



**Star Health responses to online survey re  
development of:**

***New Mental Health and  
Wellbeing Act***

**July 2021**

## **Introduction & overall comments**

Star Health is a major provider of primary health and community services across the inner and middle south of Melbourne. We offer a variety of services including in the areas of mental health, alcohol and other drugs, homelessness, GP, dental, allied health, chronic disease management, Indigenous health, and family violence. We have a strong focus on social justice, and specialist expertise in engaging high risk and hard to reach cohorts that are marginalised and disadvantaged, using mechanisms such as assertive outreach and community development, to work with local communities to enhance their health and wellbeing.

The below responses to the survey questions draw on feedback from current and previous Star Health consumers, many of who have experienced both voluntary and involuntary acute mental health admissions and treatment orders. The responses also incorporate feedback from experienced clinicians in our Mental Health and Alcohol & Other Drug teams, many of who have worked in both acute and community settings.

Overall feedback:

- Consultation processes in future need to allow sufficient time for consumers as individuals, and services who work closely with consumers, to thoughtfully and meaningfully seek consumers' feedback/ input, in line with the spirit of the Royal Commission's recommendations to ensure that the system is genuinely consumer centred.
- In general, Star Health supports the proposed changes in principle, however stresses that there is a need to ensure that measures (and appropriate resources) are put in place to "fill the gaps" left by these significant policy shifts, to ensure that these changes lead to positive overall outcomes for consumers (rather than net negative unintended consequences). For example:
  - Reducing hospital admissions will mean a greater demand on community mental health services and other "upstream" community supports. Significant additional resources and support will need to be provided to community-based services to ensure that consumers who would otherwise access hospital services do not fall through the gaps. Community health services, such as Star Health, are well-placed to provide such services, particularly through their ability to link consumers to a range of other existing health and wellbeing services and supports.
  - Similarly, a shift to less use of seclusion or restraints (particularly chemical restraints) in inpatient settings will require careful consideration of, and resources for, services to use evidence-based methods to support consumers to de-stress/calm down when distressed, so that there is less need to resort to the use of seclusion and/or restraints to ensure safety (of the consumer and/and staff). Our responses to question 11 below provide some suggestions for such measures as a starting point for this discussion.
- Suggest that there needs to be more clarity and transparency around specific goals (with timelines) that can be mandated and measured/reported on, to ensure these important reforms are translated and embedded in practice.

## A. Objectives and principles of the new Act – p.8

**Question 1:** Do you think the proposals meet the Royal Commission’s recommendations about the objectives and principles of the new Act? (Section 2.1 in the paper – p.9)

YES / NO

- Suggested amendments/improvements outlined in response to the next question.

**Question 2:** How do you think the proposals about objectives and principles could be improved? (Section 2.1 in the paper – p.9)

- **Objective 1 re highest possible standard of wellbeing** – this could more closely align with the spirit of the Royal Commission’s recommendations to reorient the mental health system more holistically. For example, under the point 3 re “providing a diverse range of... services”, this could more clearly articulate aspirations for service provision beyond diversity in the service offering, to: reorienting the system towards more treatment in community settings rather than hospital settings; for treatment to focus on recovery rather than medication and control; and for less clinical/medicalised models of care towards more therapeutic/alternative approaches.
- **Objective 2 re rights and dignity** – suggested amendment: this could be strengthened by adding point re *“ensuring that people who receive mental health treatment under the act do not experience additional distress/trauma as a result of this treatment, but are instead treated with a trauma-informed lens, and as partners in their own care”*. Many of our consumers have described traumatic experiences when being treated under the current act (with some describing instances where they did not know what was happening to them, and/or experiencing use of restraints/seclusion that triggered past traumas) further compounding underlying distress/trauma that contributed to their original admission:
  - It was “frightening and lonely and that it made [them] feel helpless”
  - [I was] “admitted against my will and treated like a criminal”
  - “As a consumer of the public mental health system, I unfortunately have had many traumas revisited after using it, and can no longer rely upon seeking help through the system.”

