mental Health Improvement Unit to:
  - increase consumer leadership and participation in all activities to reduce compulsory treatment
  - support the design and implementation of local programs, informed by data, to reduce compulsory treatment

  - provide workforce training on non-coercive options for treatment that is underpinned by human rights, safety and supported decision-making principles.

- promoting cultural change to support the dignity of risk through a systemic cultural shift and broad public education to reduce stigma and misconceptions about mental illness.

Support for proposals

Reducing the use of compulsory treatment and ultimately eliminating the use of restrictive practices is a key objective of the new Act. The ANMF (Vic Branch) supports this objective.

Our submission to the Royal Commission called for greater investment in community clinical mental health services (Priority 6). We made a range of recommendations to support prevention and early intervention, so that expert, tailored care is available early in life, early in onset and early in episode through evidenced-based, nurse-led programs in community and primary care settings.

We recommend expanding and improving these programs to facilitate routine and opportunistic mental health risk screening, therapeutic solutions and referral across the lifespan as a very cost effective and efficient approach to prevention and early intervention. [Recommendations 11-22].

We also made numerous recommendations around suicide prevention [Recommendations 23-31] and improving health care journeys, including investing in and prioritising the community-based response [Recommendations 32-39] and providing additional measures for unique, at-risk communities [Recommendations 40-52].

In relation to restrictive practices, we recommended the Department fund a dedicated nursing role to build and monitor reducing restrictive intervention compliance by:

- providing regular training and refresher training for all direct care staff and security personnel
- leading and coordinating:
  - collaborative nursing care planning
  - communication with consumers about the reason for any restrictive interventions
  - collaborative reviews after each restrictive intervention
  - debriefing and support for consumers, carers and supporters [Recommendation 38].

Areas of concern

Legislation outpacing service reforms

While the ANMF (Vic Branch) supports the move from a crisis-driven model to a system built around community-based services, we are concerned that the new Act will be enacted before essential and enabling reforms to the service system are in place.

We note the first new acute beds, announced by the Victorian Government in 2020, will not be completed until late 2022 at the earliest, and new local mental health and wellbeing services have not commenced capital works. There is currently no consultation on refurbishing current beds, nor is the ANMF (Vic Branch) aware of changes to current models of care. This means that

the Act will place additional obligations on a system and nursing workforce that remains under resourced. (We address this more fully in 2.1 and 2.6.)

Unclear criteria around compulsory treatment

ANMF (Vic Branch) members share the Department's view that best practice requires compulsory treatment to be the treatment of last resort, and that least restrictive practice is key when considering care and treatment options. However, they consider that changing the criteria for compulsory treatment from 'serious deterioration' to 'serious distress' introduces a challenging layer of subjectivity. They consider judgements about 'distress' to be much more subjective than judgements about 'deterioration' and are concerned such judgements may often differ between the decision maker and the consumer, and between decision makers. They hold similar concerns about the change requiring the harm being prevented (to the person or another person) to be 'serious and imminent'.

Terms like 'distress', 'harm', 'serious' 'risk' and 'imminent' all require subjective judgements. Ideally, words used in the legislation would facilitate an objective judgment and be supported by clear guidelines that reduce further the capacity for subjective judgements and inconsistent practice.

Lack of clarity around nurse practitioner proposal

A key change impacting nurses is the suggestion that new regulations may enable additional practitioners, including nurse practitioners (and social workers) to authorise a temporary treatment order to facilitate more holistic care. This remains a vexed issue for the ANMF (Vic Branch) and our nurse practitioner members and requires further consultation.

Our nurse practitioner members are always open to new opportunities to use their considerable expertise, but they are also keen to ensure doing so brings real and meaningful benefits to consumers without them risking or compromising their professional practice.

Members report that circumstances do arise where access to a treating psychiatrist for the purpose of obtaining a temporary treatment order is challenging. They would welcome a solution to this problem that ensures the consumer receives assessment, support, and management in a timely manner, avoids further deterioration and distress to themselves and others, and begins their recovery earlier. However, our members are unclear whether this is the main issue this proposal is attempting to address, and if so, whether the proposal to extend these powers to a wider group of practitioners is the best solution. We therefore consider further consultation is needed to identify more clearly:

- the problem to be solved
- the best solution to this problem.

Key questions to explore include the following:

- The new Act aims to reduce the use of compulsory treatment. Will extending the authority to make temporary treatment orders to more practitioners advance this objective?
- Is extending the powers to include nurse practitioners the best way to resolve lack of timely access to the treating psychiatrist? Are their other solutions worth considering?

- Given the psychiatrist would still determine the treatment, could the proposed expansion interfere with this therapeutic process?
- With many mental health clinicians (registered nurses, social workers, occupational therapists, psychologists, and medical officers) already able to place clients on an assessment order for review by a psychiatrist, what additional benefit would this change bring?
- If this power were given to nurse practitioners, what risks would they be assuming and what protections would be put in place to mitigate these risks?
- What would be the flow on effects for their workloads? For example, would nurse practitioners also be required to justify their decisions at the Mental Health Tribunal?
- What practice guidelines, safeguards and accountability requirements would be put in place to protect clinicians and consumers? For example, would nurse practitioners be required to account for their decisions to the treating psychiatrist and potentially have their decision overruled?
- Could the new power undermine the unique therapeutic role of nurse practitioners, potentially damaging the trust, rapport, and relationship they have with clients, making it more challenging to provide ongoing treatment, care and support?
- Are there limited situations where the extended powers might be the best solution, such as in CATT or MST or under specific guidelines in rural and remote services?

