



Mental Health & Wellbeing Act: update and engagement paper

**Response from the Women's
Mental Health Alliance**

August 2021

Introduction

The [Women's Mental Health Alliance](#) (the Alliance) welcomes the opportunity to contribute to the development of the new Mental Health & Wellbeing Act (the Act) through this response to the Update and Engagement Paper. This submission has been drafted by Women's Health Victoria with input from members of the Alliance. While it reflects the collective views of the Alliance on priority issues, it may not fully reflect the views of each individual member organisation, some of whom are also making their own submissions.

The Alliance was established by Women's Health Victoria in 2019. It is made up of over thirty organisations and individuals who provide expert advice to policy makers and health services on the mental health of women and girls, and undertake advocacy to ensure all women have access to evidence-based, gender-sensitive and trauma-informed mental health support. The Alliance works to ensure the voices of women with lived experience are centred in policy, advocacy and service delivery. The Alliance brings together consumer and carer advocates, service providers, clinicians, women's health organisations, human rights bodies and researchers.

While we recognise the significant time constraints imposed by the recommendations of the Royal Commission into Victoria's Mental Health System regarding a new Act, we note with some disappointment that the implementation process for this first major reform has not aligned with key principles and recommendations arising from the Royal Commission regarding co-design with people with lived experience of mental illness and psychological distress.

Given the significant human rights implications of this legislation and the challenges associated with commenting on broad proposals rather than specific legislative drafting, **the Alliance recommends that the Victorian Government release an exposure draft for further consultation**, as occurred with the *Gender Equality Act 2020*.

We also note the limitations around this consultation; it is not a review of the *Mental Health Act 2014* per se, but rather a consultation on whether the proposed changes align with the Royal Commission's recommendations. However, in many cases, the Royal Commission did not provide clear or detailed guidance or recommendations for change. Where this is the case, the Alliance has provided advice based on its expertise and our understanding of the broader intent of the Royal Commission's reforms.

It is also critical to note that while there are substantial improvements to be made to the legislation itself, a key failure of the current legislative framework has related to its implementation. This means that the new Act will require: more effective regulation and oversight, as outlined in the 'Governance and oversight' section of this submission; additional resourcing to reduce pressure on mental health services and enable them provide treatment and support in a non-coercive manner; and significant attention to supporting implementation through the development of standards, guidance and workforce development and ensuring these are also adequately resourced. The

Alliance also notes that the new Act will apply across *all* mental health and wellbeing services. Specific sector briefings and guidelines to help organisations understand any new obligations will be much needed, and welcomed, to ensure the Act is implemented in a manner which sees its principles and objectives realised.

Summary of key recommendations

The Alliance recommends that:

- the Victorian Government release an exposure draft Bill for further consultation

Objectives and principles

- the new Act require mental health services to proactively consider human rights when making decisions or taking actions
- reduction in the use and duration of compulsory treatment and elimination of seclusion and restraint be stand-alone objectives of the Act
- the objectives and principles incorporate an explicit focus on addressing the social and other determinants of mental ill-health, including gender, and require mental health services to recognise and address the impacts of inequality and discrimination on mental health, including structural inequalities, assumptions and biases that influence individuals' mental health and access to and experiences of the mental health system
- the right to safety (from others) be strengthened in the objectives and principles
- an additional sub-objective highlighting the importance of early intervention be included
- an additional principle be included that specifies that voluntary treatment is always preferred, even where someone meets the criteria for compulsory treatment
- Principle 7 be expanded to require mental health services and decision-makers to take into account – and ensure women are fully informed about – the impacts of mental health treatment on physical health
- Principle 9 be strengthened to read: *Recognise that people receiving mental health and wellbeing services, their family, carers and supporters may have specific gender-related ~~safety~~ needs and experiences and ensure that services are provided in a manner that: is safe and responsive to histories of gendered violence and trauma, including family and sexual violence; recognises how gender dynamics can affect risk factors, diagnosis, service use and experience, treatment and recovery; and recognises how gender inequality intersects with other types of discrimination and disadvantage.*
- provision of trauma-informed mental health services be included as a stand-alone principle

Supported decision-making

- further consideration be given to ensuring safeguards are in place to address the risk of coercion in relation to supporting decision-making arrangements (nominated persons)

Information-sharing

- the new Act align with the prescribed responsibilities of mental health services under the Family Violence Multi-Agency Risk Assessment and Management Framework (MARAM) and the Family Violence Information Sharing Scheme
- consumers experiencing family violence have the power to exclude people from receiving information from, and providing information to, a mental health service.