The new system needs to be underpinned by a trauma-informed approach, and it is critical that this is embedded in key policies such as the new act, from which practice reforms will flow. This sentiment is captured well by a consumer who stated that: “at end of day, when people are given more freedom and respect, they comply more, and it is safer overall for everyone”.

- **Objective 1 or 2** – Building on from the above point, to really contribute to reorienting the system, consideration should be given to these objectives more explicitly referring to the contemporary understanding of the connection between trauma and mental health. That is, it should refer to the need to reframe collective (public and professional) understanding of mental health as a symptom of/natural response to trauma, and responding to it with a

trauma-informed lens rather than from a deficits approach. This would require re-training and application of different models of care.

- **Principle 3 – suggested amendment** re compulsory treatment/restrictive practices only used as a last resort: to embed this principle in a way that is going to set up consumers, services and clinicians for success, this MUST include reference to compensatory measures being put in place to REPLACE the use of these practices, e.g. “Ensure compulsory treatment and restrictive practices are only used as a last resort... **by providing adequate and appropriate resources, support and training to equip services to understand and address consumers’ underlying distress, minimising the need for compulsory treatment/restrictive practices (particularly the use of seclusion and chemical restraints)**”. Further discussion on this principle is in our response to question 11.
- **Principle 5 or 6 – suggested amendment:** more specific reference to increased Therapeutic Communities in the community which are peer-designed and peer-led (with some suggestions that “co-design” is over-used and has become tokenistic). People with lived experience should be designing responses and we should be resourcing the ideas.
- **Principle 7 – suggested amendment:** the inclusion of AOD use is strongly supported, however this principle should go one step further and ensure that those who are engaged in substance use are not restricted from accessing mental health services.
  - Despite many years of attempted service reforms to better integrate these two service systems, and contemporary understanding of substance use often being used as a coping mechanism for underlying distress or trauma, both staff and consumers still report instances of consumers engaged in substance use being denied mental health services. That is, mental health services can require such consumers to “fix” these issues before they are able to access mental health services, with some mental health workers reporting feeling ill-equipped to support these consumers.
  - A dual diagnosis lens is strongly supported and clients with substance use issues and mental health issues should be able to access mental health services, in particular Crisis Assessment Teams and inpatient services. AOD use should not be used as an exclusion criteria and proper assessment should be made regarding the consumer’s presenting needs. Greater dual diagnosis capacity is needed across mental health services and vice versa. The AOD issue generally cannot be resolved independently of the possible mental health/trauma issues precipitating the substance use.
  - Suggested additional sentence: ***“This should include ensuring that those who are engaged in substance use are not prevented from accessing mental health services, but are supported to access mental health services when they need it (e.g. including when substance use is still being used coping mechanism).”***

## **B. Non-legal advocacy, supported decision-making, and information sharing – p.13**

**Question 3:** Do you think the proposals meet the Royal Commission’s recommendations about non-legal advocacy? (Section 3.1 in the paper – p.14)

YES / NO

- Suggested amendments/improvements outlined in response to the next question.

**Question 4:** How do you think the proposals about non-legal advocacy could be improved? (Section 3.1 in the paper – p.14)