Regardless of the answer to these questions, one thing is quite clear: the power ought not be extended to include social workers. If, after consultation, it is agreed that extending powers is the best solution, those powers ought only apply to highly trained and experienced mental health nurse practitioners, not all nurse practitioners, and certainly not to social workers.

Our members note with alarm that social workers do not hold the additional training, experience or skills required of mental health nurse practitioners. They are not equipped to assess and diagnose a client or prescribe medication – knowledge that is essential to making decisions about treatment orders. It is inappropriate to extend these powers to social workers.

Improvements and actions required

11. Ensure the provisions around compulsory treatment in the new Act are as objective as possible, and where they are subjective, include clear and unambiguous definitions of the terms used (e.g., ‘distress’, ‘harm’, ‘serious’, ‘risk’ and ‘imminent’) to prevent confusion and promote consistent practice.
12. In collaboration with the ANMF (Vic Branch), develop clear practice guidelines to further reduce the capacity for subjective judgements and inconsistent practice.
13. Consult further with the ANMF (Vic Branch) about the proposal to extend the power to make a temporary treatment order to nurse practitioners.

2.6 Reducing the use and the negative impacts of seclusion and restraint and the regulation of chemical restraint

Royal Commission recommendations

The Royal Commission recommends that the Victorian Government:

- ensure the new Act:
  - specifies measures to reduce rates and negative impacts of compulsory assessment and treatment, seclusion and restraint [Recommendation 42(2)(e)]
  - regulates the use of chemical restraint through legislative provisions in the new Act [Recommendation 54] that reflect those in the *Tasmanian Mental Health Act 2013*
- facilitate the Mental Health and Wellbeing Commission to monitor the use of seclusion and restraint, as a matter of priority [Recommendation 53(2)(a)]
- act immediately to reduce the use of seclusion and restraint in mental health and wellbeing service delivery, with the aim of eliminating these practices within 10 years
- ensure the Chief Officer for Mental Health and Wellbeing develops and leads a strategy to reduce the use of seclusion and restraint
- enable the Mental Health Improvement Unit within Safer Care Victoria to co-design, with mental health and wellbeing services and people with lived experience, a range of programs and supports aligned with the strategy that focus on:
  - working with each mental health and wellbeing service to investigate local data and practices to identify priority areas for change
  - making workforce training available for services
  - continuing to support services to embed Safewards [Recommendation 54].

Legislative proposals

Regulation and transparency on the use of seclusion and restraint as a last resort

The new Act will regulate the use of seclusion and restraint to facilitate rigorous oversight. It will:

- acknowledge the harm caused by restrictive interventions and the shared responsibility for their elimination
- define and regulate the use of chemical restraint in a way that restricts its use to 'last resort'
- require clinicians to:
  - weigh up the harm likely to be caused by a restrictive intervention with the harm they are seeking to prevent by using it
  - consider both the clinical intent and the impact of chemical restraint on the consumer
  - document the alternative treatments and supports that were tried or considered and the reasons why they were found unsuitable

- require service providers to:
  - consider factors that may impact on the person's experience such as their age, disability, culture, neurodiversity, language, religion, race, gender, gender identity, sexual orientation, and trauma history, when considering alternative strategies and the use of restrictive interventions.

Accountability

Entities across the system will share responsibility for reducing and ultimately eliminating the use of seclusion and restraint.

- The Mental Health and Wellbeing Commission will:
  - issue statutory guidelines on how the principles should be interpreted and applied in relation to seclusion and restraint
  - receive and respond to complaints about seclusion and restraint, monitor their use and, when necessary, conduct inquiries into restrictive practices.
- The Chief Officer for Mental Health and Wellbeing will:
  - set system-wide targets for reducing the use of seclusion and restraint
  - develop, monitor, and report on appropriate measures, and work towards eliminating the use of chemical restraint.
- The Mental Health and Wellbeing Commission will:
  - receive complaints and monitor progress and compliance
  - have the power to audit or investigate the use of seclusion and restraint
  - report to parliament on the progress against the objectives.
- The Department, the Chief Officer for Mental Health and Wellbeing, and the regional mental health and wellbeing boards (see 2.7), will:
  - progress the objectives through system management and planning
  - have a role in data collection and monitoring.

Support for proposals

The ANMF (Vic Branch) supports the new Act including provisions to reduce and ultimately eliminate the use of restrictive practices, including seclusion and the use of chemical restraint.

Our members note that seclusions are traumatic for the person and staff involved. They can also be time-consuming to put in place, and staff can experience increased risk to their safety during the process. Our members welcome the prospect of working in a mental health system where they are no longer necessary because the system has the infrastructure and resources required to provide safe alternatives where restrictive practices are currently necessary and has best practice early intervention and care services that ultimately remove the need for restrictive practices. This is consistent with our submission to the Royal Commission which called for the Victorian Government to:

- build a mental health system built for people not providers, with clear, seamless, readily accessible pathways to tailored, holistic care [Priority 8].
- augment the acute system to meet current unmet need [Priority 5]
- invest in community clinical mental health services [Priority 6]
- develop consistent, best-practice models of care [Priority 9].
- invest in reducing restrictive interventions to reduce trauma for people with lived experience and clinicians [Priority 8].