Compulsory treatment

- close consideration be given to any unintended consequences of removing the 'serious deterioration' criterion in relation to consumers who are severely unwell due to an eating disorder, and targeted consultation be undertaken with people with lived experience of eating disorders, their families and carers, and clinicians and service providers with expertise in this area, to ensure sufficient safeguards are in place to protect the lives and health of consumers who are severely unwell with an eating disorder

Seclusion and restraint

- the timeline for elimination of seclusion and restraint be shortened to a maximum of five years
- an intersectional gender lens be applied to any measures implemented to reduce the use of seclusion and restraint

Governance and oversight

- all data collected, analysed and published on use of compulsory treatment, seclusion and restraint be disaggregated by gender and ideally other demographic characteristics, including age and cultural background
- the role/function of the Mental Health & Wellbeing Commission in monitoring and reporting on gender-based violence be explicitly included in the new Act
- the Mental Health & Wellbeing Commission report annually on incidents of gender-based violence at system-wide and service level
- mental health services and decision-makers be subject to similar requirements to defined entities under *the Gender Equality Act 2020* (Vic), including being required to make 'reasonable and material progress' against the principles, and system-wide targets for

reducing the use and duration of compulsory treatment and eliminating seclusion and restraint, consistent with the approach used in the *Gender Equality Act 2020* (Vic)

- the Mental Health & Wellbeing Commission be granted powers similar to those of the Commissioner for Gender Equality in the Public Sector under the *Gender Equality Act 2020* (Vic)
- the Mental Health & Wellbeing Commission be empowered to impose or recommend more severe penalties in cases of serious or repeated breaches of the Act, including deregistration and/or defunding of services
- the Mental Health & Wellbeing Commission have stronger powers to initiate systemic reviews and take effective action to address breaches of the Act identified through those reviews
- the Mental Health & Wellbeing Commission have the power to intervene where there is evidence of imminent or ongoing breach of the Act
- at least 50% of the Mental Health & Wellbeing Commissioners have lived experience of mental illness or psychological distress
- the Boards and senior management of the Mental Health & Wellbeing Commission and other key regulatory, oversight and research bodies – including Regional Boards and the Collaborative Centre – comprise at least 50% women, with provision also made for representation of gender diverse and non-binary people
- the new Mental Health and Wellbeing Promotion Office and its key functions be legislated to ensure primary prevention of mental ill-health is prioritised
- the Alliance be consulted on separate legislation being drafted to establish the Collaborative Centre.

The Alliance does not currently have any Aboriginal and Torres Strait Islander individual or organisational members. The Alliance supports self-determination by Aboriginal and Torres Strait Islander people and defers to the expertise of Aboriginal community-controlled organisations in relation to proposals relating to Aboriginal and Torres Strait Islander mental health and recovery.

Proposed objectives

The Alliance notes the important role of legislation as an enabler for cultural and political change. As the Royal Commission observed, 'if properly implemented, the law can lead to new standards and ways of doing things that are in line with current values, human rights and the best available evidence'.¹ Because it is neither possible nor desirable to legislate every aspect of the reforms, it is essential to ensure that the objectives and principles of the Act set clear expectations and standards for a new mental health system and are accompanied by strong compliance measures, as outlined further below under 'Governance and oversight'.

