Office of the Public Advocate

Safeguarding the rights and interests of people with disability

Submission to Department of Health

Mental Health and Wellbeing Act

August 2021

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Recommendation 18
OPA recommends that the new Act empower personally appointed substitute decision-makers make treatment decisions for individuals on compulsory mental health treatment

orders if the individual does not pose a serious risk of harm to others. This power should extend to tribunal-appointed substitute decision-makers whom the person would probably have wanted to make those treatment decisions.

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OPA recommends that the new Act ensure people are not subject to compulsory detention under mental health legislation for more than 14 days without tribunal approval.

Recommendation 20
OPA recommends that provisions in the new Act be supported by detailed guidelines, that overtly operationalising the objective of eliminating the use of seclusion and restraint and that this purpose of the Act be echoed in its second reading speech.

Recommendation 21
OPA recommends the following settings, amongst others, should fall within the deprivation of liberty and places of detention under the *Optional Protocol to the Convention against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment, ratified by the Commonwealth*:

- Detention in a mental health service, residential treatment facility or prison following a finding of unfitness to be tried and/or not guilty because of mental impairment
- Detention in a mental health service for compulsory mental health treatment under mental health laws, such as the new Mental Health and Wellbeing Act; and
- Detention in a treatment centre for compulsory detoxification, withdrawal and/or substance dependence treatment, such as pursuant to a detention and treatment order under the *Severe Substance Dependence and Treatment Act 2010* (Vic).

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OPA recommends that the new Act be accompanied by guidelines that require open air access is available to all mental health patients for a minimum of two hours daily and any failure to do so be reported to the Chief Psychiatrist.

Information collection, use and sharing

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OPA recommends that the new Act recognise the Public Advocate and the Community Visitors' statutory safeguarding role and ensure the Act contain provisions that enable effective sharing of information with OPA and Community Visitors in support of their statutory duties.

Recommendation 24
OPA recommends that the equivalent section 217(1)(c) of the *Mental Health Act 2014* in the new Mental Health and Wellbeing Act be amended to recognise that Community Visitors have the power to inspect a range of records, including incident reports.

Governance and oversight

Recommendation 25
OPA recommends that Victorians with lived experience be embedded throughout the mental health and wellbeing service system all levels: volunteers and peer workers, employees, middle and upper management and in executive positions.

Recommendation 26
OPA recommends that data collected in response to Royal Commission recommendation 53(2)(a-d) be made publicly available. Further, OPA recommends that the data set be organised by mental health and wellbeing provider to enable the regulator to distinguish between the performance of specific providers and identify which services need specific attention.

Recommendation 27
OPA recommends that the Mental Health and Wellbeing Commission monitors and publishes data on incidences of Victorians discharged from mental health facilities into homelessness.

Recommendation 28
OPA recommends that the Mental Health and Wellbeing Commission publishes data on the critical stages in consumer mental health recovery such as 28 days post service discharge, 6 months, 12 months and 2 years post-initial mental health service contact.

Recommendation 29
OPA recommends that therapeutic activities be available seven days a week as a minimum standard in all Victorian mental health facilities.

1. About the Office of the Public Advocate

The Office of the Public Advocate (OPA) is a Victorian statutory office, independent of government and government services, that works to safeguard the rights and interests of people with disability. The Public Advocate is appointed by the Governor in Council and is answerable to the Victorian State Parliament.

The Public Advocate has seven functions under the *Guardianship and Administration Act 2019* (Vic), all of which relate to promoting the independence and human rights of people with disability and protecting people with disability from abuse, neglect and exploitation.

To this end, OPA provides a range of critical services for people with cognitive impairment or mental illness, including guardianship, advocacy, and investigation services. In 2019-20, OPA was involved in 1792 guardianship matters (950 which were new), 430 investigations, and 284 cases requiring advocacy.

A key function of the Public Advocate is to promote and facilitate public awareness and understanding about the *Guardianship and Administration Act 2019* (Vic), and any other legislation affecting persons with disability or persons who may not have decision-making capacity. To do so, OPA maintains a full-service communications function including media outreach, and runs an advice service which took 12,624 calls in 2019-20. OPA also coordinates a community education program for professional and community audiences across Victoria to engage on a range of topics such as the role of OPA, guardianship and administration, and enduring powers of attorney.

OPA is supported by more than 600 volunteers across four volunteer programs: the Community Visitors Program, the Community Guardian Program, the Independent Third Person Program (ITP Program) and the Corrections Independent Support Officer (CISO) Program. The ITP Program is a 24/7, state-wide volunteer service operating in all police stations in Victoria. ITPs assist persons with cognitive impairment when giving interviews and making formal statements to Victoria Police. In 2019-20, ITPs attended a total of 3718 interviews and statements. CISOs are experienced ITPs who support prisoners who have an intellectual disability at General Manager's Disciplinary Hearings at Victorian prisons and/or remand centres. In 2019-20, CISOs were invited to attend 170 hearings.

1.1 Community Visitors

Community Visitors are independent volunteers empowered by law to visit Victorian accommodation facilities for people with disability or mental illness. They monitor and report on the adequacy of services provided in the interests of residents and patients. They ensure that the human rights of residents or patients are being upheld and that they are not subject to abuse, neglect or exploitation. In their annual report, Community Visitors relate their observations on the quality and safety of the services they visit and make recommendations to the Victorian State Government. A total of 400 Community Visitors visit across three streams: disability services, supported residential services (SRS), and mental health services. In 2019-20, Community Visitors made 4142 statutory visits, including to sites of criminal and civil detention.

Under the *Mental Health Act 2014* (Vic),[1] Community Visitors, have a legislated role to visit public mental health units across Victoria. The units include adult and aged person's acute inpatient units, aged mental health residential units, community care units (CCU), secure extended care units (SECU), child and adolescent units, eating disorder units, mother and baby units, prevention and recovery care (PARC) and transition support units (TSU).

Mental Health Community Visitors play a vital safeguarding role for some of Victoria's most vulnerable people. They do this through usually monthly unannounced visits to a wide-range of state-funded mental health units in the public system including facilities providing 24-hour nursing care, such as mental health units in public hospitals. There, they inquire into the adequacy of services and facilities provided to people receiving mental health services.

In addition to addressing individual issues, Community Visitors report on, and alert government to, systemic issues within Victoria's mental health system throughout the year and in their annual report to parliament. Community Visitors have contributed to this submission.

