

## Tandem Report

# 'ACT for an inclusive mental health & wellbeing system'

### survey and consultation

#### Details

Tandem Inc., Level 1, 37 Mollison Street, Abbotsford 3067

**Telephone:** 03 8803 5555

**Authorised by:** Marie Piu

**Position in organisation:** Chief Executive Officer

**Mobile:** 0428 945 230

**Email:** [marie.piu@tandemcarers.org.au](mailto:marie.piu@tandemcarers.org.au)

For more information about this report please contact:

Marie Piu, Chief Executive Officer at [marie.piu@tandemcarers.org.au](mailto:marie.piu@tandemcarers.org.au)

Tandem Inc.

Representing Victoria's mental health carers

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## About Tandem

### Who we are

Tandem is proud to be the trusted voice of family and friends in mental health in Victoria. As the Victorian peak body with a sole focus on the needs and interests of mental health carers, Tandem's role is to provide leadership, coordination and knowledge for the organisations and individuals who are working to improve outcomes for Victorian people living with mental health issues. Tandem is committed to ensuring that the importance of the contribution, expertise, experiences and needs of family, friends and other carers is recognised and addressed, and that they will be essential partners in treatment, service delivery, planning, research and evaluation.

### What we do

Tandem helps raise community awareness about mental health issues and the challenges faced by carers of people with mental health issues

- provides information, education and training to Members and others involved in caring for people with mental health issues.
- ensures state and federal governments recognise the role, contribution and needs of the carers of people with mental health issues.
- facilitates communication between carers, government and other stakeholders in the mental health system.
- advocates for policy changes and improved services to address carer needs.
- supports carer participation in the planning, delivery and evaluation of services for people with mental health issues and their carers.
- facilitates the development of relationships between carers and carer-focussed organisations and other stakeholders in the mental health service system, and facilitate the establishment of partnerships between carers and service providers; and
- encourages research on best practice in carer support.

#### Who is a mental health carer?

- a) a family member, partner, friend or other person;
- b) of any age; who will commonly: be actively involved in caring for and supporting a person with mental health issues, with this role not necessarily a static role, but rather a role that is capable of fluctuation over time according to the needs of the person with mental health issues and the carer;
- c) have their life impacted by the wellbeing of the person with mental health issues; and
- d) undertake for the care of and support of a person with mental health from *Tandem's Rules of Association, 2019 p.2*

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## Executive Summary

The Royal Commission into Victoria's Mental Health System (the Commission) reported that,

***families, carers and supporters have identified problems with how the Mental Health Act is being applied, including that they are regularly shut out of decision making and not provided with the information they need to perform their caring role. (State of Victoria, Vol 4, p.34).***

Further to this, the Commission has stated that, **'The new legislation will also put the views, preferences and values of... families, carers and supporters... at the forefront of mental health laws'** (State of Victoria, Vol 4, p.35).

This report represents the views, preferences, and values of families, carers and supporters evident within a community consultation process, led by Tandem, incorporating an online survey and member consultation. An analysis of the Commission's Recommendations around the new Mental Health and Wellbeing Act, was conducted by Tandem to identify areas of relevance to families, carers and supporters. Building on this analysis, the Tandem **'Act for an inclusive mental health & wellbeing system'** survey, was adapted from the VMIAC **'Act on the Act'** survey, with VMIAC CEO agreement, and tailored to specifically address areas noted in the Commission's recommendations as well as Tandem member consultations conducted previously. 112 families, carers, supporters, and friends of people experiencing mental health challenges responded to the survey and consented to Tandem utilising their responses for advocacy purposes. The number of respondents, in a short period of time, from people who are known to be busy in a multitude of roles including their caring roles, indicates the level of importance placed on the new Mental Health and Wellbeing Act by family, carers, friends and supporters to enable their ability to 'perform their caring role'. Further to this a zoom consultation with 54 Tandem members was conducted on June 10th where the themes of the survey were discussed, and further comments and discussion of issues was conducted. Given that the Commission has highlighted that provisions within the new Act should *'seek to elevate the perspectives of people living with mental illness or psychological distress, families, carers and supporters'* (State of Victoria, Vol 4, p.37), it is hoped the views and perspectives held within this report will provide further evidence of the need to legislate for inclusive practices that recognise, promote and support the role of families, carers and supporters.

This report explores in depth, families, carers, friends and supporters, views and preferences around (1) Information sharing; (2) Reducing seclusion and restraint, including chemical restraint; (3) Compulsory treatment orders; (4) Carer access to Independent Mental Health Advocacy; (5) the new Mental Health and Wellbeing Commission; (6) Clarification around nominated person; (7) Second psychiatric opinion; and (8) the review period for the new Act. Overall however, the respondents indicated their concerns for the new Act include the person they care for receiving care in a compassionate manner, focused on relational

recovery ensuring they, as the person who support and provide care for the majority of time and the person's needs, are provided information and resources to be able to support and meet those needs.

## Findings

### 1.1 Information sharing

The Royal Commission identified that simplifying the provisions about information sharing is an **essential change** in the new Act (State of Victoria, 2021, Vol 3, p.101). Being provided with ongoing information about the treatment of the person they care for is essential for family, carers and supporters in performing their caring role. Respondents strongly felt “clearer definitions of types of information, may reduce concerns of service providers that they are breaching client confidentiality”. 87% of respondents support the new ACT providing clear definitions of what is meant by Personal information; General Information; Diagnostic information; Service information and suggested further categories. In the event the consumer does not consent to providing information, a clear provision in the Act should state general and diagnostic information can and should be provided to families, carers and supporters.

The Act should promote family inclusive practices through:

- mandated family inclusive induction, training, and upskilling alongside the ongoing incorporation of lived experience staff education would assist in promoting culture change,
- systemic accountability to carers seen as important in helping staff to develop family inclusive practices where designing policies such as recording of carer details upon admission, checklists for working with families, and safe and effective discharge practices,
- performance indicators suggested within the Act to demonstrate accountability from mental health services that all staff are aware of the importance of working with families, carers and supporters.

Tandem commends the Commission in recommending that “the Victorian Government should articulate expectations in law about how information should be shared with families, carers and supporters” (State of Victoria, 2021, Vol 3, p.101), and believes this will best be served through including in the new Act clearly delineated and defined types of information to be shared by mental health services with carers who actively provide care and support to consumers. Respondents believe having clearly defined types of information which carers can access within the Act will support service providers confidence in providing information that doesn't breach confidentiality of the people they provide care to. Respondents suggested the new Act could include provisions for consumers to nominate excluded persons where there has been abuse, violence or coercion, or where relationships have been harmful.

### 1.2 Reducing seclusion and physical and chemical restraint

Respondents identified the importance of working towards reducing restrictive practices. Whilst recognising that restrictive practices may be need for essential safety reasons, there should be a minimum standard of expectations and that services should be resourced to provide therapeutic approaches earlier in episode.