The Alliance agrees with the Victorian Mental Illness Awareness Council (VMIAC) that the proposals in the consultation paper do not adequately embed a human rights approach. The Royal Commission specifically named the Victorian *Charter of Human Rights and Responsibilities Act 2006* as a 'relevant framework to draw on' in designing the new Mental Health & Wellbeing Act,² but this is not reflected in the proposals. We support submissions from VMIAC, the Law Institute of Victoria and others in **recommending that the new Act require mental health services to proactively consider human rights when making decisions or taking actions.**

In addition, **the Alliance supports VMIAC's recommendation that reduction in the use and duration of compulsory treatment and elimination of seclusion and restraint be stand-alone objectives of the Act.** The overuse of compulsory treatment and restrictive practices in Victoria is a core focus of the Royal Commission's recommendations for the new Act.

The Alliance makes further recommendations for strengthening the proposed objectives below.

Objective 1: Achieve the highest attainable standard of mental health and wellbeing for the people of Victoria

The Alliance supports the proposed objective of the Act to 'achieve the highest attainable standard of mental health and wellbeing for the people of Victoria'.

The Royal Commission described a fundamental shift in the focus of the mental health and wellbeing system towards promoting and delivering good mental health and wellbeing as being 'at the heart' of its reforms.³ The Alliance strongly supports the sub-objective 'Promoting conditions in which people can experience good mental health and wellbeing'.⁴

- The Royal Commission noted that the current Mental Health Act 'embeds a dominant biomedical model that does not consider the social factors that affect mental health and

¹ Royal Commission into Victoria's Mental Health System (2021), Final Report, Volume 4, p 35.

² Royal Commission into Victoria's Mental Health System (2021), Final Report, Volume 4, p 42.

³ Royal Commission into Victoria's Mental Health System (2021), Final Report, Volume 1, p 142.

⁴ For further information about the need for a strong focus on primary prevention and the social determinants of mental health, including gender inequality, please refer to the submission from Women's Health in the South-East (WHISE).

wellbeing'⁵ and recommended that approaches to mental health promotion and primary prevention should concentrate on 'reducing inequities in mental health and wellbeing outcomes'.⁶ In this context, **we recommend that this sub-objective incorporate an explicit focus on addressing the social and other determinants of mental ill-health, including gender inequality and other forms of inequality and discrimination.** For example, the draft *National Preventive Health Strategy 2021-30* refers to the need to address social, environmental, structural/political, economic, cultural, biomedical and commercial determinants of health.⁷

The Royal Commission recognised the importance of early intervention and noted that it is associated with both improved consumer outcomes and substantial cost savings, but that it is often difficult to access or unavailable in the current system: 'Systemic failures mean that consumers are often unable to access services at a time when treatment, care and support would make the greatest difference.'⁸ To ensure it is prioritised by both system managers and service providers, **the Alliance recommends the inclusion of an additional sub-objective that highlights the importance of early intervention, for example: 'intervening early in life, early in onset of mental illness, and early in episode'.**

We support the sub-objective 'Reducing inequities in access and the delivery of mental health and wellbeing services'. This aligns strongly with the Royal Commission's focus on addressing inequities in mental health and wellbeing.

- The Royal Commission's report emphasises the importance of addressing the social determinants of mental health in order to address inequities in mental health outcomes.⁹ For example, financial or housing insecurity presents a barrier to accessing mental health services. **The Alliance recommends that this sub-objective include explicit reference to addressing the social and other determinants of mental ill-health in order to reduce inequities in access and delivery.** We note that the draft *National Preventive Health Strategy 2021-30* refers to the social, environmental, structural/political, economic, cultural, biomedical and commercial determinants of health.¹⁰
- There is a risk that this sub-objective will be interpreted as referring only to 'physical' access and geographic distribution of services. However, barriers to service access include a broad range of factors related to inequality and discrimination, including gender unequal norms, practices and structures, and cis-normative and heteronormative assumptions and

⁵ Royal Commission into Victoria's Mental Health System (2021), Final Report, Volume 4, p 34.

⁶ Royal Commission into Victoria's Mental Health System (2021), Final Report, Recommendation 2.