This year, Mental Health Community Visitors reported 1927 issues from 1235 visits to 172 mental health units, compared with 1486 issues from 1670 visits to 170 units during 2019-2020. Despite a 26 percent reduction in the number of visits due to COVID-19 restrictions, there was a 30 per cent increase in issues identified.[2]

OPA understands that neither the Royal Commission or the Department of Health propose any changes to the functions and powers of Community Visitors. OPA takes this opportunity to reflect on the legislated role of Community Visitors and makes a recommendation later in the submission to ensure their vital role in the oversight of the mental health system is maintained.

2. About this submission

OPA welcomed the Royal Commission into Victoria's Mental Health System final report. The Royal Commission recommended the establishment of a new Mental Health and Wellbeing Act and this submission is written in response to the Department of Health's update and engagement paper on this topic.

The current Mental Health Act remains too narrowly centred on compulsory treatment—civil detention—thus failing to fulfil the intention of the 2010 review of Victoria's mental health legislation to promote the universal right of all Victorian's to be supported in achieving good mental health. OPA strongly supports the expansion of new mental health legislation to establish critical foundations for a redesigned mental health and wellbeing system for all Victorians.[3]

How this can be achieved through a legislative instrument is by way of setting out the rights of Victorians to good mental health and access to mental health services and supports to achieve this.

[1] *Mental Health Act 2014* (Vic) pt 9.
[2] Office of the Public Advocate, *Community Visitors Annual Report 2019-2020* (2020) 56.
[3] Department of Health (Victoria) *Mental Health and Wellbeing Act: update and engagement paper (*June 2021) 5.

This submission includes observations from across all OPA program areas, including Community Visitors and other volunteer programs. It also draws extensively from OPA's recent report *Decision Time: Activating the rights of adults with cognitive disability*, in particular chapter four on the topic of mental health.

The submission addresses the four key sections of the update and engagement paper as they related to OPA's unique experience in safeguarding the rights of people with disability and people with mental illness. This submission is organised according to the questions numbered 1 through 14.

OPA notes that there are many significant aspects of the mental health system that need to be resourced adequately and operate well to enable full realisation of the objectives and principles of the proposed Act. Furthermore, there are very many issues at the interface of the mental health system and other service systems, particularly the criminal justice system, the National Disability Insurance Scheme (NDIS), and supported residential services, that must be contemplated in the drafting of the new Act.

2.1. A human rights approach

This submission applies a human rights approach that:

- holds that all people with disability have the right to enjoy equality of opportunity and to effectively participate in, and be fully included in, society
- recognises that the majority of challenges experienced by people with disability are a result of disabling systems and environments, rather than being due to an inherent 'lack' in the individual
- considers impairment as an expected dimension of human diversity
- seeks for people with disability to be supported and resourced to have the capabilities to lead a dignifying and flourishing life.

In preparing this submission, OPA takes into account the following legislative instruments that promote and protect the human rights of people with mental illness and/or disability:

- the United Nations *Convention on the Rights of Persons with Disabilities*
- the Optional Protocol to the Convention Against Torture
- *Disability Discrimination Act 1992* (Cth)
- *National Disability Insurance Scheme Act 2013 (*Cth)
- *Guardianship and Administration Act 2019* (Vic)
- *Charter of Human Rights and Responsibilities Act 2006* (Vic)
- *Mental Health Act 2014* (Vic)
- *Medical Treatment Planning and Decisions Act 2016* (Vic).

3. Objectives and principles

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

OPA welcomes the proposed objectives and principles for the new Mental Health and Wellbeing Act. However, OPA holds some concerns and, accordingly, makes recommendations about how the objects and principles can be improved to better reflect contemporary human rights practice and thinking.

OPA would like the new Act go further than ensuring mental health and wellbeing services, decision-makers and the community are 'aware of and respect' the rights of people receiving mental health and wellbeing treatment and care.

Rather, OPA would like to see an adherence in practice to upholding the human rights of people with mental illness and psychological distress, backed up with practically available enforcement measures to address breaches when they occur. As vulnerable people are sometimes unable to advocate for themselves accessible recourse pathways are critical and should be recognised as such. OPA would like to see obligations arising from the *Charter of Human Rights and Responsibilities Act 2006* (Vic) embedded through the text of the new legislation, in addition to the United Nations *Convention on the Rights of Persons with Disabilities* (CRPD).

OPA makes the following recommendations:

Recommendation 1
OPA recommends that there be a right to mental health treatment, aligning with the United Nations Convention of the Rights of Persons with Disabilities articles 25 – Health and Article 26 – Habilitation and rehabilitation.

Recommendation 2
OPA recommends that the new Act include practical enforcement measures to respond to breaches, including breaches of the objects and principles.

Recommendation 3
OPA recommends that recourse pathways must be accessible to all Victorians, including those with cognitive impairments and acquired brain injury.

Recommendation 4
OPA recommends an additional object of the Act that promotes the integration of people with mental illness or psychological distress into the wider community.

Recommendation 5
OPA recommends that the proposed objectives and principles use language that emphasises practices that protect and promote human rights and human dignity and that language that emphasises the limitation of rights not be used.

OPA is concerned the objectives and principles do not support the Royal Commission's recommendation 42(2)(f) to 'simplif[y] and clarif[y] the statutory provisions relating to

compulsory assessment and treatment such that they are no longer the defining feature of Victoria's mental health laws.'

OPA notes that the proposed objective 2:

> 'providing people living with mental illness or psychological distress with assessment and treatment in the least restrictive way possible with the least possible restrictions on human rights and human dignity'…

continues to place emphasis, in the same way as the current legislation, on negative rights and state intervention. The new Act is an opportunity to realise the intentions of the Royal Commission by shifting the emphasis from involuntary interventions and towards voluntary, high-quality, coercion-free supports that respect the will, preference. and values of Victorians with mental illness and psychological distress.

Proposed principle 2 refers to the 'least restriction of rights', which again places emphasis on involuntary intervention rather than positive rights such as access to voluntary, high-quality, coercion-free services. Similarly, proposed principle 3 features this same emphasis in its proposal to 'ensure compulsory treatment and restrictive practices are only used as a last resort.'