89% of respondents reported being highly concerned about the use of chemical restraint and stated it should be used as a last resort and only when necessary to keep someone and others safe. The act should include the provision for adequate information about medications so informed decisions could be made, and where consent cannot be obtained from the individual, that their family members, carers or supporters be informed and consulted.

### 1.3 Compulsory treatment orders

Respondents felt unsure whether compulsory treatment orders (CTO) should be removed from the new Act. Some of these fears arose through concerns around adequate resources being available as some respondents expressed that access to care was only available when the consumer was on a CTO. Respondents expressed a wish that alternative therapeutic approaches be tried before CTO.

### 1.4 Carer access to Independent Mental Health Advocacy.

Respondents strongly felt (88%) family, carers and supporters should have access to tailored Independent Mental Health Advocacy due to the complexity of the mental health system and family members feeling excluded. It was noted consumers and carers will often have different needs, and there have been times when the carers needs are not considered or addressed, examples of this include early discharge, inadequate education or information provision around treatment, and considerations of the impact of caring on the carer. Respondents expressed having no rights and not understanding treatment orders especially where marginalised and vulnerable families. Tailored Advocacy for family, carers and supporters may help to maintain and rebuild care relationships.

### 1.5 Mental Health and Wellbeing Commission

Respondents strongly supported (92%) that the MHWC should be able to act on the concerns of families, carers and support people.

### 1.6 Clarification around nominated persons

Respondents strongly supported (84%) the new Act explaining that a nominated person may also be a family member (by birth or choice) but not necessarily and also that services should be required to report on whether nominated persons have been involved in consumer care, according to consumer preferences (77%). Some respondents reported that they were the only people remaining in their family member's life, so removing the right for family members to be a nominated person could potentially leave these consumers without a nominated person that knows them.

### 1.7 Second Psychiatric Opinion

Approximately two thirds (62%) of respondents felt the Second Psychiatric Opinion Service should be run independently of public mental health services and 70% that a private psychiatrist of the consumer and family choice could be utilised for a second opinion, funded by the government.



## 1.8 New Act review period

Most respondents (30%) felt the full review should happen in the current changes; 25% within 5 years and 23% within 2 years.

### Recommendations

#### A. Objectives and principles

##### **The new Mental Health and Wellbeing Act will:**

1. honour the intent of the Royal Commission to establish accountability of services for the involvement of families, carers and supporters by clearly articulating the value of carers and the expectation they be meaningfully engaged throughout the recovery journey and that this be enshrined in the objectives or principles of the new Mental Health and Wellbeing Act

#### B. Information sharing

##### **The new Mental Health and Wellbeing Act will:**

1. continue to recognise family members as needing access to information to support them in their caring role and strengthened to mandate the minimum amount of information provision to families to create consistency across services
2. clearly define the types of information that services can share with carers, families and supporters in the event a consumer does not provide consent (e.g. general, therapeutic approaches, service and diagnostic information); and
3. clearly state in what circumstances consent can be overridden (e.g. risk of harm to self and others) and information provided to families, carers and supporters
4. mandate the inclusion and identification of family members and support persons at key points of the recovery journey, including admission and discharge
5. include provisions for consumers to nominate excluded persons which are reviewed on a regular basis.

#### C. Seclusion and restraint – including ‘Chemical Restraint’

##### **The new Mental Health and Wellbeing Act will:**

1. specify the use of less restrictive and therapeutic alternatives of care and these be clearly documented before the use of seclusion and restraint
2. define, regulate and reduce the use of chemical restraint, and stipulate targets for this
3. stipulate limitations around chemical restraint to be used as a last resort for the purpose of maintaining safety of the consumer or others, and only after alternative therapeutic approaches have been tried and clearly documented
4. include the provision of adequate information about medications so informed decisions can be made, and where consent cannot be obtained from the individual, that their family members, carers or supporters be informed and consulted.

5. establish clear guidelines around the use of any restrictive practices with a clear objective of working towards the reduction of seclusion and restraint. This will be supported by monitoring, accountability, and additional resources for implementation. The new Act should stipulate consequences for services in the event of excessive or unjustified use of restrictive practices and failure to meet reduction targets.

#### D. Compulsory Treatment Orders

**The new Mental Health and Wellbeing Act will:**

1. clearly identify targets for the reduction in the use of compulsory treatment orders
2. indicate compulsory treatment orders occur only as a 'last resort' following the adoption of alternative therapeutic approaches
3. specify that families, carers and supporters be engaged in the consultation process and their views and preferences sought prior to the administration of compulsory treatment orders
4. stipulate accountability measures and consequences for services that continue to overuse compulsory treatment orders outside of "last resort"
5. establish a provision for second (independent) opinions regarding administration of compulsory treatment orders.

#### E. Nominated Persons

**The new Mental Health and Wellbeing Act will:**

1. explain that a nominated person may also be a family member (by birth or choice) but not necessarily
2. stipulate that services are required to report on whether nominated persons have been involved in consumer care, according to consumer preferences.

#### F. Independent Mental Health Advocacy

**The new Mental Health and Wellbeing Act will:**

1. provide, as for consumers, an "opt out arrangement" for carers, families and supporters to receive tailored mental health advocacy at point of service engagement.

#### G. Second Psychiatric Opinion

**The new Mental Health and Wellbeing Act will:**

1. stipulate that the Second Psychiatric Opinion Service should be run independently of public mental health services

#### H. The Mental Health and Wellbeing Act review period

The new Mental Health and Wellbeing Act should include a full review during this period, with a further review in 5 years.

## 2. Introduction

### 2.1 Family inclusion in the new Mental Health and Wellbeing Act

The Royal Commission into Victoria's Mental Health System (The Commission) recognised the importance of rebalancing the ***“relationship between the mental health system and families, carers and supporters (State of Victoria, 2021, Vol 3, p.92).*** The future mental health and wellbeing system was identified as requiring accountability for including the needs and views of families and carers at both service delivery and systems levels. A systemic approach was identified as being required, including the establishment of accountability but further, in ***“embedding the expectation that mental health and wellbeing services will work with consumers' families, carers and supporters, including through government commissioning decisions; and providing dedicated supports for families, carers and supporters in their own right” (State of Victoria, 2021, Vol 3, p.92).***

There have been increasing government mandated policies for the engagement of families and carers, including those enshrined in legislation, such as in section 11(1) of the Mental Health Act 2014 (Vic), which includes principles about involving carers (including children) of people receiving mental health services in decisions about assessment, treatment and recovery whenever possible, as well as recognising, respecting and supporting the role of carers (State of Victoria, 2021, Vol 3, p.92). However, despite this and several other legislative recommendations and practice guidelines, the Commission noted the mental health system, through structural and power imbalances, failed to work effectively with families, carers and supporters. Steps recommended by the Commission to establish accountability for the involvement of families, carers and supporters included recognising the value of carers in the objectives or principles of the new Mental Health and Wellbeing Act. The Commission further identified that “simplifying provisions about information sharing with families, carers and supporters is an essential change required to the legislation” (State of Victoria, 2021, Vol 3, p.101). Highlighting that the biggest improvement in information sharing practices will be achieved through both legislative and practice and cultural changes. The Commission goes on to recommend that to “support new cultures of information sharing, the Victorian Government should articulate expectations in law about how information should be shared with families, carers and supporters” (State of Victoria, 2021, Vol 3, p.101) to ensure and enable people are effective in their caring roles. However, the Commission goes on to recommend a consent system be established that will, “mean families, carers and supporters can get more detailed information where a consumer requests it, more easily” (State of Victoria, Vol 5,p.99). Concerns remain for families, carers and supporters inclusion where a consumer may not provide consent.