⁷ Australian Government Department of Health (2020), [National Preventive Health Strategy \(consultation draft\)](#).

⁸ Royal Commission into Victoria's Mental Health System (2021), Final Report, Volume 1, p 313.

⁹ Royal Commission into Victoria's Mental Health System (2021), Final Report, Volume 1, p 155.

¹⁰ Australian Government Department of Health (2020), [National Preventive Health Strategy \(consultation draft\)](#).

discrimination. *For example, gendered norms include dismissive attitudes towards women who present with suicidal and self-harming behaviours; gendered practices include failure to screen for and appropriately respond to experiences of gendered violence and offering a narrow range of treatment options that don't meet the needs of women; and gendered structures include failing to provide a safe environment for women, trans and gender diverse people.* **The Alliance recommends that 'inequities in access and delivery' be broadly defined in the Act to include addressing all barriers to service access including those related to inequality and discrimination**, including but not limited to: cost, geographic location/ distribution, transport options, gender safety and responsiveness, cultural safety and responsiveness, providing a range of treatment and support options, access to peer workers/peer support, access to bilingual/bicultural workers, access to child care, visa restrictions/entitlements, physical accessibility for people with disabilities, access to information in community languages and accessible formats, access to interpreters (both for people with disabilities and people who speak languages other than English) including interpreters of a chosen gender, digital literacy and internet access, coordination with other health and support services, and addressing dismissive, discriminatory and stigmatising attitudes and practices to ensure services are welcoming for all users. At a minimum, statutory guidance should be provided which defines 'inequities in access and service delivery' as outlined above.

We support the sub-objective 'Providing a diverse range of comprehensive, compassionate, safe and high quality mental health and wellbeing services'. In particular, the Alliance welcomes the inclusion of safety as a critical aspect of service delivery, given women's experiences of violence within mental health services.¹¹

We support the sub-objective '[services that] respond to the needs and preferences of people and delivered in a timely and accessible way'.

- The Alliance notes that current approaches to care, treatment and support are based on practice, research and evidence that has systematically excluded women, gender diverse people and other marginalised populations.¹² This means that in order to respond to the needs and preferences of all service users, **gaps in the mental health system's understanding of and capability to respond to the needs and experiences of population groups who have historically been under-served, including women, must be addressed through investment in research, workforce development and organisational culture change.** In line with our recommendation above, the Alliance also recommends that 'accessible' be broadly defined to include addressing all barriers to service access, including

¹¹ See, for example, Mental Health Complaints Commissioner (2018), [The right to be safe: Ensuring sexual safety in mental health inpatient units – sexual safety project report](#).

¹² Kulkarni, J (2014), [Women's mental health: Still not a priority, still not good enough](#) in *Australian and New Zealand Journal of Psychiatry* 48(8):701-704.

those related to inequality and discrimination, including gender unequal norms, practices and structures.

We support the sub-objective '[services that] connect and coordinate with other support services to respond to the broad range of circumstances that influence mental health and wellbeing'. This aligns closely with the Royal Commission's emphasis on the importance of addressing the social determinants of mental health in order to address inequities in mental health outcomes. For example, the underlying cause of a person's psychological distress or mental illness may relate to their social and economic circumstances, for example, financial insecurity or loss of employment, housing instability or experiences of abuse and violence. Mental healthcare on its own will not be sufficient to support a person's mental health and wellbeing in an effective and sustainable way.

- The Alliance highlights the importance of **ensuring connection and coordination of mental health services with services supporting victim-survivors of gendered violence (including family and sexual violence), including as part of Regional Multi-Agency Panels.**¹³
- **The Alliance recommends that this sub-objective extend beyond *connecting and coordinating with other support services* and incorporate holistic and multidisciplinary approaches to care, treatment and support.** Women in particular have called for services that prioritise understanding mental distress in the context of their lives and enable all dimensions of problems experienced to be addressed, including both physical and mental health, as well as other problems and experiences, such as family violence and legal issues.¹⁴

We support in principle the sub-objective '[services that] recognise and respond to the diverse backgrounds and needs and of the people who use them, including those related to age, disability, culture, neurodiversity, language, communication, religion, race, gender, gender identity, sexual orientation or other matters'. A mental health system that better responds to the needs and experiences of all Victorians is essential for increasing equity in mental health outcomes.