- **Overall comments about non-legal advocacy:**
  - Consumers described overwhelmingly positive experiences with the current providers of non-legal advocacy services, Independent Mental Health Advocacy (IMHA), such as reports that engaging with IMHA was the first time on consumer felt they had “someone on [their] team”, though several also described not being aware that this service was available at all.
  - Overall, strong support from consumers & staff about an opt-out rather than opt-in system, especially for when people are too unwell/distressed initiate this themselves.
  - Some suggestions that non-legal advocacy services need to be more adequately resourced to ensure that demand can be met.
  - Consideration also needs to be given to ensuring that consumers still have access to this service when they’re unwell/if they change their mind, as well as during the immediate post-discharge period.
- **Extension of access to/role of non-legal advocacy services for consumers being treated involuntarily:**
  - Whilst an opt-out system is supported by consumers we heard from, some have suggested that even this is not enough – if a consumer cannot decline treatment, then it follows that they would also be unwell enough to make an informed decision regarding using an IMHA.
  - Alternatively, suggest that if a consumer chooses not to engage with IMHA at one point in time, other mechanisms be considered to ensure the consumer still has options to be connected to non-legal advocacy services – e.g. allow IMHA to engage with the consumer’s carer/s, and/or give the consumer time/opportunity to change their mind about their engagement with IMHA. For example, IMHA could be allowed to re-offer the service at different touchpoints in the hospital/process once the consumer has had time to digest information, or they are well enough to make an informed decision.
  - One consumer suggested that IMHA have access to advance statements so they are aware of how best to advocate for the consumer’s preferences.
  - Suggest that IMHA should be allowed/resourced to continue to be involved in discharge planning and post-discharge follow-up (even if no need for engagement during the admission period), as this is where people can fall through the gaps. Some reports have been provided of people experiencing significant distress upon returning home after discharge from acute mental health inpatient admissions, expressing feelings of abandonment and suicidality due to lack of support or access to basic necessities such as fresh food when they get home.

- In terms of post-discharge support, there are some policy issues that need to be addressed to ensure consumers don't fall through the gaps – e.g. for consumers with NDIS psychosocial plans, if they have an NDIS Plan they are usually not eligible for other services. However, there are often instances when consumers have run out of hours in their Plan, leaving them with no services at all. The resultant discontinuity of care can increase the risk of re-admission.
- **Non-legal advocacy for consumers being treated voluntarily:**
  - The right to non-legal advocacy should be extended to people receiving treatment voluntarily (consumers can currently only access non-legal advocacy if they are being treated involuntarily) – with commensurate additional resourcing for IMHA.
  - For example, there are some cases when consumers receiving treatment voluntarily but are also on the cusp involuntary treatment, who might benefit from this service.
  - Staff report that many people receiving treatment voluntarily are unaware of their rights and ability to make treatment decisions for themselves – this can be exploited leading to people who are being treated voluntarily essentially being involuntary
- **Non-legal advocacy service providers:**
  - Consumers reported positive experiences with IMHA in the past, though some have reported that it took too long to access these services or they did not know this service existed. This points to a need for this service to be more adequately resourced and promoted.
  - One consumer suggested that IMHA be resourced to access non-legal advocacy support out of hours (ideally 24/7), as consumers can be admitted out of hours.
  - The consultation paper is unclear about whether or not IMHA will continue to provide these services or if it will be opened up for other service providers to offer non-legal advocacy services (for profit and/or not-for-profit service providers?):
    - As the current sole provider of non-legal advocacy services, IMHA (as part of Victoria Legal Aid (VLA)) partners with VLA's Mental Health and Disability Law team, and can assist consumers with legal advice and represent them at the Mental Health Tribunal when possible.
    - Given the specialist expertise required to undertake this role, and the positive feedback received from consumers who have used IMHA's services in the past, consumers have raised some concerns about opening up this role to other service providers, particularly in terms of the quality of services. If it is the case, strong safeguards must be put in place for any new providers to ensure quality of services, such as audits and checks of these organisations. However, from a quality perspective, it would make more sense to better resource IMHA to expand its existing services.
  - Providers of non-legal advocacy services should ensure that the services provided are culturally appropriate for all client cohorts, particularly for Aboriginal and Torres Strait Islander and culturally and linguistically diverse (CALD) consumers.

**Question 5:** Do you think the proposals meet the Royal Commission’s recommendations about supported decision making? (Section 3.2 in the paper – p.16)

YES / NO

- Suggested amendments/improvements outlined in response to the next question.