Areas of concern

Unprepared service system

The ANMF (Vic Branch) and members stress that the current mental health system is not yet ready for the elimination of restrictive practices and trying to eliminate them before the system is ready will put consumers and clinicians at risk. As made plain in the Royal Commission's report, the system lacks the funding, infrastructure, staffing, and other resources required to be a best practice system.

Our members consider that seclusion and restraint are already used as 'last resort', however they note that resources, including staffing, often do not provide staff with the time they need to de-escalate a situation in which the person receiving health and wellbeing services has become a risk to themselves or others. They advise that on some occasions, several nurses may need up to 45 minutes to de-escalate a situation and prevent the use of seclusion and restraint. While this is a worthy use of resources for that consumer, it means other consumers in that unit are not receiving treatment, care and support to aid their recovery during this time.

Members are also particularly concerned about the rise in people presenting with drug induced psychosis, especially from methamphetamine use. People presenting in this way often display violent or erratic behaviour, creating a risk to themselves and others. Member's report being punched, spat on, and kicked when trying to manage situations security staff won't deal with. In these instances, restrictive interventions may well be the intervention of last resort that best prevents harm to the person, to others sharing the service environment, and to staff.

As already noted, resources such as additional community beds; additional nurses 'on the ground' with backup available when needed; specialist mental health ED areas; improved ward environments with natural light and calming indoor and 'green' outdoor timeout spaces; increased peer and consumer support; additional therapies and associated resources; as well as early intervention services, new models of care, practice guidelines and targeted training, will all need to be in place before restrictive practices can be eliminated. While the service system remains unprepared, restraint, chemical or otherwise, will remain an important last resort mechanism to safeguard staff and consumers. A strategic, multi-faceted approach with a clear pathway to elimination is essential.

Therefore, the 10-year elimination strategy – to be co-produced with consumers, families, carers, the workforce and service providers – is integral to achieving this change, and we stress again the need to expedite this work by the Chief Officer for Mental Health and Wellbeing. We also stress the importance of including the ANMF (Vic Branch) in the co-production arrangements.

We consider many of our recommendations in our submission to the Royal Commission would support this strategy, and urge the Department to review and adopt the following recommendations:

- strengthening PARC/YPARC services by providing clinical nursing care 24/7
- reinstating and funding the acclaimed MHNIP program to augment primary care provided by GPs and psychologists
- introducing nurse navigators to improve health care journeys by creating a streamlined and simpler experience while making significant service efficiencies
- optimising nurse practitioners for expert, efficient and cost-effective mental health nursing care for complex clients
- embedding trauma-informed care to increase safety for people with lived experience and clinicians [Priority 8].

Staff safety

It is imperative that no arrangements in the new Act, including those around restrictive practices, compromise the safety of nursing staff.

As it currently stands, all the proposed provisions in the Act detailed in the Paper focus on the rights of consumers, families, carers and supporters. The ANMF (Vic Branch) considers it essential that the Department of Health and the new Act also recognise the right of our members to be safe at work, as enshrined in the *Victorian Occupational Health and Safety Act 2004* (OHS Act).

This could be done in part by embedding an occupational health and safety committee into the new Act to deliver a much-needed mechanism to provide oversight and monitor compliance with both the new Act and the OHS Act. This committee would support continuous improvement and best practice by:

- considering workplace safety during the implementation of the new Act, and ensuring potential health and safety impacts on staff are identified and eliminated or mitigated
- considering workload management during the implementation of the new Act, and making recommendations to rectify impacts
- monitoring and making recommendations to improve workplace safety over the lifespan of the new Act
- participating directly in the review of the new Act at years five and seven
- supporting ongoing research into workplace safety in mental health settings
- ensuring a collaborative and transparent approach to the above matters.

This occupational health and safety committee would be appointed by the minister and be similar to the models in the current OHS Act and the *Workplace Injury Rehabilitation and Compensation Act 2013.* It would include independent experts, the ANMF (Vic Branch) and other relevant unions, employer representatives, consumers and other stakeholders, such as WorkSafe Victoria.

We note that the existing Mental Health Act provides for committees with external experts (sec 143) and that the current Restrictive Interventions Committee chaired by the Chief Psychiatrist is one such committee.

Safewards

We note the Royal Commission recommended the Victorian Government continue to support services to embed Safewards [Recommendation 54]. This reflects recommendation 56 in our submission to the Royal Commission that the Victorian Government 'fund ongoing education for new and existing nursing staff on Safewards and enabling practices to ensure its sustainability'.

The state-wide implementation of Safewards was formally launched in 2016, and the Victorian Managed Insurance Authority, in partnership with the Office of the Chief Mental Health Nurse, committed to a four-year program to consolidate the implementation in the trial sites, expand it to all public mental health services across Victoria, and pilot the model in EDs and acute medical or surgical inpatient units in the later years of the program.

We look forward to working with the Department to continue and complete the roll out of Safewards to all programs by year 2023.

Other actions needed to uphold 0HS rights

However, a commitment to Safewards alone is not sufficient to protect the health and wellbeing of our members. The impact of the daily safety challenges faced by nurses in mental health settings, particularly acute settings, was captured in case studies we provided to the Royal Commission. An example is included here at Appendix 2.