- It is important to recognise that inequities of need, access and outcome arise not from a person's 'social identity', but from structural inequalities and experiences of discrimination. A 'diversity' lens also fails to recognise that people experience multiple and compounding forms of inequality and discrimination at the same time (for example, racism, sexism and homophobia) and that this experience is indivisible. Further, a 'diversity' lens positions everyone who is not white/male/cisgender/heterosexual/able-bodied or otherwise 'mainstream' as 'other'. **The Alliance recommends that this sub-objective be amended to**

¹³ It should be noted that this term is likely to be confused with Family Violence Risk Assessment and Management Panels (RAMPs), upon which area mental health services are represented. The Department may wish to consider changing the name of this mechanism.

¹⁴ Australia's National Research Organisation for Women's Safety (2020), [Violence against women and mental health](#) (ANROWS Insights, 04/2020); Tseris, E. (2013), Trauma Theory Without Feminism? Evaluating Contemporary Understandings of Traumatized Women. *Affilia-Journal of Women and Social Work*, 28(2), 153-164.

ensure that any approach to recognising and responding to the diverse needs of service users is underpinned by an understanding of the impacts of inequality and discrimination on mental health and – in addition to ensuring services are responsive to people's needs and experiences – also addresses the structural and systemic inequalities, assumptions and biases that influence individuals' mental health and access to and experiences of the mental health system. This should focus on addressing inequality at a structural level within the mental health system, rather than individualised approaches that aim to 'fix' or 'empower' the individual to access a system that marginalises their needs and experiences or sees their needs through the lens of 'other'. This will require the development of both tailored responses and inclusive mainstream services and must be supported by system- and workforce capability building.

- Given current inequities in access to services, the Alliance suggests consideration be given to amending the wording from 'people who use [mental health services] to 'people who need or want to use [mental health services]' (or similar).
- The Alliance also supports Tandem's recommendation that this sub-objective be expanded to include recognising and responding to the diverse backgrounds and needs of the family/carers and supporters of people who use mental health services.

Objective 2: Protect and promote the rights and dignity of people living with mental illness or psychological distress

The Alliance supports the proposed objective of the Act to 'protect and promote the rights and dignity of people living with mental illness or psychological distress'. However, **we recommend that this objective be amended to include protecting and promoting the safety of people living with mental illness or psychological distress.** There is a long history of women experiencing gendered violence within mental health facilities, as recognised in Chapter 10 of the Royal Commission's report and Recommendation 13. In this context, the Alliance believes explicit inclusion of a commitment to safety in the objectives of the Act is desirable. It will be important to ensure that the right to safety is articulated in a way which focuses on respecting and promoting rights and freedoms rather than through the language of 'protection' and 'vulnerability', which further disempowers people.

The Alliance supports the sub-objective 'providing people living with mental illness or psychological distress with assessment and treatment in the least restrictive way possible with the least possible restrictions on human rights and human dignity'.

- Trauma in childhood and/or adulthood is a key social determinant of women's mental health.¹⁵ Seclusion and restraint risks retraumatising women and girls who have previously

¹⁵ Mental Health Complaints Commissioner (2018), [The right to be safe: Ensuring sexual safety in mental health inpatient units – sexual safety project report](#), pp 50-51.