**Question 6:** How do you think the proposals about supported decision making could be improved? (Section 3.2 in the paper – p.16)

- **Definition of supported decision-making:**
  - Suggest it needs to be made clearer what supported decision-making is, and how this relates to the more contemporary methodology of shared decision-making, which is underpinned by a set of principles and practices. That is, there needs to be more rigour around the concept of supported decision-making in the act so that it cannot be used as a broad, catch-all term to refer to a range of ways of working that do not genuinely enable consumers to be partners in their care.
  - On the other hand, there needs to be a way of ensuring the consumers understand what this approach means in terms of their expectations. That is, under the current system, any decisions/support from a support person needs to be taken into account by the psychiatrist, who has the final decision-making power (including taking safety into account).
- **Supported decision-making – service provider/workforce skills and capacity:**
  - Several consumers have reported experiencing hospital admissions where supported decision-making principles have not been followed. For example, they have reported not been adequately informed about what is happening to them, nor about their rights or options. Another example is a consumer reporting signing forms to start a new high-risk medication and not being in “the right state of mind” to do this.
  - Consumers we heard from support more protections being put in place to facilitate supported decision-making, particularly around ensuring that they are supported to provide informed consent, and consideration of measures to ensure accountability/enforcement of supported decision-making practices.
  - Suggest that the act also needs to be more specific in ensuring that resources/support is provided to services to embed supported decision-making practices into day to day care, such as funding and mandatory training to all mental health care workers/clinicians. It should not be assumed that all mental health workers/clinicians are trained in these contemporary practices, nor that services have sufficient resources (adequate staffing, etc.) to implement this in practice.
  - Consumer suggestion for a ‘cooling off period’ with regards to decision-making, to allow consumers to be able to change their minds about treatment.
- **Advance statements:**
  - Consumers we heard from are generally supportive of advance statements, however some reported instances where advance statements have not been followed in the past, and have suggested that more robust mechanisms need to be put in place to monitor this.
  - One consumer reported a situation where their advance statement was not followed, and is unsure how effective having a doctor write down their reasons for not following an advance statement will be. Suggests having an independent person reviewing the written reasons as to why an advance statement is not followed may be more effective/transparent.

- Suggestion from a consumer that IMHA have access to advance statements so they are aware of how best to advocate for their preferences.
- Suggest that funding should be made available to service providers to assist in consumer education about advance statements, and provide support/assistance to prepare/complete their own advance statements.
- **Second psychiatric opinions:**
  - Some consumers reported that second opinions have not been followed in the past.
  - Suggestion from a consumer that in instances where consumers clearly do NOT have capacity, and no previously documented advance statement, then:
    - A second psychiatric opinion must also be compulsory. Next of kin should be able to reserve the right to select this secondary consultation.
    - Where it has, and a doctor gives reason for declining it in preference of other compulsory treatment, this treatment should also be approved by a second consultation.
    - If next of kin are not available, there must be a register of psychiatric doctors available to provide this secondary consultation.
    - Where this treatment extends beyond both chemical (antipsychotic/sedative) and/or physical restraint and towards ECT - then this must necessarily require a third specialist to approve.

**Question 7:** Do you think the proposals meet the Royal Commission’s recommendations about information collection, use and sharing? (Section 3.3 in the paper – p.20)

YES / NO

- Suggested amendments/improvements outlined in response to the next question.

**Question 8:** How do you think the proposals about information collection, use and sharing could be improved? (Section 3.3 in the paper – p.20)

- **Consumers accessing own files/information:**
  - Consumers and staff we spoke to were very supportive of consumers being able to easily accessing to their own files/information as a principle.
  - Several consumers reported that the current system takes too long to access information, and some have given up because it is not an easy process. Need to ensure that this process doesn’t come with a huge amount of bureaucracy (like FOI) – should be more of a standard process that is quick and simple, and does not require completion of several forms, etc.
  - Consumers and staff suggest that it would be useful to have systems in place to ensure people aren’t harmed by receiving information about them. Receiving reams of paper in the mail with personal information about oneself (and in some instances including information that a consumer feels is inaccurate, or which describes sensitive/traumatic issues) can be very distressing/confronting. For example, upon releasing such information, it could be offered to a consumer for a support person/advocate is present when the information is received/consumed.
  - Suggestion that consumers be proactively told that they can access their files, because some may not know that this is possible/a right.
- **Sharing of information between providers:**
  - Consumers have raised concerns about diagnostic labels or other information in clinical notes (particularly information that they don’t agree with/ think is inaccurate) impacting on treatment provided by other health services and professionals.
  - Consumers have reported instances where they feel the level of detail in clinical notes/documentation is unnecessary.
  - Consumers report wanting to maintain control over who gets to see their files.
  - Advance statements – consideration should be given to where these are kept and how they can be shared when a consumer becomes unwell, particularly when a consumer may be connected with services from multiple service providers.
- **Clinical documentation standards:**
  - Suggest further support and training for mental health workers/clinicians about how to write clinical notes so they are appropriate/sufficient to meet clinical needs, but are also recovery-focussed in nature to ensure they are appropriate to be read by consumers at the same time (particularly in terms of documenting trauma/abuse/grief).