As per the Royal Commission's recommendation 42(2)(f), OPA suggests that the government consider re-wording its proposals to ensure the language of the Act meaningfully shifts the focus of Victoria's mental health laws away from involuntary intervention. The language of the current proposals serves only to maintain the status quo where involuntary interventions are the defining feature of the legislation. Instead, the Act should explicitly refer to the importance of voluntary support and the responsibility of service providers to create and implement coercion-free crisis support. OPA makes the following recommendation:

Recommendation 6
OPA recommends that the proposed objectives and principles be amended to shift the legislation's focus away from involuntary intervention and, instead, emphasise a requirement to provide high-quality, coercion-free supports.

Supported decision-making and respect for risk

The *Mental Health Act 2014* (Vic) falls short in 'promoting and protecting human rights, respecting dignity and autonomy, and enabling supported decision-making practices.'[4] In response to this criticism, OPA would welcome recognition in the objects and principles of the importance of (and a requirement for) supported decision-making.

Further, OPA believes that supported decision-making should be embedded throughout the Act. Further, that the Act (in addition to subordinate legislation) should contain non-exhaustive guidance about how to assist people to make decisions and that clinicians be obliged to consider the will and preference of people under compulsory treatment. Please see OPA's further discussion under 'Supported decision-making' and 'Treatment, care and support.'

[4] * State of Victoria, Royal Commission into Victoria's Mental Health System, Final Report, Volume 4: The fundamentals for enduring reform, Parl Paper No. 202, Session 2018–21 (document 5 of 6) p. 31.

The drafting of the new Mental Health and Wellbeing Act is an opportunity to harmonise the legislation by adopting consistent language and concepts common to related Victorian legislation.

- *Guardianship Administration Act 2019* (Vic);
- *Powers of Attorney Act 2014* (Vic); and
- *Medical Treatment Planning and Decisions Act 2016* (Vic).

OPA notes the *Guardianship and Administration Act 2019* (Vic) states that the will and preference of a person can only overridden if necessary to prevent serious harm to the represented person (s 9) and explicitly recognises the *Convention of the Rights of Persons with Disabilities* (CRPD) (s 7). However, under the current Mental Health Act decision-makers only need 'have regard to' a person's advance statement and the views of the nominated person. OPA considers this an important opportunity for the government to strengthen the position of the views, preferences and values of people living with mental illness or psychological distress within the legislation to ensure they are at the forefront of policies, programs and services. The paper states that the new act will 'reflect contemporary human rights practice and thinking.'[5] In addition to their place in the opening objectives and principles provisions of the Act, OPA believes that the values here expressed need to be reinforced throughout the body of the Act.

OPA would like to echo the drafting suggestions posed by Melbourne Social Equity Institute below:

> 'Proposed Objective 1 should refer to *all* peoples right to practice self-determination and their decision-making power, including their right to free and informed consent and individual choice. This will bolster the positive obligations of services to respect the needs and rights of persons with mental health conditions or psychological distress.
>
> The second bullet point of Objective 2 could alternatively read: providing people living with mental illness or psychological distress with assessment and treatment ~~in the least restrictive way possible~~ using leading practices that protect and promote their human rights and human dignity.
>
> Principle 2 and 3 could abandon the reference to 'least restriction of rights' in this section, seemingly without ill-effect. An alternative could be as follows:
>
> - 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
> - ensure ~~compulsory treatment and restrictive practices are only used as a last resort~~ the use of leading practices that protect and promote their human rights and human dignity.
>
> If required, a later principle… could acknowledge that in some circumstances involuntary intervention will be authorised under the terms of the Act, and that any such intervention must occur in accordance with the person's rights, and that services are required to take active steps to reduce and prevent recourse to coercion.
>
> Principle 9 could be amended to encompass recognition 'that people receiving mental health and wellbeing services may have specific gender-related ~~safety~~ needs and experiences, including those relating to safety, 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 risk factors, diagnosis, service use and

[5] Department of Health (Victoria) *Mental Health and Wellbeing Act: update and engagement paper (*June 2021) 6.

experience, treatment and recovery; and recognises how gender inequality intersects with other types of discrimination and disadvantage'. These changes would:

- recognise the significance of safety for women and gender diverse people while also being wide enough to encompass all gender-specific needs; and
- recognises the structural causes and consequences of gender inequality and require services and decision-makers to respond to them.'

OPA considers that the objects and principles of the new Act require further definition and detail including standards or non-exhaustive lists of examples that are in keeping with community expectations. For example, without clear definitions, terms may be interpreted differently by the regulator, service providers, clinicians, and consumers.

OPA would welcome an additional object of the Act that goes towards integration of people with mental illness or psychological distress into the wider community. OPA would welcome an object that articulates a clear legislative intent to move away from solely crisis-response care to well-formulated wellbeing goals, noting that wellbeing goals will be different for different system users.

The new Act must be an Act for all Victorians. This means that the diversity of needs and divergent wellbeing goals of marginalised Victorians including people experiencing homelessness, without access to education, under employed or unemployed, with cultural or digital exclusion challenges, and Victorians with dual disability, including acquired brain injury, need to be addressed.

Lastly, OPA would welcome an objective or principle that highlights the importance of involvement and participation of people with lived experience in the design, implementation and evaluation of mental health and wellbeing services. OPA makes the following recommendation:

Recommendation 7
OPA recommends an additional objective or principle that mandates the involvement and participation of people with lived experience in the design, implementation and evaluation of mental health and wellbeing services.

The voices representing the diversity of people with lived experience, and their families and carers, should be heard and they should continue to be consulted throughout the Bill drafting process.

4. Non-legal advocacy

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

OPA supports the application of an opt-out advocacy service to all people under a compulsory treatment order. However, the eligibility threshold of 'at risk of being under a compulsory treatment order' is vague. An opt-out advocacy service would be best applied to all people engaged in the mental health system at all stages and level of care. OPA believes that advocacy is best provided at an early stage to avoid a person becoming 'at risk' of being under a compulsory treatment order and avoiding definitional complications associated with the vagueness of this proposed eligibility threshold.

If the government maintains that a threshold is required to carve out the class of mental health and wellbeing service users deemed eligible for opt-out advocacy, OPA's preferred threshold is all people who have accessed or are accessing a public mental health service. This threshold aligns with the Royal Commission's recommendation 42(2)(e-f) to 'reduce rates and negative impacts of compulsory assessment, treatment, seclusion and restraint' and render compulsory assessment and treatment 'no longer the defining feature of Victoria's mental health laws.'