Recent research shows attrition among the nursing workforce is driven in large part by workplace stressors, including verbal and physical aggression. It argued for the workplace stress of mental health nurses to become an urgent priority for governments, with assertive measures implemented to reduce these stressors and strengthen staff wellbeing.[1]

Our submission to the Royal Commission addressed staff safety in detail, and made several key recommendations [53-59] including, that the Victorian Government:

- embed trauma-informed care to increase safety for people with lived experience and clinicians
- enforce the state-wide implementation of the ANMF (Vic Branch) 10-point plan to reduce occupational violence and aggression across all adult mental health services and in Forensicare
- consider implementing more targeted and effective incident reporting, inspection, investigation and accreditation mechanisms and accountabilities
- deliver resilience education programs for nurses working in adult mental health as a protective measure

[1] See K Foster, M Roche, J Giandinoto & T Furness 2019, Workplace stressors, psychological well-being, resilience, and caring behaviours of mental health nurses: a descriptive correlational study', *International Journal of Mental Health Nursing,* Australian College of Mental Health Nurses Inc.

- continue to invest in and support the highly successful Nursing and Midwifery Health Program Victoria (NMHPV).

We urge the Department of Health to adopt these recommendations as a matter of urgency.

Definitions and under treating

The Royal Commission recommended that the new Act reflect the Tasmanian model to regulate chemical restraint.

We note the Tasmanian *Mental Health Act 2013* defines chemical restraint as 'medication given primarily to control a person's behaviour, not to treat a mental illness or physical condition'.

The Paper raises concerns about this definition, including that it is 'based on the intent of the clinician in prescribing medication' and that 'this can be difficult to determine when medications have strong sedative effects' (page 31).

The Paper proposes that chemical restraint be regulated, including through clinical guidelines, in a way that considers both the clinical intent and the impact of chemical restraint on the consumer.

Our members have a keen interest in the definition that will be used. They are concerned that an unclear definition may lead to the under-prescribing of medications that have sedation as a side-effect, to the detriment of the person receiving mental health care. They note that if the first purpose in using the medication is to treat the mental illness, then it ought not to be considered a chemical restraint.

As noted previously, our members stress again that the mental health system is not yet ready to eliminate chemical restraint, and that until it is, chemical restraint may be preferable to seclusion or physical restraint in circumstances where a person's mental or physical state is causing behavioural changes that put their safety, or the safety of other people in the care environment, including staff, at risk.

Improvements and other actions

14. Complete the roll out of Safewards to all programs by 2023.
15. In collaboration with the ANMF (Vic Branch), review and adopt the recommendations from our submission to the Royal Commission in relation to creating safe workplaces, including the following:
    - embed trauma-informed care to increase safety for people with lived experience and clinicians
    - enforce the state-wide implementation of the ANMF (Vic Branch) 10-point plan to reduce occupational violence and aggression across all adult mental health services and in Forensicare
    - consider implementing more targeted and effective incident reporting, inspection, investigation and accreditation mechanisms and accountabilities

- deliver resilience training programs for nurses working in adult mental health as a protective measure
- continue to invest in and support the highly successful Nursing and Midwifery Health Program Victoria (NMHPV).
- standardise all occupational violence and aggression and de-escalation training offered to staff working in mental health units.

16. Embed an occupational health and safety committee into the new Act to provide oversight and monitor compliance with both the new Act and the OHS Act and support continuous improvement and best practice by:
    - considering workplace safety during the implementation of the new Act, and ensuring potential health and safety impacts on staff are identified and eliminated or mitigated
    - considering workload management during the implementation of the new Act, and making recommendations to rectify impacts
    - monitoring and making recommendations to improve workplace safety across the lifespan of the new Act
    - participating directly in the review of the new Act at years five and seven
    - supporting ongoing research into workplace safety in mental health settings.
17. Consult further with the ANMF (Vic Branch) about the definition of chemical restraint to be used in the new Act when the Department has a definition to propose.

2.7 Governance and oversight

Royal Commission recommendations

The Royal Commission recommended that the Victorian Government:

- establish an independent statutory authority, the Mental Health and Wellbeing Commission, with the complaints and oversights function to:
  - hold government to account for the performance and quality and safety of the mental health and wellbeing system
  - support people living with mental illness or psychological distress, families, carers and supporters to lead and partner in the improvement of the system
  - monitor the Victorian Government's progress in implementing the Royal Commission's recommendations
  - address stigma related to mental health [Recommendation 44(1)]
  - monitor, inquire into and report on system-wide quality and safety, including to monitor, the use of seclusion and restraint; use of compulsory treatment; incidence of gender-based violence in mental health facilities; incidence of suicides in healthcare settings
  - work with the Department of Health and relevant regulators to build a comprehensive understanding of quality and safety issues in mental health and wellbeing services
  - ensure on an ongoing basis that complaints-handling and investigation approaches meet the needs of consumers, families, carers, and supporters; support services to resolve concerns; advise government on issues of concern and areas for improvement; and record, report and publish service-level complaints and other relevant data and information [Recommendation 53]
- establish and legislate the role of Chief Officer for Mental Health and Wellbeing at deputy secretary level to lead the Mental Health and Wellbeing Division in the Department of Health, and empower the Chief Officer to take responsibility for the implementation of the Royal Commission's recommendations [Recommendation 45(1-2)]
- establish a multiagency panel in each region to coordinate the delivery of multiple mental health and wellbeing services for people living with mental illness or psychological distress, including children and young people, who may require ongoing intensive treatment, care and support. [Recommendation 4(5)]
- replace interim regional bodies with legislated skill-based Regional Mental Health and Wellbeing Boards to:
  - undertake workforce, service and capital planning for mental health and wellbeing services; and
  - lead engagement with their respective communities
  - commission mental health and wellbeing services

- hold individual providers to account to improve the outcomes and experiences of people who use their services
- be accountable for the delivery of agreed outcomes through new accountability arrangements [Recommendation 4(2-4)].