## C. Treatment, care and support

**Question 9:** Do you think the proposals meet the Royal Commission’s recommendations about **reducing the use and negative impacts of compulsory assessment and treatment?** (Section 4.1 in the paper – p.25)

YES / NO

- Strong support from consumers and staff in principle. As per earlier responses, it critical to ensure compensatory measures are put in place to ensure that this policy shift does not result in net negative (unintended) outcomes for consumers.

**Question 10:** How do you think the proposals about **compulsory treatment and assessment could be improved?** (Section 4.1 in the paper – p.25)

- **Overall comments re changes to use of compulsory treatment:**
  - General support from consumers and staff who agreed compulsory treatment orders should only be used when people are genuinely a risk to themselves or others.
  - The Mental Health Tribunal’s role, particularly in relation to compulsory treatment, needs review and potential reform in terms of its transparency and reporting.
  - The Royal Commission’s report mentions aspirations for reducing compulsory treatment over, say a five-year period. Victoria has very high rates of compulsory treatment, including for ECT. There should be clear, mandated, and timely reporting and evaluations to achieve meaningful reductions in compulsory treatment. These should be driven by the other structural reforms that are outlined in the proposals.
- **Changes to compulsory treatment:**
  - Consumer concerns that this change may make health professionals hesitant to give compulsory treatment where appropriate for fear of second guessing or undermining their authority – there is a fine line between appropriate care and taking “the easy road”. Measures need to be put in the place to support “appropriate” decision-making.
  - A consumer has reported that they have witnessed numerous cases where individuals on treatment orders are not followed up with properly (by health professionals) to their detriment (as well as that of those they live with). The act needs to recognise that treatment without monitoring and very regular follow up can have detrimental impacts.
  - Currently, the Mental Health Tribunal can make orders of any time (up to 12 months), with one consumer suggesting 12 months is too long for any person to be on an order for, and that a shorter maximum period for orders (e.g. 6 months) should be considered.
  - Consumers should be supported to have their treatment orders revoked (i.e. supported to be in a position where it is no longer required). Service providers should be required to demonstrate/document/evidence how they have supported consumers to address the reasons why they are on an involuntary order, so that consumers are not on orders for longer than they need to be.

- **Proposed changes to who can impose compulsory treatment:**
  - The proposal to increase the range of clinicians who can impose compulsory treatment (beyond psychiatrists) is NOT supported. Both consumers and staff raised concerns about the proposal to permit a broader range of professionals to authorise temporary treatment orders, such as nurse practitioners and social workers (in addition to doctors/psychiatrists) – with most NOT supporting the proposal, indicating that only psychiatrists should be able to make decisions about compulsory treatment.
  - If it was to proceed, significant caution would need to be taken to ensure it was accompanied by very well-considered and robust safeguards – such as mandatory training and/or credentialing for staff whose roles will be expanded to include ability to authorise temporary treatment orders.
  - Instead, suggest that as decision-makers, psychiatrists should be encouraged/enabled to gather as much information as possible via integrated and collaborative approaches with the consumer’s supports, who may have more extensive experience working with that person (e.g. community mental health and/or AOD workers, as well as family and carers), ensuring decisions are as well-informed as possible, rather than relying on one assessment.
  