OPA believes that if Victorians receive access to advocacy earlier, together with high-quality, coercion-free support, ultimately fewer Victorians will receive compulsory treatment orders. Expanding the scope of opt-out advocacy by amending the eligibility threshold will enable the government to satisfy the Royal Commission's recommendation and align the new Mental Health and Wellbeing Act with the intention of the Royal Commission. OPA makes the following recommendation:

Recommendation 8
OPA recommends that the opt-out advocacy service be offered to all Victorians who have accessed or are accessing a public mental health service.

The purpose of advocacy is to be an independent check and balance on the Victorian mental health service system. An advocacy provider, such as IMHA, being named in the primary legislation will cause a reduction or perceived reduction in its independence. To better safeguard the rights of Victorians with mental illness and psychological distress, IMHA should be identified in guidelines and regulations rather than primary legislation. Similarly, OPA's Community Visitors Program must both retain and be seen to retain its independence from government. OPA advocates for this program to be identified as the state-wide provider of systemic, non-legal advocacy in guidelines and regulations.

OPA's Community Visitor program provides both systemic and individual advocacy. Its systemic advocacy work supports and compliments IMHA's provision of advocacy on an individual basis. The Community Visitor program has delivered essential non-legal advocacy since it was established in 1986 and, in 2019-20, Community Visitors made 4142 statutory visits including to sites of criminal and civil detention. OPA considers systemic advocacy to have an equal role in achieving the highest attainable standard of mental health and wellbeing for Victorians and, as such, advocates for its Community Visitors Program to receive appropriate funding for the work it undertakes, noting that, as a volunteer program, resources are directed towards coordination and training and the vast majority of labour delivered to Victoria's mental health system is provided on a voluntary basis at no cost to government. OPA makes the following recommendation:

Recommendation 9
OPA recommends that the regulations and guidelines relating to advocacy services and other supports reference both Community Visitors and Independent Mental Health Advocacy (IMHA).

In addition to providing non-legal advocacy, the new Act would better satisfy recommendation 42(2)(e-f) by implementing a similar opt-out service that provides legal advocacy for all people who have accessed or are accessing a public mental health service. Further, OPA considers that both legal and non-legal advocacy should be offered within the first 24-hours a person is under a compulsory assessment or temporary treatment order.

OPA is interested in how the government defines 'non-legal advocacy', the availability of non-legal advocates in practice and the funding allocation for the proposed program. OPA is particularly interested in the ease of access to legal and non-legal advocacy for marginalised Victorians, such as Victorians in regional areas, those living with dual disabilities and Victorians who experience intersectional disadvantage on the basis of any marker of vulnerability including age, sex characteristics, sexual orientation, gender expression, disability or race.

5. Supported decision-making

As in other areas of law that are related to decision-making capacity, people should be routinely offered greater support when seeking to make and implement their own decisions. In the context of consumers of mental health services, this involves identifying the practices that allow people to have the time, space and resources to make and support to implement their own decisions.

As raised earlier in this submission, OPA believes that supported decision-making should be embedded in the Act, that the Act (in addition to subordinate legislation) should contain non-exhaustive guidance about how to assist people to make decisions and that clinicians to consider the will and preference of people under compulsory treatment. OPA makes the following recommendations:

Recommendation 10
OPA recommends that supported decision-making be embedded in the Act and clinicians be obliged to consider the will and preference of Victorians under compulsory treatment.

Recommendation 11
OPA recommends that the new Act create opportunities for self-determination for people with a range of capabilities—not just those who are able to appoint their own substitute decision-maker.[6]

OPA's recent report *Decision Time* discussed OPA's position on laws and policies that can have an impact on the decision-making of people with disability and describes guiding and practical reforms that would help achieve OPA's vision for a just, inclusive society. Its recommendations contained in chapter 4—Mental Health—go beyond the proposals contained in the update and engagement paper. OPA commends the report to the Department of Health. It is provided as an attachment to this submission.

Decision Time explored a range of reform ideas that, if implemented, would enable people to play a greater role in the decisions that affect them, ranging from legislating opportunities for self-determination for people with a range of capabilities, to the need to make it easier for people with mental illness to create binding advance directives that would constitute advance consent or refusal of treatment. On the latter, OPA proposed this should apply to voluntary patients as well as compulsory patients so long as the risk of the treatment intended to redress was to the person, not to others. For compulsory patients, OPA proposed that the approval of the relevant mental health tribunal would be required to override such advance directives.

[6] Ibid 79.

OPA also proposed that people should be able to personally appoint a substitute decision-maker, and that there be provision for automatic statutory-appointed decision-makers to make decisions about mental health treatment for people who are not on compulsory treatment.

OPA supports the position advocated by the Victorian Law Reform Commission, that, in a compulsory setting, personally appointed decision-makers should be able to make treatment decisions even if there is no significant risk to other people (in other words, where the primary risk is to the person themselves).[7] This power should extend, as the commission also proposed, to a tribunal-appointed person who the individual would probably have appointed were they able to do so.[8] This is explored further in the compulsory treatment section.

Advance planning

Under the Mental Health Act, advance statements set out a person's treatment preference in case they become unwell and need compulsory mental health treatment. Currently, an authorised psychiatrist must have regard to a person's advance statement when making a treatment decision. Advance statements are an important mechanism to give effect to a person's will and preferences.

OPA and Community Visitors have observed that there has been a low uptake of advance statements by both mental health services and consumers, and variable attention given to them. OPA and Community Visitors have observed that awareness of advance statements is low and there is little understanding of, or weight attributed to, advance statements in the instances where they have been made. Advance statements need to be a tool embedded throughout the system. OPA welcomes the proposal that the provision of written reasons be a requirement for *all* instances where an advance statement is overridden, rather than only when requested per s 73(2)(b) of the current Act.