## 2.2 Ongoing Consultations with families, carers and supporters

Whilst Tandem is pleased the legislators drafting the new Mental Health and Wellbeing Act will consider the views, values and perspectives of people with lived experience of mental health challenges or psychological distress and their families, carers and supporters that were collated by the Commission, Tandem has undertaken a broad range of consultations, since the release of the Commission's Final Report to further glean families, carers and supporters views. These consultations have included the survey, and supplemented with a zoom consultation of 54 members, to support the important work of the Commission. Tandem conducted an analysis of the Commission's Recommendations around the new Mental Health and Wellbeing Act to identify areas of possible relevance to families, carers and supporters. The Tandem **'Act for an inclusive mental health & wellbeing system'** survey, was adapted from the VMIAC Act on the Act survey, with VMIAC CEO agreement, and tailored to specifically to address areas noted in the Commission's recommendations as well as Tandem member consultations conducted previously. The online survey was distributed to Tandem members and stakeholders on the 4<sup>th</sup> of May 2021 and remained open until the 4<sup>th</sup> of June 2021. The data was uploaded into SPSS 27 for analysis and the extended response answers were reviewed by a team of four to consider emergent themes.

## 3. Findings

### 3.1 Demographics of survey

In a four week period, 112 families, carers, supporters, and friends of people experiencing mental health challenges responded to the survey and consented to Tandem utilising their responses for advocacy purposes, including through published articles or social media ([Appendix A](#)). The number of respondents, in a short period of time, from people who are known to be busy in a multitude of roles including their caring roles, indicates the level of importance placed on the new Mental Health and Wellbeing Act by family members. Most respondents were female (85%), which reflects the accepted demographics of the 'mental health caring' community. The respondents ages were spread from 25 to over 65 years with the highest category (30%) being 55 to 64 years. Most respondents were from metropolitan Melbourne (71%), with 25% reporting living in regional Victoria. Of the 106 respondents who reported gender and geographical location, there was a higher proportion of females (93%) who responded in regional Victoria than in metropolitan Melbourne (85%). Diversity reported by the respondents included LBGTIQ+ (7%), culturally and linguistically diverse (12%) and young carers (5%). No carers identified as Aboriginal or Torres Strait Islander, although we disseminated the survey through a range of first nations stakeholders including VACCHO.

When families, carers and supporters were asked how they define themselves with respect to their caring role, the term carer was only used by 35% of respondents, with most respondents identifying themselves as family member (79%), supporter (13%), nominated person (9%) and friend (9%).

Whilst the Commission and legislation identifies families, friends, supports and carers as carers, with the term carer only being used by 35% of respondents, and most respondents identifying themselves as family member (79%), there are implications for family inclusive practice as if a consumer or carer is asked “who is your carer”, there may be a response of nobody. However, this person may have several supporters, and it is important that the Act and service practices acknowledge this. The Commission acknowledged the importance of having conversations early with consumers about who they may want to receive information about their treatment early in the therapeutic relationship. Tandem suggests incorporating language that consumers and family members use would add to this recommendation.

Key areas of importance to respondents within the new Act include: (1) Information sharing; (2) Reducing seclusion and restraint, including chemical restraint; (3) Compulsory treatment orders; (4) Carer access to Independent Mental Health Advocacy; (5) the new Mental Health and Wellbeing Commission; (6) Clarification around nominated person; and (7) Second psychiatric opinion.

### 3.2 Information sharing

The Royal Commission has identified that *‘simplifying provisions about information sharing with families, carers and supporters is an **essential** change required to the legislation’* (State of Victoria, 2021, Vol 3, p.101). Whilst the Commission highlighted that the biggest improvement in information sharing practices will be achieved through both legislative and practice and cultural changes, Tandem is concerned that changes within the Mental Health Act 2014, to recognise families and carers, did not lead to practice and cultural changes, with many mental health service professional continuing to use patient confidentiality as an excuse to not engage with families.

Information sharing is a well-documented and often discussed concern for families, carers and supporters of people with mental health challenges, with one respondent stating “Imagine caring for a loved one and not knowing how to manage medications, treatments, behaviours or know who to call in a crisis?”. Within this survey 98.2% of respondents identified that being provided with ongoing information about the treatment of the person they care for is very important to their role as a carer, supporter, or nominated person ([Appendix B](#)). Respondents also considered it was very important for people to have access to their health records in real time (84%). Fewer respondents (61%) felt that being able to add information to the health record of the person they care for was very important, although advantages of inclusion of family to bring current and contextual information to treatment planning was identified in the extended response questions. Respondents supported receiving medical information regardless of whether the consumer consented (84%) and reasons for this were elaborated on in the extended response questions including pleas for information to maintain the safety of the person they care for.

Respondents (87%) strongly supported the suggestion that it would be useful for the new ACT to provide clear definitions of what is meant by the following types of information: Personal information; General

Information; Diagnostic information; Service information and suggested further categories in the extended response answers. Respondents also agreed there were advantages in identifying with whom information should be shared (83%) and possibly people who may be excluded from receiving information (70%), however with clear guidance.

Themes arising from the extended response questions around information sharing strongly agreed with the Royal Commission's recommendation that current requirements for the sharing of information with families and carers be simplified (State of Victoria, 2021, Vol 3, p.101).

### ***Act still to advise that carers are to receive information***

Themes emerged from the data in that respondents identified that safe care is inclusive care and families play an important role in a person's life. A number of distressing statements were revealed by respondents including, ***"My son died because information was not shared, and furthermore when I raised concerns just the week before my son took his life....no basic safety check was done. I was NOT believed."***

Respondents highlighted that families can inform service providers about the life of the person both when they are well and factors that lead to them becoming unwell. This can be inhibited by service practices that are not inclusive of sharing information with one respondent stating, ***"Quite often it is the carer who wants to provide information but the conflicting understanding of 'sharing information' hampers that important information transmission"***. Another respondent went on to report that carers can provide a lens around cultural considerations through the sharing of information.

However, the strongest evidence for the act continuing to advise that families, carers and supporters are still to receive information, is the importance of having information to enable respondents to provide care.