Legislative proposals

To meet these recommendations, the Department of Health is proposing that the new Act establish the following new roles or entities:

- Mental Health and Wellbeing Commission
- Chief Officer for Mental Health and Wellbeing
- Regional mental health and wellbeing boards
- Statewide and regional multiagency panels.

Mental Health and Wellbeing Commission

This new entity will assume the powers of the existing Mental Health Complaints Commissioner. However, it will be given a broader remit, with its quality, oversight and complaint handling functions extending to all providers funded by the Victorian Government to deliver mental health and wellbeing treatment, care and support. This will include:

- services delivered by public health, community health, non-government and private organisations
- delivery in hospitals, the community, public and private prisons, and police cells.

It will also be given new powers, including the power to:

- initiate 'own motion' investigations
- consider complaints from families, carers and supporters in relation to their experiences as a family member, carer or supporter
- receive complaints about noncompliance with the new Act's principles
- make recommendations to the Premier, any minister and heads of public service bodies about areas of concern and areas for improvement in the quality and safety of mental health service delivery.

It will also have new responsibilities, including:

- reporting to Parliament on:
  - the performance and quality and safety of the mental health and wellbeing system, including performance against targets to eliminate the use of seclusion and restraint
  - performance of its functions, including those relating to complaints, investigations and inquiries
- advising the Parliament and relevant ministers on areas of concern and areas for improvement in the quality and safety of mental health service delivery.

Chief Officer for Mental Health and Wellbeing

The proposed role of the Chief Officer for Mental Health and Wellbeing will include:

- developing mental health and wellbeing strategy, policy and guidelines
- planning, developing and commissioning mental health and wellbeing services that respond to Victoria's diverse communities
- monitoring the performance, quality and safety of mental health and wellbeing service providers
- developing and supporting the mental health and wellbeing workforce
- supporting the new regional mental health and wellbeing boards to perform their functions
- setting and revising targets for reducing compulsory treatment/seclusion and restraint
- implementing the Royal Commission's recommendations.

The existing Chief Psychiatrist – who will now report to the Chief Officer for Mental Health and Wellbeing – will continue to focus on clinical leadership and oversight of specific mental health and wellbeing practices, with correctional settings now included in the role's jurisdiction.

Regional mental health and wellbeing boards

Under the proposed changes, the department will remain the primary funder and manager of Victoria's mental health and wellbeing system and will take on the role of strategic commissioner. The department will set clear expectations in relation to how regional mental health and wellbeing boards undertake their functions. These boards will:

- support mental health and wellbeing services to be planned and organised in a way that responds to community needs and improves outcomes
- support greater integration across services beyond the mental health and wellbeing system, including both Victorian Government and Commonwealth Government funded services
- be skills-based, inclusive of people with lived experience of mental illness or psychological distress as consumers and family members or carers.

Statewide and regional multiagency panels

Regional multiagency panels, to be established in each region, will:

- bring together different service providers to support collaboration and accountability in providing integrated treatment, care and support to this group of consumers
- have diverse membership, which varies across regions and between meetings based on local needs and services and the needs of individual consumers
- provide strategic advice to Regional Mental Health and Wellbeing Boards and the department regarding broader policy or service delivery matters related to people who require ongoing intensive treatment, care and support from multiple agencies.

The new Act will also legislate a statewide panel to resolve complex issues requiring a system-level response. The panel will comprise the chair of each regional panel and be chaired by the Chief Officer for Mental Health and Wellbeing.

Support for proposals

ANMF (Vic Branch) commends the proposed provisions and the commitment to additional oversight and accountability they demonstrate. This is consistent with our submission to the Royal Commission which called for improved governance [Priority 10] and sought:

- a new mental health plan integrating service, capital and workforce planning and identifying:
  - specific, evidence-based outcomes to be achieved
  - the best mix of services to achieve them, including the most practical service regions based on community needs
  - the organisations to be involved in achieving them
  - the specific investment and workforce measures to support each outcome
  - the reporting and evaluation mechanisms built in to ensure best practice is maintained [Recommendation 1].

We particularly support the plan to establish regional boards to provide support at the local level along with statewide and regional multiagency panels to provide strategic advice on broader policy or service delivery matters for people requiring ongoing intensive treatment, care and support from multiple agencies.

We consider these two initiatives are also consistent with our submission to the Royal Commission which called for improved care journeys and best practice models of care [priorities 8 and 9].

Areas of concern

Safe staffing

We welcome the proposals to:

- expand the remit of the Mental Health Complaints Commissioner to include all providers funded by the Victorian Government to deliver mental health and wellbeing treatment, care and support
- expand the jurisdiction of the Chief Psychiatrist to include correctional settings.

This means the quality, oversight and complaint handling functions exercised by the Mental Health Complaints Commissioner will extend to:

- services delivered by public health, community health, non-government and private organisations
- delivery in hospitals, the community, public and private prisons, and police cells.

It also means that correctional settings will be subject to the Chief Psychiatrist's standards, oversight, monitoring and reporting.

However, to ensure our members in these settings are resourced to provide the level of care required and expected by consumers, families, carers and supporters, changes must also be made to the *Safe Patient Care Act 2015* and funding agreements to require:

- all public services included in this remit are subject to agreed safe staffing levels prescribed under the amended Safe Patient Care Act
- all non-government services included in this remit are required, through their funding agreements, to meet the same safe staffing levels.