Department of Health and Human Services (DHHS) data is shared with Community Visitors shows that, on average, 2 to 6 per cent of mental health service consumers have an advance statement. The best performing mental health service had 15 per cent of their clients with an advance statement, highlighting how more work is to be done here. OPA's medical treatment and decisions team has not seen any advance statements and suspects that consumers, and possibly practitioners, may lack confidence in the instrument.[9]

Promoting self-determination for Victorians with mental illness or psychological distress requires respect for risk. OPA supports all Victorians being empowered to make decisions about their lives and mental health care where there is no risk of harm to others. People without disabilities are free to make decisions about their lives to a greater extent than people with disabilities.[10] Article 12 of the CRPD requires that a person with disabilities can enjoy legal capacity on an equal basis with others. This means that a person with mental illness or psychological distress should be equally able to make decisions 'whether or not the outside world views them as 'good' or not.'[11] OPA urges the mental health branch and the chief

[7] Office of the Public Advocate, *Decision Time: Activating the rights of adults with cognitive disability (*2021) 79 citing Victorian Law Reform Commission, Guardianship Final Report No 24 (2012) 546–7.
[8] Office of the Public Advocate, *Decision Time: Activating the rights of adults with cognitive disability (*2021) 79 citing Victorian Law Reform Commission, Guardianship Final Report No 24 (2012) 548.
[9] Office of the Public Advocate (Vic), Submission to Royal Commission into Victoria's mental health system (July 2019).
[10] Quinn, G. (2010, February). *Personhood & legal capacity: Perspectives on the paradigm shift of article 12 CRPD*. Paper presented at Harvard Project on Disability Conference, Cambridge M.A.
[11] Anna Artsein-Kerslake, 'Legal Capacity and Supported Decision-making: Respecting Rights and Empowering People' (2016) *University of Melbourne Law School Research Series* 1.

psychiatrist to promote cultural change that supports the dignity of risk via education and communication about the Act. OPA notes that this communication needs to be directed at all risk averse parties, including families.

Advance planning in relation to mental health treatment—particularly compulsory mental health treatment—is far less broadly accepted and practiced that it is in relation to general medical treatment. The new Mental Health and Wellbeing Act provides an opportunity to promote self-determination.

Consistent with the Department of Health's proposal to 'align substituted decision-making frameworks for mental health with those for medical treatment decisions (under the *Guardianship and Administration Act 2019* and *Medical Treatment Planning and Decisions Act 2016*), OPA's view is that common language and concepts should be adopted around advanced supported decision-making and a person's will, preference and values within the new Mental Health and Wellbeing Act to minimise circumstances in which a person who has decision-making capacity can have decisions about their treatment, care and support made by someone else.' Consistency can contribute to cultural change.

Confusion arises because advance statements under the Mental Health Act are different to instructional directives under the Medical Treatment Planning and Decisions Act. Consistency in language and legal status of advance statement vis a vis advance care directive (instructional directive) will resolve the confusion. Under the Medical Treatment Planning and Decisions Act, instructional directives cannot be overridden and must be witnessed by a registered medical practitioner.

To this end, OPA recommends the following:

Recommendation 12
OPA recommends that the new Act dispense with the advance statement in favour of advance care directives set out in the *Medical Treatment Planning and Decisions Act 2016* (Vic).

Increased self-determination in relation to treatment decisions could be achieved through implementation of the following recommendation:

Recommendation 13
OPA recommends that the new Act ensure that a person's advance care instructional directive is binding even when the person is subject to a compulsory treatment order. Apart from the other exceptions in the *Medical Treatment Planning and Decisions Act 2016* (Vic) relating to instructional directives, an additional exception should be added where the person subject to compulsory treatment poses a risk to others.

OPA also makes the following recommendation to resolve an inconsistency between the Mental Health Act and the Medical Treatment Planning and Decisions Act in relation to a medical treatment decision for a person who is subject to compulsory treatment:

Recommendation 14
OPA recommends that consent to medical treatment where a patient does not have capacity to give informed consent be determined according to the provisions of the *Medical Treatment Planning and Decisions Act 2016* (Vic).

Importantly, OPA considers these changes should occur with the enactment of the new legislation and not be delayed until a future review. Further, OPA would welcome the addition of 'practical and appropriate support' to be highlighted in the new Act, not only around assessing decision-making capacity but also to require it as part of supported decision-making.

6. Compulsory assessment and treatment and Seclusion, physical restraint and chemical restraint

The consistent theme in OPA's *Decision Time*—the balance that needs to be struck between adult protection laws and practices and the promotion of individual autonomy and decision-making freedom while protecting people from harm—was noted as being contentious in the field of compulsory treatment, than in the fields of medicine or social welfare.

On compulsory treatment, Decision Time articulated some of those contentious issues:

> The justification for such treatment is often about saving lives, and the high stakes mean that risk aversion almost becomes a default position. Framed in this way, the idea of allowing a person to make their own decisions can easily appear a gamble that is not worth the taking.
>
> It is important, though, to be mindful that most people—including most of those who design laws and policies in this field—have not experienced compulsory mental health treatment. And some of those who have experienced it describe it in harrowing terms.[12]

It further noted that one argument supported by at least some UN committees is that the CRPD prohibits involuntary treatment and involuntary confinement on the basis of disability, including mental disability. Australian mental health laws do not yet reflect this position despite it being a signatory to the convention.[13]

Compulsory treatment criteria

On the topic of adult protection laws and compulsory mental health treatment, *Decision Time* argued the following:

> When considering reform possibilities for compulsory treatment and detention criteria, two options should be pursued. One is to consider whether a lack of ability to consent to treatment should be a required minimum criterion for compulsory treatment and detention; the other is ensuring that people who are primarily a risk to themselves retain greater access to advance planning and support from self-appointed, substitute decision-makers compared with people who pose a risk to others in the community.[14]

Decision Time goes on to explore this issue in more detail. OPA refers the Department of Health to chapter 4 of the report.[15]

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[12] Office of the Public Advocate, *Decision Time: Activating the rights of adults with cognitive disability (*2021) 79 citing Skye-Blue Ford, Terry Bowyer and Phil Morgan, 'The Experience of Compulsory Treatment: The Implications for Recovery-Orientated Practice?' (2015) 19(3) *Mental Health and Social Inclusion* 126, 128
[13] Office of the Public Advocate, *Decision Time: Activating the rights of adults with cognitive disability (*2021) 65.
[14] Office of the Public Advocate, *Decision Time: Activating the rights of adults with cognitive disability (*2021) 73.
[15] Office of the Public Advocate, *Decision Time: Activating the rights of adults with cognitive disability (*2021) <Decision Time - Office of the Public Advocate>.

Recommendation 15
OPA recommends that the new Act ensure only people who lack decision-making capacity in relation to the treatment of their mental illness be subject to compulsory treatment and detention.[16]

OPA is in favour of the new act containing a definition of decision making-capacity being in the legislation, for reasons of consistency with other laws and to increase accountability. OPA makes the following recommendations:

Recommendation 16
OPA recommends that decision-making capacity be defined in the new Act, in alignment with section 5 of the *Guardianship and Administration Act 2019* (Vic).