Similar expressions of despair were expressed as represented by this statement, ***"As carer I am often 'kept in the dark' and it makes supporting the person I love very difficult without all of the information"***. Some respondents suggested there should be mandated information provisions to families to promote consistency across services.

### ***Clear definitions of types of information***

Respondents felt "clearer definitions of types of information, may reduce concerns of service providers that they are breaching client confidentiality". Respondents identified that service provider concerns about breaching confidentiality stopped the service provider sharing information with them. One carer clearly defined the types of information that assisted them in providing support,

***It is very helpful for families to have basic information on medications (side effects to watch for etc.), Service information is essential - particularly for 'first time' families. General information on psychiatric illnesses and those associated with a possible diagnosis.... a diagnosis is possibly less important than what is to be expected in terms of 'recovery' and where to access further support. Personal information should really only***

***be shared with the consent of the patient but there is no reason this shouldn't be sought, tactfully/sensitively by the mental health practitioners.***

Other respondents suggested, ***“The Act should include a glossary of certain expressions especially if they are open to interpretation”*** and another ***“Plain English definitions of such terminology are vital”***.

Ultimately respondents want to be able to receive information to be able to provide care, however other definitions around information that promote safety or minimises risk, were suggested such as legal information like family violence orders.

#### ***Sharing of information to promote safety and care***

Respondents identified several instances where the sharing of information without the consumers consent should occur. These were largely centred around maintaining or promoting safety,

***Where there are safety concerns - risks of harm to self and or harm to others. If the consumer is refusing treatment and the consumer will be discharged into the care of the family/ carer then they need to be aware of this.***

Other areas included information about the impact of medication or refusals around taking medication. Also, where there are higher risk treatments, such as ECT or medication changes, or compulsory treatment and restraint. Safety was also raised in the provision of information where children are involved. Respondents believe more support should be given to the family when there are children involved, to both maintain safety, but to also assist with the children coping with the situation.

Respondents also felt they should be able to receive information without the consumer’s consent being sought again when they are named by the consumer as the nominated person or the person to whose care the consumer is being discharged to. Not being advised of a person’s discharge either in a timely manner or at all was referred to by a number of respondents, and the impact this had on both the consumer’s safety and the ability of the carers to provide support.

#### **Identification of who should receive information**

Respondents were interested in a minimum amount of information being stipulated that must be shared with family, carers and supporters. Some respondents supported the idea of nominated persons being included, also known service providers such as general practitioners as indicated by

***Our family GP has been wonderful and has a close relationship with our son. He has struggled to get information out of the hospital in past times and this is ridiculous as he is the main out of hospital medical contact.***

Other respondents suggested that persons who should be excluded from receiving information should be defined in the new Act. It was suggested consumers could exclude persons where there had been abuse, violence or coercion, or where relationships had been harmful.



However, in discussing the issue of persons identified in the Act of being in receipt of information or excluded, respondents identified these instances should be clearly defined and mandated for regular review.

***Education and support for workforce around sharing information***

Respondents suggested that education on the importance and benefits of working with families should be undertaken at induction and a mandatory annual training. Mandated family inclusive induction, training, and upskilling alongside the ongoing incorporation of lived experience staff education would assist in promoting culture change.

***Working with carers and families should be part of core practice in mental health services to both assist them [families] in their caring role to better support the consumer but also to support the carer and family with their own emotional and support needs.***

Strengthening the family/carer workforce will also promote culture change with suggestions that lived experience advocates (consumer and carers) needing to be imbedded in all mental health services, inpatient and community and they should attend all clinical meetings to promote and support change.

Respondents suggested systemic accountability, seen as important in helping staff to develop family inclusive practices, included designing policies such as recording of carer details upon admission, checklists for working with families, and safe and effective discharge practices, to ensure the following doesn't occur,

***When the person is to be discharged the Carer should be notified of the pending discharge. Last year my son was hospitalized for nearly six weeks, the doctor was increasing my son's medication and [he] was to stay in hospital to see his response. Instead after upping the medication in the morning [he] was later in the day, discharged without informing me. He was discharged and was not offered transport to get home in the middle of the pandemic.***

Some respondents suggested performance indicators stipulated in the Act to demonstrate accountability from mental health services, that all staff are aware of the importance of working with families, carers and supporters.

Finally, respondents suggested professional codes of conduct could be considered, with a respondent stating

***legislation and education of mental health professionals and services that mental health recovery is not only about the consumer. Families and carers have their own journey of recovery and as the consumer improves so do they. The research about working collaboratively with families should be interwoven into all mental health practice and through higher education institutions.***



### 3.3 Reducing seclusion and restraint

Respondents expressed the importance of working towards reducing seclusion and restraint, with the support of monitoring, accountability, and additional resources to achieve this. The need for seclusion and restraint for essential safety reasons was noted by 10 of the 44 people who responded to the open question about seclusion and restraint. However, respondents also identified there should be a minimum standard of expectations of what seclusion and restraint involves including basic safety measures, and therapeutic restraint informed by care plans. Respondents (60%) felt it was important that the new Act make it mandatory that seclusion or restraint must end immediately when the ‘imminent risk’ stops (e.g., the person is asleep or unconscious) ([Appendix C](#)).

The need for more resources, additional training and the use of other options was highlighted by a number of respondents, e.g., more staff, more support and training for staff (including support for services to meet their benchmarks), and utilizing less restrictive and more therapeutic means (e.g. de-escalation techniques, quiet rooms and sensory plans). One respondent identified,

***Without supportive systems in place, these practices are likely to continue. The system is based on reactivity to crisis management, then financial constraints and demand push people through the system before they are ready to be discharged. Once services are resourced to properly accommodate people, there may be some change.***

Another respondent identified the value they had seen in the ‘Safewards’ model and recommended it being utilised across the state.

A number of respondents referred to accountability – the need for specific targets and KPI reporting for each service, ‘checks and balances’ (whilst ensuring safety), regular auditing and independent assessment and evaluation of services when seclusion and restraint is used and overall transparency and understanding of when and why seclusion and restraint are used.

Other themes expressed by respondents were the importance of working in partnership with families, providing information to consumers and families of how, when and why seclusion and restraint may be used (so it does not feel like a punishment), providing debriefing support for consumers and families (staff and witnesses) post use of restraint, and having independent advocates present at every situation where restraint and seclusion are considered (and used). Females should not be restrained by male security staff.

A need was expressed for more support and education for families in early management of behaviours in the person they support.

#### 3.3.1 Chemical Restraint

The Commission has recommended chemical restraint be defined in the new Act to protect consumers and enable the practice to be monitored (State of Victoria, 2021, Vol 4, p.40). In suggestions for defining chemical restraint, the majority of respondents (78%) ([Appendix C](#)) agreed with the statement ‘The effect of

the medication is restraint on a person's body, thinking and/or emotions', followed by 77% agreeing with the statement 'The intention of the medication is to control a person's behaviour', and then 67% agreed with the statement 'The medication impairs a person's ability to make decisions.' Respondents agreed that the definition should include that chemical restraint constitutes 'how the medication is given (e.g.: intramuscular injections)' (56%) and in 'what circumstances medication is given (e.g.: if bodily restraint is used)' (53%).