- **Ensure that there are other options to fill the gaps left by less use compulsory treatments**
  - Again, reducing the reliance on community treatment orders will require an increase in provision of other services to support consumers who may otherwise require this approach.
  - For example, there should be resourcing and support for more step up/step down options. Currently there are few options and it is generally only when someone is so unwell they meet CATT or hospital admission criteria that they can get access to treatment. The systems needs to be designed and resourced to respond before they get that unwell, as recovery is much longer and harder for those who are left to deteriorate (without any support) until they are unwell enough to access more acute treatment.
  - There needs to be more intermediate care options, for example Prevention and Recovery Centres (PARC) or residential mental health respite facilities, as well as more funding for assertive outreach models of care, to reduce admissions into acute settings.

**Question 11:** Do you think the proposals meet the Royal Commission’s recommendations about reducing the use and **negative impacts of seclusion and restraint, and regulation of chemical restraint?** (Section 4.2 in the paper – p.29)

YES / NO

- Suggested amendments/improvements outlined in response to the next question.

**Question 12:** How do you think the proposals about seclusion and restraint could be improved? (Section 4.2 in the paper – p.29)

- Strong in-principle support from consumers and staff about less reliance on seclusion and restraints, with some consumers suggesting that restrictive practices should be completely abolished, whilst others acknowledging that there are some situations when they may still be needed (“should only be used to stop you hurting yourself or others”).
- A suggestion for clearer goals, timelines, and mandated reporting on this goal to ensure that this important change is realised.

- **Inappropriate use and/or over-use of seclusion and restraints:**
  - Some consumers have reported seclusion being used as punitive treatment (even for past events instead of being a current/present threat to staff) instead of for the current safety of them/others – this needs to be addressed.
  - Consumers have reported being coerced into compliance with the threat of a restraint (with the aim of not using it) or threatened with seclusion when reporting physical symptoms as a result of medication (e.g. leg shaking/anxiety) – describing this as unethical and traumatising for some, particularly for consumers with PTSD.
  - Reports that coercive behaviour is prevalent in clinical settings, both in the EDs and Inpatient Units, and needs to be addressed. There needs to be education, research, and evaluations conducted to assess how this type of practice can be reduced. Consumers regularly refer to this, particularly in relation to the perceived threat of being placed on treatment orders.
  - Consumers also report that chemical restraints are often over-used. Many believe that the usage is often a case of workforce convenience particularly re the use of PRNs (that is, medications used as the circumstances arise) at nighttime, when minimal staff are rostered on. This is particularly relevant in the aged psychiatry sector.
  - Some consumers have reported that there was no support to address anxiety that people can often experience in that setting.
  
- **Consent and accountability:**
  - Consumers report the seclusion can be frightening or traumatic, describing often not understanding what was happening or when the seclusion would end, indicating that there needs to be more steps taken prior to secluding someone, and helping people to understand what is happening to them and why.
  - Suggestion that the process needs more accountability – e.g. require an independent party to review the decision to seclude someone to ensure it is appropriate/consistent with the act.
  
- **Ensure that there are other options to fill the gaps left by less use of seclusion and restraints:**
  - To make sure services are equipped (incl. time, resources and skills) to understand and address consumers' underlying causes of distress to help them to calm down and not have to resort to the use of seclusion and restraints.
  - Some quotes from consumers that provide examples of distress that could be de-escalated in ways that precludes the need for seclusion or restraints:
    - “in the hospital, no-one tries to calm people down when they are anxious”
    - after being put in a hold “no one explained it to me, I wanted to leave, become angry when I couldn’t do so, then had a code grey called on me”.
  - Both staff and consumers have pointed to a lack of resourcing and staff burn out as a factor contributing to over-use of seclusion/restraints (i.e. limited time/energy/patience of staff to spend supporting a distressed consumer to calm down). Addressing staff wellbeing, happiness and resourcing needs is important to ensure high quality services.
  - Another example of reasons for distress is what clinicians have described as instances of consumers not being given access to cigarettes (used as a coping mechanism by some), which can lead to an escalation in stress and violence, resulting in restrictive practices (e.g. seclusion) being used which they otherwise would not be needed. Hospitals need to have better ways of managing this rather than taking away rights/preventing use of effective coping strategies (such as cigarettes) completely.