Jurisdictional crossover

With the broader remit and powers given to the Mental Health and Wellbeing Commission, we note this complaints entity will continue to be a subject to National Law s150. This requires AHPRA, Boards and health complaints entities to notify each other if they receive a complaint which falls within the other agency's jurisdiction. They must then reach agreement about which agency will deal with the complaint, or whether different parts of the complaint should be managed by each agency concurrently [Schedule *Health Practitioner Regulation National Law Act 2009*, Part 8 Health, performance and conduct].

With the increased potential for jurisdictional crossover caused by the Mental Health and Wellbeing Commission's expanded remit, it is essential that a clear decision-making protocol for determining who will investigate complaints about registered practitioners, including nurses and midwives, is publicly available.

Forensic mental health care

In our submission to the Royal Commission, we discussed forensic mental health care at length, referring to:

- the 2014 Victorian Law Reform Commission Report of the *Review of the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* [recommendations 50 and 100]
- the 2016 Victorian Government Department of Health and Human Services report: *Targeting zero Supporting the Victorian hospital system to eliminate avoidable harm and strengthen quality of care Report of the Review of Hospital Safety and Quality Assurance in Victoria,* [pages 138-141].

These reports highlighted serious concerns around the capacity of Victorian forensic mental health services and the safety and quality of care available to people certified for compulsory treatment, with the 2016 report calling for:

- the development of a mental health infrastructure plan to include a forensic mental health infrastructure sub-plan, with a clear implementation timeline to expand medium-security forensic bed capacity, to address other needs including additional high-security beds and a specialist adolescent inpatient unit to meet the needs of young people.

We note the Royal Commission recommended that the Victorian Government:

- expand the existing forensic community model to:
  - enable Adult and Older Adult Area Mental Health and Wellbeing Services and Infant, Child and Youth Area Mental and Wellbeing Services to provide consistency in treatment, care and support to people in contact with, or at risk of coming into contact with, the criminal justice system

- establish a specialist behaviour response team
- establish a program for people in prison living with mental illness who require ongoing intensive treatment, care and support to transition the delivery of supports from correctional settings to the mainstream settings on release
- expand specialist youth forensic mental health programs to a statewide model to provide consistent and appropriately specialised treatment, care and support to children and young people in contact with, or at risk of coming into contact with, the youth justice system [Recommendation 37]
- refurbish the existing 136 beds at Thomas Embling Hospital
- provide an additional 107 beds, a small number of which should be allocated for people living with mental illness whose treatment, care and support requirements cannot be safely and appropriately met in acute inpatient settings or through the forensic community model
- provide up to another 20 beds to support people living with mental illness whose treatment, care and support requirements cannot be, or are unlikely to be, safely and effectively met in other extended rehabilitation settings [Recommendation 38].

We share the Royal Commission's concerns about forensic mental health services, including concerns about the availability of beds and low staffing levels, and we welcome these recommendations. The impact of low staffing levels in prisons was outlined in a case study in our submission to the Royal Commission (see Appendix 3). A May 2021 survey of ANMF (Vic Branch) members working at various Forensicare sites found that the three most pressing issues for members were the need for:

1. additional staff
2. better safety and prevention of occupation violence and aggression
3. improved access to professional development.

With correctional mental health services to be included in the remit of the Chief Psychiatrist, it is imperative that:

- the Royal Commission's recommendations are expedited so that models of care that comply with the Chief Psychiatrist's standards are in place as soon as possible
- all increases in bed numbers are accompanied by an agreed increase in nurse numbers.

These critical improvements will require further consultation with the ANMF (Vic Branch) to determine appropriate staffing levels for the new beds and additional workforce development measures to ensure adequate numbers of qualified staff are available to achieve these levels.

Improvements and actions required

18. In consultation with the ANMF (Vic Branch), amend the *Safe Patient Care Act 2015* to include safe staffing levels for all mental health services that fall under the expanded remit of the Mental Health and Wellbeing Commission and the Chief Psychiatrist, and require:
    - all public services included in this remit to be subject to agreed safe staffing levels prescribed under the Safe Patient Care Act
    - all non-government services included in this remit to meet the same relevant safe staffing levels as part of their funding agreements
19. Require the Mental Health and Wellbeing Commission to work with AHPRA to develop and publish a clear decision-making protocol for determining who will investigate complaints about registered practitioners.
20. Expedite the Royal Commission's recommendations in relation to correctional mental health services [recommendations 37 and 38] so that models of care that comply with the Chief Psychiatrist's standards are in place as soon as possible and:
    - consult with the ANMF (Vic Branch) to determine appropriate staffing levels for the new beds and additional workforce development measures to ensure adequate numbers of skilled staff are available to achieve these levels.