One hundred of the 112 respondents answered the open question on chemical restraint compared to 44 answering the question on seclusion and physical restraint, suggesting participants are highly concerned around the issue of chemical restraint. Themes for the open ended responses to questions around what should be incorporated in defining chemical restraint in the Act were: chemical restraint should be used as a last resort and only when absolutely necessary to keep someone and others safe; chemical restraint should be considered with the same limitations as seclusion and physical restraint including minimal dose and duration, with oral administration used before intramuscular routes; consumers, families and family members should be included in decisions about chemical restraint and medication use; and considerations around the negative impact on consumers of chemical restraint (i.e. trauma and resulting distrust in care) was further highlighted by a number of respondents, as well as comments around applications of unnecessarily high doses beyond what should be a "calming effect". Family members were clear they would want alternatives considered before chemical restraint. Respondents suggested clear guidelines around chemical restraint in relation to alternate therapeutic approaches like those mentioned for seclusion and physical restraint. Suggestions included:

- staffing should be set to prevent the over reliance on medication and chemical restraint,
- more staff training and support in de-escalation
- adequately resourced practices that engage with consumers and assist families to provide support before escalation of symptoms occur
- talking with/involving family/carers/supporters in treatment may expand options for early intervention
- considerations around how to attract staff better able to support people on inpatients units
- groups/activities to be facilitated on a daily basis that support people in their recovery and transition to community or outside services.
- environmental design to include quiet spaces
- use of nominated persons and advanced statements as regular practice
- guidelines around safe practice.

The act should include the provision of adequate information about medications so informed decisions could be made, and where consent cannot be obtained from the individual, that their family members, carers or supporters be informed and consulted.

Respondents suggested that,

***family/carer or supporters might be a useful resource to engage before chemical restraint to try to identify how to reduce arousal and anxiety in consumer. Better understanding of what exacerbates and what reduces consumer stress and anxiety might be the first thing to try before chemical restraint.***

One carer was concerned that data on chemical restraint would need to be monitored, as targets set by the Commission to reduce seclusion and physical restraint may lead to an increase in the use of chemical restraint. Another carer suggested the definition for chemical restraint should be co-written with consumers, family and carers.

### 3.4 Compulsory treatment orders

Respondents were mainly unsure (47%) whether compulsory treatment orders should be removed from the Act, with 36% saying no, 17% saying yes ([Appendix D](#)). The mixed feelings about the removal of compulsory treatment by respondents included fears around loved ones deteriorating and becoming very unwell; that loved ones will be of risk to themselves and to others, including family members; that there will not be adequate community supports in place of treatment orders to keep supported persons safe. Some respondents felt there may be a need for compulsory treatment orders at times as this is the only way the consumer was able to receive care, the extended length of time needs to be monitored. Other respondents expressed hope that there will be appropriate community support in place concurrently with the reduction in compulsory treatment; that there will be early intervention supports for people so compulsory treatment orders do not become necessary; services will be resourced so that compulsory treatment is not the go-to; and an overall hope that frequency of use of compulsory treatment orders will be reduced.

***Compulsory treatment can be a horrific infringement on the rights of the individual. For some people though, and their families, it can be life-saving such as when an individual is experiencing strong suicidal ideation and intent. My hopes are for a stronger, earlier, more holistic, and comprehensive system that intervenes earlier so that compulsory treatment is not needed. My primary fear is that without this, the removal of compulsory treatment may mean that many people experiencing acute illness may not get access to the treatment they need.***

In considering what should be tried before compulsory treatment orders, the majority (92%) of respondents stated, 'specialist trauma services' should be tried, followed by 'providing the opportunity to voluntarily try multiple medications' (87%), then equally 81% 'family psychoeducation, multiple family group or similar program/family therapy/participation in an open dialogue' and 'peer support' ([Appendix D](#)). Respite was identified by 79% of respondents as an alternative that should be tried. Other alternatives suggested in

extended response answers included support being given to families through the compulsory treatment process; families being informed of the treatment plan and provided guidance and support throughout; the use of advanced statements must be promoted, developed and established in full collaboration with consumers and family/family members; family group work and open dialogue techniques; consulting with and involving people's informal support networks; and a tripartite care approach with the consumer, their family/carer/supporter and professionals seen as critical for reducing the need for compulsory treatment. A number of respondents commented on the severity of their loved one's mental health challenges, including references to little or no insight into their need for treatment, making compulsory treatment orders feeling like "the only option". However, when asked about the criteria for compulsory treatment within the new Act and what should be included and excluded from the definition of 'serious deterioration' or 'serious harm', the majority (96%) of families, carers and supporters stated, 'physical injury to others', 'imminent death' (94%) and 'physical injury to self' (94%) should be included ([Appendix D](#)). Respondents also agreed (75%) 'the concern or fears of the person's family/ friends/ supporters' should be included, as well as 72% agreed the 'ability to self-care (not eating, sleeping or showering)' should be included.

Changes seen as helping to reduce the use of compulsory treatment orders identified by respondents included 'requiring the involvement of other mental health professionals in deciding on an order (not just a psychiatrist)' (81.3%), followed by 80% who selected 'compulsory treatment must change or stop if it negatively impacts physical health or personal recovery', then 76% selected 'treatment orders should specify what the treatment will be (e.g.: types and doses of drugs)', 64% selected 'high risk treatments and/or off label use of medications should not be permitted for compulsory treatment' and 61% selected 'include an official objective and targets to reduce compulsory treatment' ([Appendix D](#)).

When asked whether the Act should ensure family/friends/supporters/nominated persons have been identified/recorded and engaged in the recovery journey of the consumer before compulsory treatment is considered, 100 (89%) respondents said yes, 2 (2%) said no and 4 (4%) were unsure.

### 3.5 Carer access to Independent Mental Health Advocacy.

The Commission has recommended that Independent Mental Health Advocacy (IMHA) to become an opt out service. When respondents were asked whether family, carers and supporters need access to mandatory advocacy where the person you care for is on a compulsory treatment order, the majority (88%) stated yes ([Appendix E](#)). Comments included by respondents were that the family members need for advocacy were often based around the complexity of the mental health system and family members feeling excluded. Respondents identified they felt; "we have no rights", the need to understand "the what, how and why" of treatment orders, often they are not heard by the system, especially where more vulnerable and marginalized families, such as CALD family/family members or where English is a second language and they do not have the time or capacity to navigate their way through the system on their own. Some respondents especially

expressed concern when children turned 18, identifying instances of compulsory treatment orders including ECT without the knowledge of the parent.