- Other examples of potential alternatives to seclusion/restraint that could be put in place to support consumers to minimise distress:
  - Access to sensory rooms and other quiet spaces (e.g. libraries, gardens, music rooms) – places to de-stress. This must be made a priority in the improvement/design of existing and new acute mental health facilities, if a significant reduction in the use of seclusion and restraints is to be achieved.
  - Resourcing for dedicated staff who are trained and have the remit/time to support consumers who are distressed to help them calm down.

**Other feedback about treatment, care and support:**

- **Leave** – Consumers have described the leave process and how difficult it can be to access leave as an inpatient. Suggest further protections for leave when people are admitted to hospital under the new act.
- **Gender specific wards** – Gender specific wards (not just wings that are still accessible) should be considered. Many consumers speak of being retraumatised and entering into or being coerced into sexual relationships when they are unwell and unable to properly consent.
- **Borderline Personality Disorder (BPD)** – Increased recognition and tailored response to clients with BPD diagnosis is needed. It is listed and recognised in DSM but very poorly responded to by Crisis Assessment and Treatment Teams (CATT), Emergency Departments (ED) etc., and is still a very stigmatised diagnosis.
- **Post-discharge/transition back home after inpatient admissions** – Reports of people experiencing significant distress upon returning home after discharge from acute inpatient settings, expressing feelings of abandonment and suicidality due to lack of support or access to basic necessities such as fresh food when they get home. This needs to be addressed.
- **Aged Care Psychiatric Services** – Our ageing population means that demand for services in this sector are growing as we speak, and proactive planning is not evident. There are already many people finding gaps in access to mental health services in this sector, and this did not receive detailed attention in the Royal Commission’s report, other than broad statements. Again, this is an area that community health service providers should be resourced to address, when the implementation process begins.

## D. Governance and oversight

**Question 13:** Do you think the proposals meet the Royal Commission’s recommendations about governance and oversight? (Section 5.1 in the paper – p.36)

YES / NO

- Suggested amendments/improvements outlined in response to the next question.

**Question 14:** How do you think the proposals about governance and oversight could be improved? (Section 5.1 in the paper – p.36)

- Staff and many of the consumers we heard from support the principle of increased transparency and accountability.
- Some consumers have questioned if a new body will actually ensure accountability or good outcomes for consumers and their families. Suggestion to instead consider better using resources/mechanisms already in place instead of creating a new body (which will itself require significant resources that could otherwise be redirected to direct service delivery).
- If a new body is created, consumers have suggested that it needs to ensure that investigations are thorough and hold mental health professionals to account for quality of care (and the body needs adequate resources to facilitate this approach).
- Consumers have suggested that access to such a body needs to be accessible, in terms of the language used (plain language and/or consumer appropriate language – particularly important to enable access for consumers when their mental wellbeing is fluctuating).
- This body should be efficient in the way it deals with complaints (ensure no long wait times).
- If a new body is created, suggestions for it to have more clearly articulated, regular reporting requirements (e.g. quarterly) and be more transparent than the existing Mental Health Complaints Commission.
- Suggest that reporting frameworks should be designed in a way that ensure transparency, but also ensure that there is a clear purpose for all information/data requested from service providers (e.g. data that is directly used to improve services for consumers). Information collected without a clear purpose (and ultimately not used to inform policy or system improvements) unnecessarily increases the reporting burden on service providers, instead redirecting resources away from direct service delivery.
- Suggest that measures need to be put in place to ensure funders work collaboratively with service providers to ensure high quality services are being delivered – recent years have seen a stronger emphasis on “contract management” over collaboration, and more punitive approaches which lose sight of the broader objectives which both funders and services are both ultimately trying to achieve (improved health and wellbeing outcomes for all Victorians).