Appendix 1: Proposed principles

Mental health services and decision-makers should:

1. respect and promote the rights, dignity and autonomy of people living with mental illness or psychological distress and empower people to exercise those rights
2. provide access to a diverse mix of treatment, care and support, taking into account the needs and preferences of people living with mental illness or psychological distress and with the least possible restriction of rights with the aim of promoting recovery and full participation in community life
3. ensure compulsory treatment and restrictive practices are only used as a last resort
4. 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
5. recognise, respect and support the role of families, carers and supporters (including children) in decisions about assessment, treatment and recovery of people receiving mental health and wellbeing services
6. value the lived experience of people living with mental illness or psychological distress, their carers, families and supporters as leaders and active partners
7. recognise and respond to the medical and other health needs (including any related to the use of alcohol and other drugs) of people living with mental illness or psychological distress and consider and respond to the ways in which these needs may affect their mental health and wellbeing and use of services
8. recognise that people receiving mental health and wellbeing services may have specific diversity-related needs and experiences (as to age, disability, neurodiversity, culture, language, communication, religion, race, gender, gender identity, sexual orientation or other matters) and ensure that services are provided in a manner that is safe, sensitive and responsive to these needs and experiences and upholds people's rights
9. recognise that people receiving mental health and wellbeing services may have specific gender-related safety needs and experiences and ensure that services are provided in a manner that: is safe and responsive to histories of family violence and trauma; recognises how gender dynamics can affect service use, treatment and recovery; and recognises how gender intersects with other types of discrimination and disadvantage
10. recognise and respond to the range of circumstances that influence mental health and wellbeing including relationships, accommodation, education, financial circumstances and employment status
11. provide culturally safe and responsive mental health and wellbeing treatment and care to Aboriginal and Torres Strait Islander peoples that is appropriate to, and consistent with, their cultural and spiritual beliefs and practices and in having regard to the views of their families and, to the extent that it is practicable and appropriate to do so, the views of significant members of their communities, including Elders and traditional healers, and Aboriginal and/or Torres Strait Islander mental health workers
12. recognise and promote the best interests of children and young people receiving mental health and wellbeing services, including providing treatment and support in age and developmentally appropriate settings and ways
13. recognise and protect the needs, wellbeing and safety of children, young people and other dependants of people receiving mental health and wellbeing services.

Appendix 2: Case study 1 – Safety in adult acute psychiatric ward

Nurse R – Enrolled nurse, adult acute psychiatric ward (published in our submission to the Royal Commission into Victoria's Mental Health System)

I am employed as a psychiatric enrolled nurse in an adult acute psychiatric ward. I love my job; taking care of patients with a large variety of mental illnesses and often making a difference in people's lives, both patients and their families, makes me so happy.

But the system is broken! We don't have enough beds or staff. The amount of violence on the ward has escalated and nurses are assaulted on a daily basis, mostly verbally, but often also physically. For one and a half years we have had a permanent security guard on the ward. This helps a lot, but it is to be reviewed soon and we don't know if we will continue to have this support. This uncertainty makes us feel unsafe.

The illicit drug crystal methamphetamine is causing so many more drug-affected patients coming to the ward with drug induced psychosis and these patients are in most cases very violent towards both nurses and other patients. It is our job as nurses to protect the other patients, so we are often in the firing line of these violent outbursts. This can in the long run cause PTSD and many psychiatric nurses experience this after only a short number of years working in the acute wards.

I have been physically assaulted by a patient on the ward and I was on WorkCover for some time. Luckily our nursing unit manager is fantastic and with her help and the return-to-work manager, and a lot of hard work, I was able to return. A lot of nurses do not return after assaults.

I recently heard that there has been allocated money to train psychiatric nurses in being more resilient, but we are very resilient – if not we would not be working in these wards.

I often go to work worrying about my safety, my patient's safety and whether I will have to discharge a patient who is not ready yet. We always have patients waiting in the EDs across the service for beds in my ward. These patients have sometimes been waiting for a long time and have been sedated and/or physically restrained and are cared for by staff who are not trained to deal with mental illness.

Psychiatric nursing is so much more than just caring for the physical health of a patient. We have to be like mini psychologists and draw a lot on experience, life learnings and intuition. Often patients are guarded regarding their mental health and you need to form a bond with them through different avenues. Making a risk assessment on a patient is not like taking the temperature with a machine; we need to be able to bond with people and read them, and gauge through questions about patients' interests, family or other things how they are feeling and thinking and their risk of harm to self or others. We also support the families of the patients who have often burned out due to lack of support in the community. These tasks are very time consuming and you often don't have time to do them all.

I usually get to work at 06.45am as I like to get in and have a look at my patient load and plan my day before handover starts at 07.00am which is officially the time I start work. Today I was allocated five patients; usually it is four, but like many days, today we are a nurse short and have to have an extra workload.

I classify my patients according to acuity and fill out the 'shift planner' I have made myself to help me remember everything I need to do during the shift. You need to be super organised to be able to do everything. There are so many tasks to do. Today I left work at 16.00. I had no lunch break, no morning tea break. I made a cup of coffee that I would sip from when in the office. I did manage to have two five minutes break outside the ward but felt very bad about leaving the ward in case anything would happen and my colleagues would need me. I didn't have enough time to speak to and care for my patients.

I have often been feeling bad when on my way home as I didn't have enough time to care properly for my patients or I had to discharge a patient I did not believe was ready to go or did not have enough support in the community. I sometimes cry when on my way home for the same reasons or because I am so exhausted after my shifts.

I can only work seven shifts per fortnight otherwise I am not able to be there for my family. My kids are adults now so no longer need me as much, and my husband can cook, but if I work more I just feel too exhausted to do anything on my days off.

The workforce is getting younger and younger and less experienced as a lot of experienced staff leave their employment in acute wards due to PTSD, not feeling safe at work and the frustration with the way the system works. Younger and younger nurses are forced into becoming assistant nurse unit mangers and nurses in charge.

I believe adult acute psychiatric wards are not equipped to deal with patients with drug induced psychosis. Patients with this should be separated from other mental health patients. Drug affected patients are very destabilising in the wards. Other mental health patients, who are often vulnerable, are scared of them and this can hinder and prolong their recovery. It is frustrating and saddening that under these conditions, we nurses struggle to protect other mental health patients.