One carer identified the need for an Independent Mental Health Advocate;

***To be able to advocate on your loved one's behalf. Behaviour often changes when someone is experiencing mental health challenges and having a familiar support person to also advocate for them, in conjunction to an assigned advocate, must be an option provided. This support person, often family/carer, need information/advice and support themselves - thus an advocate to support them.***

Further to this consumers and family members will often have different needs, and there have been times when the family members needs are not considered or addressed, examples of this include early discharge, inadequate education or information provision around treatment, and considerations of the impact of caring on the carer. Tailored Advocacy may help to maintain and rebuild care relationships.

Other instances when respondents felt IMHA should be notified included: when a consumer attended an emergency department unaccompanied; when ECT has been ordered; to assist with discharge planning if no support person has been identified; when police are in attendance and when the person is under 18 and in the presence of their family.

### 3.6 Mental Health and Wellbeing Commission

The Royal Commission has recommended that a new Mental Health and Wellbeing Commission (MHWC) be established. This new commission will have a monitoring and regulation function. The Royal Commission has also recommended that the role and function of the Mental Health Complaints Commission be transferred to the MHWC. When asked about how the MHWC should respond to services who don't comply with the act, the majority of respondents 94% felt there should be increased support (e.g. training) to resolve any issues preventing good service; 88% of respondents felt there should be a formal review of service, and 68% felt there should be quarterly reporting ([Appendix F](#)). Further suggestions from respondents included ensuring adequate resourcing to services are in place; observing for indicators that service is not managing or is underperforming, including markers such as staff turnover; actions to be taken if service is functioning poorly include transferring administration into the Commission (such as in a business going into administration) and triggering independent investigations.

When asked about what should be included in public reports about mental health services issued by the new MHWC, respondents rated from the highest; actions the MHWC has taken in response to service non-compliance with human rights obligations under the Act (85%), identification and inclusion of family/carers/nominated persons in service design delivery and governance (84%), analysis of reductions in seclusion and restraint, including performance of individual services and the sector (78%), and all with 74% agreement were individual service compliance with principles of the Act, sector-wide compliance with

principles of the Act and analysis of reductions in compulsory treatment, including performance of individual services and the sector.

Respondents strongly supported (92%) that the MHWC should be able to act on the concerns of families, carers and support people.

### 3.7 Clarification around Nominated Persons

The Commission has recommended that the role of nominated persons be clarified in the new Act.

Respondents strongly supported (84%) the new Act explaining that a nominated person may also be a family member (by birth or choice) but not necessarily and also that services should be required to report on whether nominated persons have been involved in consumer care, according to consumer preferences (77%) ([Appendix G](#)). Whilst it had been suggested within the Commission's final report that there '*may be tension between the different roles of nominated persons and carers*' (State of Victoria, Vol 4, p.403), some respondents reported that they were the only people remaining in their family member's life, so removing the right for family members to be a nominated person could potentially leave these consumers without a nominated person that knows them. Becoming a nominated person has been seen by families as an opportunity to become more included in the treatment plan and to be able to provide contextual information to the treating team. However, some respondents also identified that family may have different views to the consumer and another person may be better suited to being the nominated person. However, if the family are still actively involved in caring, they must remain informed and part of the treatment team. Should the new Act describe nominated persons in a different way, respondents felt improvements to the description would be that nominated persons agree to promote consumer personal and social wellbeing and to have regard to the need to respect consumer individuality (87%); agree to read and understand any advance statement consumers make (86%); agree to provide consumers with support to make their own decisions (86%); sign a statement that they understand their obligations (80%); and agree to express the views, preferences and values of consumers, not their own personal views and preferences (64%).

### 3.8 Second Psychiatric Opinion

To try and strengthen the rights of consumers, the new Act might make changes to how the right to a second psychiatric opinion operates. Approximately two thirds (62%) of respondents felt the Second Psychiatric Opinion Service should be run independently of public mental health services and 70% that a private psychiatrist of the consumer and family choice could be utilised for a second opinion, funded by the government ([Appendix H](#)). Other thoughts included the psychiatrist having greater contact with known general practitioners, carers and nominated persons being consulted by second psychiatrist and that the second opinion needs to be transparently independent.

### 3.9 New Act review period

The Royal Commission has recommended that the new Act be independently reviewed in 5 to 7 years. This review will look at ensuring the law is contemporary, effective and responsive to people's needs. Some other recommendations to enhance human rights are suggested for this review. The majority of respondents (30%) felt the full review should happen with the current changes; 25% within 5 years and 23% within 2 years. ([Appendix I](#)).

### 3.10 Ongoing Consultations

On the 10<sup>th</sup> June 2021, Tandem undertook further consultation with members through providing members with findings from the survey and allowing opportunities for further discussion. Additional points for consideration around the new Act included:

- concerns around the strength of the Carer Recognition Act 2012 and whether this can be reinforced through the new Act
- concerns around the missing severe – those who have the most severe mental illness yet receive the least standard of care – inability to get sustained specialist care (staffing in wards by casual and not mental health trained staff, lack of skills in de-escalation and poor communication with the family) – trauma arising from emergency response by police
- difficulties with the Mental Health Tribunal having mainly audio hearings and not forwarding correspondence to carers as nominated persons
- second Psychiatric opinion to be discussed in person and not sent in the mail
- how will emergency departments be included within the new Act given that they are not nominated mental health services under the current Act
- clearer definition around the term 'carer' including bereaved carer and the incorporation of language that is used by consumers, family, supporters, and friends within the Act. Especially in relation to being the support person for an adult consumer
- legal accountability for failures to protect the safety of consumers by services and individuals (similar to the Occupational Health and Safety Act), currently only penalties are around privacy and confidentiality
- Drug Act incorporated within the Mental Health and Wellbeing Act to recognise co-morbidity
- minimum training levels around working with families mandated including organisational responsibility to abide
- consider treatment information to be a defined category in the new Act
- impact of Act on the private mental health sector
- need for legal accountability around information sharing



## 4. Recommendations

### 4.1. Objectives and principles

#### **The new Mental Health and Wellbeing Act will:**

1. honour the intent of the Royal Commission to establish accountability of services for the involvement of families, carers and supporters by clearly articulating the value of carers and the expectation they be meaningfully engaged throughout the recovery journey and that this be enshrined in the objectives or principles of the new Mental Health and Wellbeing Act

### 4.2 Information sharing

#### **The new Mental Health and Wellbeing Act will:**

1. continue to recognise family members as needing access to information to support them in their caring role and strengthened to mandate the minimum amount of information provision to families to create consistency across services
2. clearly define the types of information that services can share with carers, families and supporters in the event a consumer does not provide consent (e.g. general, therapeutic approaches, service and diagnostic information); and
3. clearly state in what circumstances consent can be overridden (e.g. risk of harm to self and others) and information provided to families, carers and supporters
4. mandate the inclusion and identification of family members and support persons at key points of the recovery journey, including admission and discharge
5. include provisions for consumers to nominate excluded persons which are reviewed on a regular basis.