Recommendation 17
OPA recommends that the new Act contain a provision, equivalent to section 56 of the *Medical Treatment Planning and Decisions Act 2016* (Vic), that the assessment of a patient's lack of decision-making capacity and the reasons for this are documented on the patient's record.

Decision Time confronted the question of whether the person needs to be detained in order to facilitate treatment and/or prevent the imminent risk of serious harm. It argued, as a second proposed reform to compulsory treatment criteria involves separating the standard risk criterion of 'risk to self or others' into two distinct criteria, with different authorisation processes then ensuing according to the nature of the risk involved. It elaborated:

> If the risk presented by the person is to their own health and wellbeing and not to the safety of others, the individual themselves (where they had written an advance directive) or others appointed by them could have a greater role in making treatment decisions in compulsory settings.[17]

This is further discussed in the earlier section, in the context of advance panning.

OPA makes the following recommendations:

Recommendation 18
OPA recommends that the new Act empower personally appointed, substitute decision-makers make treatment decisions for individuals on compulsory mental health treatment orders if the individual does not pose a serious risk of harm to others. This power should extend to tribunal-appointed, substitute decision-makers whom the person would probably have wanted to make those treatment decisions.[18]

Recommendation 19
OPA recommends that the new Act ensure people are not subject to compulsory detention under mental health legislation for more than 14 days without tribunal approval.[19]

[16] Office of the Public Advocate, *Decision Time: Activating the rights of adults with cognitive disability (*2021) 74.
[17] Office of the Public Advocate, *Decision Time: Activating the rights of adults with cognitive disability (*2021) 74-75.
[18] Ibid.
[19] Ibid 81.

Seclusion and restraint

OPA welcomes the Department of Health's proposed ten-year plan to eliminate the use of restrictive interventions, and further welcomes the co-production of this plan with consumers, families, carers and the workforce and service providers.

OPA welcomed the acknowledgement in the Mental Health and Wellbeing Act: update and engagement paper that 'the rate and duration of compulsory treatment orders in the Victorian mental health system is too high.'[20] As flagged in OPA's submission to the Royal Commission into Victoria's mental health system:

> Data from the Victorian Government's *2017-18 Mental Health Services Annual Report* shows no diminution in the use of seclusion, restraint, and compulsory treatment in the mental health system in the past three years.[21] Furthermore, Community Visitors point to Victorian Health Services performance data showing that seclusion events in child and adolescent units have doubled.[21]

OPA is highly supportive of the Department of Health's systems level explicit commitment to reduce and ultimately eliminate the use of restraints and seclusion within the sector. OPA further recommends the following:

Recommendation 20
OPA recommends that provisions in the new Act be supported by detailed guidelines, that overtly operationalising the objective of eliminating the use of seclusion and restraint and that this purpose of the Act be echoed in its second reading speech.

OPA considers that the elimination of restrictive practices will allow service users to have experiences that are 'safe, of high quality, offer choice and provide a positive experience.'[22]

OPA emphasises 'the need to train mental health staff to implement alternative interventions (for example, teaching staff de-escalation techniques, developing patient management plans, the provision of comfort rooms).'[23] Without comprehensive planning, resourcing, staff training and appropriate physical environments, OPA questions whether seclusion and restraint can ever be eliminated.

While the mental health system is working towards the elimination of restraints and seclusion, a robust safeguarding system that includes oversight and review provisions should be developed. This would ensure the protection and promotion of an individual's human rights.

Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

The Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) objective is to 'establish a system of regular visits undertaken by independent international and national bodies to places where people are deprived of their liberty, in order to prevent torture and other cruel, inhuman or degrading

[20] State of Victoria, Royal Commission into Victoria's Mental Health System, Final Report, Volume 4: The fundamentals for enduring reform, Parl Paper No. 202, Session 2018–21 (document 5 of 6), p. 364.
[21] Office of the Public Advocate (Vic), Submission to Royal Commission into Victoria's mental health system (July 2019).
[22] Department of Health and Human Services (Vic), Mental Health Services Annual Report (2017-18) 62.
[23] Office of the Public Advocate (Vic), Submission to Royal Commission into Victoria's mental health system (July 2019) 22.

treatment or punishment'.[24] The national or domestic visiting body, the NPM, is only empowered to inspect 'places of detention'.[25] OPA considers it important to understand the range of places that constitute places of detention and, consequently, which people will receive the benefit of the NPM's functions.[26]

OPA repeats a recommendation made to the Australian Human Rights Commission on Australia's implementation of the OPCAT.

Recommendation 21
OPA recommends the following settings, amongst others, should fall within the deprivation of liberty and places of detention under OPCAT:

- **Detention in a mental health service, residential treatment facility or prison following a finding of unfitness to be tried and/or not guilty because of mental impairment**
- **Detention in a mental health service for compulsory mental health treatment under mental health laws, such as the new Mental Health and Wellbeing Act**
- **Detention in a treatment centre for compulsory detoxification, withdrawal and/or substance dependence treatment, such as pursuant to a detention and treatment order under the *Severe Substance Dependence and Treatment Act 2010* (Vic).[27]**

OPA supports the suggestion from Foundation House that the drafting of the powers and roles of the Mental Health and Wellbeing Commission have regard to the requirements set out in the OPCAT treaty to ensure that monitoring is effective. Foundation House notes, for example, that article 20 of OPCAT goes beyond the power to obtain information provided in Royal Commission recommendation 44(3)(a) but will be necessary for the Mental Health and Wellbeing Commission to undertake its role of undertaking inquiries.

OPA's submissions to the two Australian Human Rights Commission consultations on OPCAT envisaged that the Community Visitors Program may be designated as an NPM body, along with other bodies. However, the current mandate and practical capabilities of the Community Visitors would need to be expanded to meet OPCAT requirements. OPA sees value in the Department of Health engaging with the Community Visitors model in the context of articulating the possible operational role of NPM bodies.