I really hope that the Royal Commission into mental health can come up with a plan and solutions to our broken system so we can care for patients with mental illness better and at the same time stay safe in our workplace, retain experienced staff and keep enjoying our work.

Appendix 3: Case study 2 – Safe staffing in forensic mental health

Nurse D – Prison nurse, (published in our submission to the Royal Commission into Victoria's Mental Health System)

I have worked in mental health in a variety of settings since 1996. Settings include geriatric psychiatry, long term secure mental health rehabilitation, community mental health, acute psychiatric inpatient services, registered nurse undergraduate education (psychiatric placements) and registered psychiatric nurse education. My qualifications include a Bachelor of Health Science (Nursing) and a Postgraduate Diploma in Advanced Clinical Nursing (Psychiatric Nursing).

In my current position, I can perform four roles in any given week: unit nurse, risk assessment nurse, risk review nurse or reception nurse. As unit nurse, I work on the 10-bed complex and challenging behaviour unit. As the risk assessment nurse, I assess prisoners identified as being at risk of suicide or self-harm. As the risk review nurse, I review prisoners who are considered high risk for suicide and/or self-harm and are on a management plan to ensure their safety. As reception nurse, I undertake mental health assessments, identify the mental health needs and initiate treatment or care of prisoners who have arrived at prison direct from police cells or the courts.

Unit Nurse	**Risk Assessment Nurse**	**Risk Review Nurse**	**Reception Nurse**
Nursing handover	Nursing handover	Nursing handover	Nursing handover
Custodial handover	Custodial handover	Custodial handover	Custodial handover
Assessment of prisoners on unlock	Collection of radio and paperwork	Collection of radio and paperwork	Review incoming Reception list
Medication administration	Department Risk and Referral meeting	Assess current risk review list – review electronic database	Gather information from electronic records including CMI
Allied health handover	Assess current risk review list – review electronic database	Department Risk and Referral Meeting	Walk to Reception area
Mental State & Risk Assessment	Attend to 'At Risk' calls over the radio	Walk to Health Centre/Unit for review	Conduct MSE and Risk assessments
Facilitation of therapy program	Gather information from electronic records	Conduct MSE and Risk assessments	Establish treatment plans – Mental Health Care Plan
Physical health Assessment	Walk to Health Centre/Unit for review	Clinical documentation	Prepare Risk Management Plan
Primary mental health nursing	Conduct MSE and Risk assessment	Prepare Risk Management Plan	Liaise with Custodial Officers re risk
Case management/ Treatment planning	Liaise with Custodial Officers re risk	Attend Daily Risk Review Meeting	Clinical documentation
Working in an MDT	Clinical documentation including Risk Management Plan	Finalise clinical documentation based on Risk Review Meeting	Finalise clinical documentation based on assessment
Liaising with external providers	Assist At Risk Review Nurse (if quiet)	Refer for additional services as identified	
Clinical documentation			

The needs of my client base tend to vary in that they generally do not always present with an Axis I diagnosis, but most will at some point have a history of being diagnosed with some type of personality disorder (Axis II). The primary definition of our work is with clients who have a history of complex and or challenging behaviour. We do not work with families during periods of incarceration.

'Keeping people out of hospital' for nurses in this environment means treating a patient on a voluntary basis to keep them from being 'certified' and hospitalised under the Menta Health Act 2014. All nurses also play an active role in managing prisoners at risk of suicide, especially when working in the 'at risk' and 'risk review' roles. The unit nurse also plays a role in suicide prevention, working with individual patients for three months. The reception nurse could play a greater role in suicide prevention, but time pressures make this very difficult.

The provision of recovery orientated mental health practice is the underpinning principle of the nurse's role on this unit. This includes supporting the patients on their journey in recovery, facilitating the development and ongoing review of a recovery plan, planning for admission and discharge, and providing a recovery treatment program once a week. When it comes to the management of a patient's wellbeing, this is managed in conjunction with another provider, but the unit has the prime responsibility for monitoring, managing and implementing an education program in relation to healthy diet, exercise and medication management with a focus on metabolic syndrome. Given the limited consultant support and often inexperience of the registrar team, it is prudent that all the mental health nursing practitioners have a significant amount of experience which is reflected in the ongoing care and management.

The service is accountable to the Department of Justice (including Corrections Victoria) and works closely with the Office of the Chief Psychiatrist and the Chief Mental Health Nurse.

One significant gap in this service is the current allocation of EFT. No matter how many patients the unit has, whether it be 30, 25 or 10, the nursing allocation remains the same: Three nurses across the two day shifts and three on night duty. The nurse allocated to the 10-bed unit overnight is also responsible for a second unit while also managing and assessing risk overnight for the entire prison population of between 1 100 and 1 300 prisoners.

Another area of concern is that no intensive case management staff are allocated to work on weekends. This means the role of managing acutely unwell patients becomes the responsibility of the reception nurse on a Saturday. This is a role that is unfunded and not accounted for in the allocation of EFT.

We have very little consultant support ourselves and have to mentor junior registrars. This requires a great deal of resolve and patience on behalf of the nurses who are required to manage a complex and challenging group of patients as well as inexperienced and junior medical staff.

The nursing team is made up of many international nurses with varying degrees of training and understanding of teamwork, and this also effects service delivery. Unsurprisingly there is a high attrition rate, which often means experienced nurses are replaced with graduate nurses with little or no experience in mental health.