### 4.3 Seclusion and restraint – including ‘Chemical Restraint’

#### **The new Mental Health and Wellbeing Act will:**

1. specify the use of less restrictive and therapeutic alternatives of care and these be clearly documented before the use of seclusion and restraint
2. define, regulate and reduce the use of chemical restraint, and stipulate targets for this
3. stipulate limitations around chemical restraint to be used as a last resort for the purpose of maintaining safety of the consumer or others, and only after alternative therapeutic approaches have been tried and clearly documented
4. include the provision of adequate information about medications so informed decisions can be made, and where consent cannot be obtained from the individual, that their family members, carers or supporters be informed and consulted.
5. establish clear guidelines around the use of any restrictive practices with a clear objective of working towards the reduction of seclusion and restraint. This will be supported by monitoring, accountability, and additional resources for implementation. The new Act should stipulate



consequences for services in the event of excessive or unjustified use of restrictive practices and failure to meet reduction targets.

#### 4.4 Compulsory Treatment Orders

**The new Mental Health and Wellbeing Act will:**

6. clearly identify targets for the reduction in the use of compulsory treatment orders
7. indicate compulsory treatment orders occur only as a 'last resort' following the adoption of alternative therapeutic approaches
8. specify that families, carers and supporters be engaged in the consultation process and their views and preferences sought prior to the administration of compulsory treatment orders
9. stipulate accountability measures and consequences for services that continue to overuse compulsory treatment orders outside of "last resort"
10. establish a provision for second (independent) opinions regarding administration of compulsory treatment orders.

#### 4.5 Nominated Persons

**The new Mental Health and Wellbeing Act will:**

3. explain that a nominated person may also be a family member (by birth or choice) but not necessarily
4. stipulate that services are required to report on whether nominated persons have been involved in consumer care, according to consumer preferences.

#### 4.6 Independent Mental Health Advocacy

**The new Mental Health and Wellbeing Act will:**

1. provide, as for consumers, an "opt out arrangement" for carers, families and supporters to receive tailored mental health advocacy at point of service engagement.

#### 4.7 Second Psychiatric Opinion

**The new Mental Health and Wellbeing Act will:**

1. stipulate that the Second Psychiatric Opinion Service should be run independently of public mental health services

#### 4.8 The Mental Health and Wellbeing Act review period

The new Mental Health and Wellbeing Act should include a full review during this period, with a further review in 5 years.

## References

State of Victoria, (2021), Royal Commission into Victoria’s Mental Health System, Final Report, Volume 3: Promoting inclusion and addressing inequities, Parl Paper No. 202, Session 2018–21 (document 4 of 6).

State of Victoria, (2021), 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).

State of Victoria, (2021), Royal Commission into Victoria’s Mental Health System, Final Report, Volume 5: Transforming the system—innovation and implementation, Parl Paper No. 202, Session 2018–21 (document 6 of 6).

## Appendices

### Appendix A – Demographics

*Table 1 Demographics*

<b>Sample size</b>	<b>112 respondents</b>	
<b>Age range</b>	<b>Respondents (%)</b>	<b>Number</b>
Under 18 years	0%	0
18-24 years	0%	0
25-34 years	8.0%	9
35-44 years	12.5%	14
45-54 years	25.9%	29
55-64 years	29.5%	33
Over 65 years	22.3%	25
<b>Gender</b>		
Identify as female	84.8%	95
Identify as male	13.4%	15
Not identified	1.8%	2
<b>Diversity</b>		
LBGTIQ+	7.1%	8
CALD	11.6%	13
Aboriginal or Torres Strait Islander	0%	0
Young Carer	4.5%	5
Other	58.9%	66
<b>Location</b>		
Metro Melbourne:	71.4%	80
Regional Victoria:	25.0%	28
<b>How respondents define themselves in caring role</b>		
As a family member	78.6%	88
Carer	34.8%	39
Supporter	13.4%	15
Nominated person	8.9%	10
Friend or other	8.9%	10

## Appendix B – Information sharing data

Table 2 Carers views on information sharing in new Act

	Very Important	Not at all important	Unsure
How important is it to your role as a carer/ supporter/ nominated person that you are provided with ongoing information about the treatment of the person you love?	98.2%	0%	0.9%
	Very Important	Not at all important	Unsure
How important is it in your view for people to have access to their health records in 'real time'?	83.9%	0.9%	13.4%
	Yes	No	Unsure
Should you, as the family member/ friend/ supporter/ nominated person, be able to add information to the health record of the person you love?	60.7%	8.0%	27.7%
	Yes	No	Not answered
Are there any circumstances in which you believe a health service must share medical information with you regardless of whether you have the consent of the consumer?	83.9%	9.8%	6.3%
	Yes	No	Maybe
Would it be useful the for the new ACT to provide clear definitions of what is meant by the following types of information: Personal information; General Information; Diagnostic information; Service information	86.6%	3.6%	8.9%
	Yes	No	Maybe
Would it be useful the for the new ACT to identify with whom personal information, general Information, diagnostic information, or service information can be shared?	83.0%	3.6%	8.9%
	Yes	No	Not answered
Are there circumstances where you believe having a definition of excluded persons would be beneficial to the person you love?	69.6%	17.9%	12.5%

## Appendix C – Seclusion and restraint data

Table 3 Actions to reduce seclusion and restraint

What changes are needed to the Act to reduce seclusion and restraint?	
The new Act should include an objective to reduce seclusion and restraint so that it is eliminated within 10 years	25.9%
The new Act should include the Royal Commissions targets for reducing seclusion and restraint	42.0%
The new Act should link reductions in seclusion and restraint to services' funding and performance indicators	31.3%
The new Act should make it mandatory that seclusion or restraint must end immediately when the 'imminent risk' stops (e.g., the person is asleep or unconscious)	59.8%

Table 4 Definitions of chemical restraint in the Act

What constitutes chemical restraint? How it should be defined in the Act.	Agree	Disagree	I don't know
The intention of the medication is to control a person's behaviour	71.4%	14.3%	11.6%
The effect of the medication is restraint on a person's body, thinking and/or emotions	76.8%	11.6%	8.9%
The medication impairs a person's ability to make decisions	61.6%	20.5%	14.3%
The circumstances in which the medication is given? e.g. if bodily restraint is used to administer the medication	49.1%	11.6%	33.9%
How the medication is given, e.g. intramuscular injections	50.0%	14.3%	27.7%
Any medication given without informed consent	45.5%	19.6%	28.6%

## Appendix D – Compulsory treatment orders data

Table 5 Considerations around Compulsory Treatment Orders within the new Act

	Yes	No	Not sure
Should CTOs be removed from the new Act?	18.8%	33.3%	47.3%
Should the Act ensure family/ friends/ supporters/ nominated persons have been identified/recorded and engaged in the recovery journey of the consumer before compulsory treatment is considered?	89.3%	1.8%	3.6%