Outdoor spaces

OPA reiterates that, while it welcomes the Victorian government's funding for the refurbishment of outdoor spaces, the Victorian government 'has failed to endorse a more meaningful

[24] OPCAT, art 1
[25] OPCAT, art 4.
[26] For a more in depth exploration of OPCAT matters, please see OPA's submission to the Australian Human Rights Commission consultations <OPCAT: Optional Protocol to the Convention against Torture | Australian Human Rights Commission>.
[27] Office of the Public Advocate (Vic), Submission to Australian Human Rights Commission – Australia's implementation of the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (July 2017) 4.

requirement for daily access to open air within mental health services.'[28] OPA does not accept the Victorian Government's reasoning that:

> "A patient's access to these spaces and the duration of access is dependent on a number of multidimensional clinical factors that are taken into account by the service on a daily basis. This is based on the individual needs of the patient and their mental health risks and assessment at the time."[29]

As stated in OPA's submission to the Royal Commission, OPA takes this opportunity to again respond to the above-mentioned unaccepted reasoning:

> Community Visitors continue to report restrictions on access to open air in some mental health services.
>
> OPA points to Article 21(1) of the United Nations Standard Minimum Rules for the Treatment of Prisoners that 'every prisoner who is not employed in outdoor work shall have at least one hour of suitable exercise in the open air daily if the weather permits.' It is concerning that mental health services (i.e. places of voluntary or civil detention) operate with lower minimum standards than places of criminal detention. To impose such strict restrictions on mental health patients is a breach of human rights obligations under the Victorian Charter and the UN Convention. OPA repeats the following recommendation made by the Community Visitors Board.
>
> … [That t]he Victorian Government should publish guidelines to ensure open air access is available to all mental health patients for a minimum of two hours daily.
>
> … [That p]ublic designated mental health facilities should be required to report sustained failure to provide patients with access to open air to the Chief Psychiatrist.[30]

OPA makes the following recommendation:

Recommendation 22
OPA recommends that the new Act be accompanied by guidelines that require open air access is available to all mental health patients for a minimum of two hours daily and any failure to do so be reported to the Chief Psychiatrist.

Chemical restraint

OPA supports the Royal Commission's recommendation that the new Act will define and regulate the use of chemical restraint to protect consumers and enable this practice to be appropriately monitored

OPA notes that the new Act will include a definition that restricts its use to only as a last resort. OPA refers the Department of Health to the definition of chemical restraint as it applies to the NDIS and aged care facilities, and OPA proposes alignment with that definition. It is critical that any use of chemical restraint is supported by appropriate safeguards, including clear review

[28] Office of the Public Advocate (Vic), Submission to Royal Commission into Victoria's mental health system (July 2019) 23.
[29] Department of Health and Human Services (Vic), The Victorian Government Response to the Community Visitors Annual Report 2015-16 (2016) 19.
[30] Office of the Public Advocate (Vic), Submission to Royal Commission into Victoria's mental health system (July 2019) 23.

and renewed consent after a time period, with a view to ceasing its use. This is a critical issue that needs further exploration and OPA suggests the Department of Health consult with OPA, people with lived experience, their families and carers, and medical practitioners to develop the definition through the drafting process. It is critical that guidance is developed to support application of the definition in practice, including examples of how chemical restraint is administered.

7. Information collection, use and sharing

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

OPA performs a key legislated safeguarding role as do Community Visitors. It is critical that appropriate information be shared with OPA and Community visitors to enable effective safeguarding to promote the rights of people with disability and people with mental illness, and to protect them from abuse, neglect and exploitation. OPA makes the following recommendation:

Recommendation 23
OPA recommends that the new Act recognise the Public Advocate and the Community Visitors' statutory safeguarding role and ensure the Act contain provisions that enable effective sharing of information with OPA and Community Visitors in support of their statutory duties.

In relation to Community Visitors and information sharing enhancements to enable them to provide their important safeguarding role, OPA recommends the following:

Recommendation 24
OPA recommends that the equivalent section 217(1)(c) of the *Mental Health Act 2014* in the new Mental Health and Wellbeing Act be amended to recognise that Community Visitors have the power to inspect a range of records, including incident reports.

More broadly, OPA considers that the scope of information sharing should be limited so that relevant information only is shared for the purpose of making a decision, for example a medical decision. The information shared must have direct relevance to the decision at hand. OPA believes the scope should be limited in this way to avoid services such housing services discriminating against Victorians with mental illness or psychological distress because the service has gained access to the person's information. Denying a person services because of a characteristic arising out of mental illness, such as a behaviour of concern, requires comprehensive support and not exclusion from housing. This would open the floodgates to direct discrimination on the basis of disability.

An issue that OPA's Advocate Guardians (guardians) have experienced that OPA considers could be addressed in legislative guidelines is hospitals' expectations of guardian's requests for information sharing and Freedom of Information applications to be sent via fax. In the current COVID-19 pandemic environment, with most guardians working from home, reliance on fax is untenable. OPA would like to see practicalities impediments such as this considered and addressed in the information sharing regime. Common standards and shared protocols between different hospitals would go some way in achieving a consistent information sharing system across Victorian hospitals and mental health and wellbeing facilities.

While this suggestion may strictly speaking fall outside the remit of the update and engagement paper, OPA urges the Department of Health to consider the intersection between Victorian legislation such as the new Mental Health and Wellbeing Act and the *National Disability Insurance Scheme Act* 2013 (Cth). OPA's guardians have provided feedback that their experience of information sharing under the *National Disability Insurance Scheme Act 2013* (Cth) is that it is unwieldy. OPA encourages the Department of Health to engage in further consultation to problem solve issues arising from this related Act so as to learn from its failings and draw on those lessons through the drafting process of the new Mental Health and Wellbeing Act. Taking a broad view of the system, it will be important to consider how related legislation such as the *Health Records Act 2001* (Vic) and incident reports created under that Act will interact with information collection, use and sharing under the new Mental Health and Wellbeing Act.

OPA welcomes the move to replace CMI/ODS per recommendation 62(1)(c) 'a new Mental Health Information and Data Exchange that allows interoperability between the proposed Mental Health and Wellbeing Record and other services' major ICT systems to support information sharing in real time within and across services and sectors.' OPA is hopeful the introduction of a new Information and Communications Technology will ameliorate hospitals' reluctance to share information and reduce hospitals' concerns around risk and liability in sharing. Further OPA welcomes that the Department of Health's update and engagement paper discusses families and people in care teams playing a vital role in the mental health and wellbeing system. Importantly, however, OPA would like to raise that where families are often involved intensively at the discharge stage, where there is no family OPA recommends that the new Act authorise and mandate that the guardian of a represented person be involved.

Lastly, OPA urges the Department of Health to consider how access to information will be facilitated equitably for all Victorians including those under treatment orders or in custodial settings.