Table 6 Inclusions for defining compulsory treatment orders

Criteria for compulsory treatment. What should be included and excluded from a definition of 'serious deterioration' or 'serious harm'?	Include	Exclude	Don't know
Non-conforming behaviour or beliefs	21.4%	57.1%	14.3%
Taking financial risks	31.3%	37.5%	25.9%
Doing things that might damage the reputation of the person you love	30.4%	44.6%	19.6%
The concern or fears of the person's family/ friends/ supporters	66.1%	15.2%	14.3%
Ability to self-care, e.g.: not eating, showering or sleeping	69.6%	15.2%	11.6%
Physical injury to self	90.2%	5.4%	1.8%
Physical injury to others	92.0%	2.7%	2.7%
Imminent death	89.3%	2.7%	4.5%

Table 7 Suggested actions to occur prior to compulsory treatment

What should the Act say should be offered or tried before compulsory treatment is used as a “last resort”?	Agree	Disagree	Not sure
Family psychoeducation, Multiple family group or similar program / family therapy/ participation in an open dialogue	82.1%	9.8%	6.3%
Peer support	79.5%	8.9%	8.9%
Providing the opportunity to voluntarily try multiple medications	85.7%	4.5%	8.0%
Specialist trauma services	91.1%	1.8%	5.4%
Respite services	78.6%	5.4%	13.4%

Table 8 Possible changes to reduce the use of compulsory treatment orders

Which of following changes would help reduce use of CTOs?	%
Shorten the maximum duration of treatment orders, including CTOs	35.7%
Concerns about "compliance" cannot be a justification for an order	43.8%
Require the involvement of other mental health professionals in deciding on an order (not just a psychiatrist)	79.5%
Include an official objective and targets to reduce compulsory treatment	64.3%
Treatment orders should specify what the treatment will be (e.g., types and doses of drugs)	73.2%
Compulsory treatment must change or stop if it negatively impacts physical health or personal recovery	77.7%
High risk treatments and/or off-label use of medications should not be permitted for compulsory treatment	61.4%

## Appendix E – Mandatory access to Independent Mental Health Advocacy data

Table 9 Carers access to Independent Mental Health Advocacy

	Yes	No	Not sure
Do you as a family member, carer, etc., also need access to mandatory advocacy where the person you care for is receiving compulsory treatment?	87.5%	4.5%	5.4%

Table 10 Options to support access to advocacy

Which of the following options should be included in the new Act to support consumers and carers gaining access to advocacy?	
IMHA advocates must have a protected right of access to all authorized mental health services	75.0%
IMHA advocates cannot be stopped from attending meetings with consumers, unless the person does not want them there	79.5%
IMHA advocates cannot be prevented by a service from meeting with a consumer or survivor, unless the person does not want to meet with them	79.5%
IMHA advocates should be able to access consumer medical records if the person consents	72.3%
IMHA must be notified when a person is subjected to a treatment or assessment order within 24 hours	82.1%
IMHA must be notified within 24 hours when a person is subjected to seclusion or restraint	82.1%
IMHA must have access to the mental health system database to see who is on an order and their contact details	53.6%
Services must respond to IMHA advocates' requests within a maximum of 3 three days	83.9%



## Appendix F – New Mental Health and Wellbeing Commission

Table 11 Actions against services who don't comply with new Act

<b>How should the new Mental Health and Wellbeing Commission respond to services who don't comply with the new Act?</b>	
I don't think there should be any consequences when services don't comply with the Act	1.8%
Increased support (e.g. training) to resolve any issues preventing good service	93.8%
Quarterly public reporting	67.9%
Formal review of service	88.4%
Application of fines	45.5%
Sanctions such as reducing funding	46.4%
Deregistration of services	58.9%
If applicable criminal penalties	60.7%

Table 12 Inclusions in public reports about mental health services

<b>What should be included when the new commission issues public reports about mental health services?</b>	
Individual service compliance with principles of the Act	74.8%
Sector-wide compliance with principles of the Act	74.8%
Identification and inclusion of family/carers/nominated persons in service design delivery and governance	84.3%
Analysis of reductions in compulsory treatment, including performance of individual services and the sector	74.8%
Analysis of reductions in seclusion and restraint, including performance of individual services and the sector	78.3%
Actions it has taken in response to service non-compliance with human rights obligations under the Act	85.2%
Any investigations, including recommendations and outcomes	77.4%

Table 13 MHWB Commission acting on family concerns

	Yes	No	Not sure
Should the new Commission be able to act on the concerns of family/carers/supporters/nominated persons?	92.2%	0.0%	6.1%



## Appendix H – Nominated Persons

Table 14 Clarification of nominated person in new Act

	Yes	No	Not sure
Should the new Act explain that a nominated person may also be a family member (by birth or choice) but not necessarily?	83.9%	1.8%	12.5%
Should services be required to report on whether nominated persons have been involved in consumer care, according to consumer preferences?	76.8%	0.0%	19.6%

Table 15 Improved description of nominated person in new Act

The new Act might describe nominated persons in a different way.			
Which of the following would improve the description of nominated persons:	Yes, include	No, don't include	Not sure
Nominated persons sign a statement that they understand their obligations	80.4%	0.9%	8.9%
Nominated persons agree to express the views, preferences and values of consumers, not their own personal views and preferences	64.3%	8.9%	16.1%
Nominated persons agree to promote consumer personal and social wellbeing and to have regard to the need to respect consumer individuality	86.6%	4.5%	2.7%
Nominated persons agree to read and understand any advance statement consumers make	85.7%	0.9%	4.5%
Nominated persons agree to provide consumers with support to make their own decisions	85.7%	1.8%	6.3%

## Appendix I – Second Psychiatric Opinion

*Table 16 Considerations around second psychiatric opinion*

<b>The new Act might make changes to how the right to a second psychiatric opinion operates, to try and strengthen the rights of consumers.</b>	
<b>Which of the following options do you think would improve second psychiatric opinions?</b>	
The Second Psychiatric Opinion Service should be run independently of public mental health services.	61.6%
We can see a private psychiatrist of our choice for a second opinion, for free (gov. funded)	69.6%

*Table 17 Access to second psychiatric opinion report*

<b>If you get a second psychiatric opinion, and you give consent, who should a copy be sent to:</b>	
The Independent Mental Health Advocacy (IMHA) service	80.4%
Lawyer (if there is one)	61.6%
The Mental Health Tribunal	67.0%
The registered family/friend/supporter and/or nominated person	92.0%

## Appendix J – New Act review period

Table 18 Time period for review of new Act

<b>The Royal Commission has recommended that the new Act be independently reviewed in 5 to 7 years. This review will look at ensuring the law is contemporary, effective and responsive to people’s needs. Some other recommendations to enhance human rights are suggested for this review. When do you think this more thorough review should happen?</b>	
Right now, in the current review	30.4%
Within 2 years	23.2%
Within 3 years	17.0%
Within 5 years	25.0%
Within 7 years	2.7%