8. Governance and oversight

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

OPA welcomes the Department of Health's recognition in its update and engagement paper of the Community Visitors safeguarding function that will continue under the new Act.

OPA is very supportive of the Royal Commission's statement that '[t]ransforming Victoria's mental health and wellbeing system requires strong system leadership and accountability, including the leadership of people with lived experience,'[31] with particular support for the inclusion of leaders living with mental illness and psychological distress. For this to be more than tokenistic, leaders contributing insight and systems knowledge gathered through lived experience must be remunerated as experts in their knowledge field. Further, the perspectives of leaders living with mental illness or psychological distress must be attributed meaningful weight. For example, the perspective of a leader with lived experience providing insights based on the social model of disability must be viewed as a legitimate perspective when being balanced against a psychiatrist's perspective that is based in the medical model of disability.

[31] State of Victoria, Royal Commission into Victoria's Mental Health System, Final Report, Volume 4: The fundamentals for enduring reform, Parl Paper No. 202, Session 2018–21 (document 5 of 6), p. 77.

Importantly, this shift will go some way in recognising and addressing the history of power asymmetry between 'men in white coats' employing a deficit model in which people with mental illness are reduced to their symptoms and their personhood overlooked. It is a meaningful shift towards 'nothing about us without us.' OPA recommends that people with lived experience be embedded in mental health and wellbeing service system at all levels – volunteers and peer workers, employees, middle and upper management and in executive positions.

Recommendation 25
OPA recommends that Victorians with lived experience be embedded throughout the mental health and wellbeing service system at all levels: volunteers and peer workers, employees, middle and upper management and in executive positions.

OPA notes that the new Act will establish the following new roles or entities, including Regional Mental Health and Wellbeing Boards and Statewide and Regional Multiagency Panels.

OPA notes that Figure 1 'Snapshot of key governance and oversight functions in Victoria's redesigned mental health system' in the paper does not include the broader landscape of Ministerial advisory groups and clinician advisory groups or outline how they will interact and inform the system. OPA notes that the composition of multi-agencies is not explored in detail in the paper. OPA suggests multi-agencies consider general practitioners, practitioners supporting people post injury and compensation, psychologists, addiction support groups, supported accommodation providers and regulators, family violence services, practitioners with expertise around disability, trauma and suicidality, acute psyche teams, aged care providers, veteran services, prison system and re-integration supports, migrant and refugee services, allied health professionals, disaster response, police including family violence, other emergency services and counsellors who are often first responders.

Data collection and reporting

OPA welcomes the Royal Commission's recommendation 53(2)(a-d) '…facilitate the Mental Health and Wellbeing Commission to monitor, as matters of priority, the use of seclusion and restraint, use of compulsory treatment, incidence of gender-based violence in mental health facilities and incidence of suicides in healthcare settings.' OPA similarly welcomes the proposed reporting requirements imposed on providers in the mental health and wellbeing service system to help satisfy this recommendation.

From the engagement and update paper, OPA understands that the Mental Health and Wellbeing Commission will be accountable to the Victorian Parliament and will report against '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' and 'performance of its functions, including those relating to complaints, investigations and inquiries.'[32] OPA recommends that in the interests of real and perceived transparency, these findings be made publicly and easily available in various formats including plain English, easy English, and languages other than English. OPA makes the following recommendations:

Recommendation 26
OPA recommends that data collected in response to Royal Commission recommendation 53(2)(a-d) be made publicly available. Further, OPA recommends that the data set be organised by mental health and wellbeing provider to enable the

[32] Department of Health (Victoria) *Mental Health and Wellbeing Act: update and engagement paper (*June 2021) 37.

regulator to distinguish between the performance of specific providers and identify which services need specific attention.

OPA is aware that occasionally people for whom the Public Advocate is guardian are discharged into homelessness, against the guardian's views which under the current Act must only be 'considered.' OPA would welcome a legislative change in the new Act that seek to ameliorate this issue. In terms of the extensive changes around data collection discussed above, OPA considers data around discharging Victorians into homelessness to be a significant issue and recommends the Mental Health and Wellbeing Commission monitor and publish this data.

Mental Health sector published data also needs to encompass critical stages in the recovery journey for those with a mental illness. The capture and publication of this data broken into key recognisable timeframes such as the first 28 days post service discharge, 6-12 months after initial service access, and longer term e.g. 2 years post initial service access will allow a more open and transparent view of whether the new Mental Health and Wellbeing service system is meeting consumers' needs. It will assist the service system to identify problems and develop the strategies necessary to address them.

Recommendation 27
OPA recommends that the Mental Health and Wellbeing Commission monitors and publishes data on incidences of Victorians discharged from mental health facilities into homelessness.

Recommendation 28
OPA recommends that the Mental Health and Wellbeing Commission publishes data on the critical stages in consumer mental health recovery such as 28 days post service discharge, 6 months, 12 months and 2 years post-initial mental health service contact.

Enforcement mechanisms responding to breaches

OPA welcomes the proposed Mental Health and Wellbeing Commission's power to initiate 'own motion' investigations. This is welcome because it ameliorates issues arising when investigations depend on a specific complainant bringing an action. Placing the burden of responsibility on a complainant who is already a vulnerable person by virtue of their mental illness or psychological distress is intersectional disadvantage built into the system that is meant to provide care and support. OPA hopes that 'own motion' investigations become a prominent feature of the Commission's work.

OPA understands that the Mental Health and Wellbeing Commission will have the power, to receive and consider complaints, have matters conciliated, accept undertakings and issue compliance notices to providers to respond to issues. This is welcome. However, apart from 'conciliation' which could conceivably be between the proposed Commission as one party and the provider as the second party, nowhere in the engagement paper is there discussion about what remedies will be available to service users where their service provider has acted in breach of the objects and principles of the Act.

For real change to occur, OPA believes that the requirements imposed on providers must be more than aspirational. Breaches of requirements under the new Act, including breaches of the objects and principles, must be enforceable via available remedies for service users. Further, enforcement pathways must be made accessible to people with mental illness and

psychological distress. Again, OPA emphasises the need for information about enforcement to be available in various formats such as plain English, easy English, and languages other than English.

Recommendation 29
OPA recommends that therapeutic activities be available seven days a week in all mental health facilities as a minimum standard.

The National Mental Health Standards stipulate that therapeutic activities must occur but do not offer a minimum standard.