been subject to trauma, including abuse and sexual violence.¹⁶ The Royal Commission acknowledged the role of seclusion and restraint in creating and perpetuating consumers' trauma and recommended its elimination on this basis.¹⁷ Recognition of the ways in which use of restrictive interventions can retraumatise consumers should be central to any efforts to eliminate their use. **The Alliance recommends that provision of trauma-informed mental health services be explicitly included in this sub-objective or as a stand-alone sub-objective.** Trauma-informed care 'seeks to create safety for patients by understanding the effects of trauma and its close links to health and behaviour'.¹⁸ It should be noted that trauma-informed care extends beyond individual practice to the whole organisation 'from the environment to the reception staff' and incorporates integrated care across services, recognising women's complex needs (mental health problems, family and sexual violence, child abuse, war- and migration-related trauma, alcohol and drug issues).¹⁹

The Alliance supports the sub-objective 'recognising, respecting and accepting the right of people living with mental illness or psychological distress to speak and be heard in their own voices, from their own direct experience, and from within their own communities and cultures'.

- We note that this must include addressing entrenched biases and power imbalances within the mental health system and broader society that present a barrier to people with lived experience exercising these rights. **The Alliance recommends strengthening the wording of this sub-objective to include 'enabling' people with lived experience to speak and be heard,** which might include actively incorporating practices that aim to mitigate and redistribute power.

The Alliance supports the remaining sub-objectives under Objective 2.

Objective 3: Recognise and promote the role of families, carers and supporters in the care, support and recovery of people living with mental illness or psychological distress.

The Alliance endorses this objective, but supports Tandem's recommendation that it **be strengthened through inclusion of the words 'active support', that is, the objective should be to 'recognise, promote and actively support the role of families, carers and supporters...'**

¹⁶ Juliet Watson et al (2020), [Preventing Gender-based Violence in Mental Health Inpatient Units](#) (ANROWS).

¹⁷ For example: Royal Commission into Victoria's Mental Health System (2021), Final Report, Volume 4, p 304.

¹⁸ Kelsey Hegarty et al (2017), [Women's Input into a Trauma-informed systems model of care in Health settings: The WITH study – Final report](#) (ANROWS), p 1.

¹⁹ Kelsey Hegarty et al (2017), [Women's Input into a Trauma-informed systems model of care in Health settings: The WITH study – Final report](#) (ANROWS), p 3-5.

Proposed principles

The proposed principles do not generate clear responsibilities for mental health services to act in a way that is compatible with human rights. The Alliance recommends that the new Act replicate the model in section 38(1) of the *Charter of Human Rights and Responsibilities Act 2006*, which makes it unlawful for a public authority to act in a way that is incompatible with a human right or, in making a decision, to fail to give 'proper consideration' to a relevant human right.²⁰ This would entail:

- identifying human rights that are relevant to the act or decision at hand
- if there are rights relevant to the act or decision at hand, considering whether they are being limited by the proposed action or decision
- considering the possible impact of a decision on a person's rights
- assessing whether any limitations on rights are reasonable, justified and proportionate (in making this assessment, a range of factors may be considered or balanced against one another; for example, whether there are competing rights and interests, public interest considerations, or less restrictive approaches that could be used to achieve the sought objective).²¹

The Alliance also notes that the principles only appear to apply to mental health 'services' and decision-makers. As noted above, the proposed objective of the Act to 'promote good mental health and wellbeing' requires addressing the social, environmental, structural/political, economic, cultural, biomedical and commercial determinants of mental health, which must involve systems and sectors outside mental health. However, there does not appear to be any mechanism for enabling or operationalising this within the new Act.

The Alliance makes further recommendations for strengthening the proposed principles below.

Principle 1: Respect and promote the rights, dignity and autonomy of people living with mental illness or psychological distress and empower people to exercise those rights.

As noted in relation to Objective 2 above, **the Alliance recommends that promoting the safety of people living with mental illness or psychological distress also be included in this principle.**

Principle 3: Ensure compulsory treatment and restrictive practices are only used as a last resort.

The Alliance supports VMIAC's recommendation that a principle be added that specifies that voluntary treatment is always preferred, even where someone meets the criteria for

²⁰ *Charter of Human Rights and Responsibilities Act 2006 (Vic)*, section 38(1).

²¹ *Bare v Independent Broad-based Anti-Corruption Commission* (2015) VSCA 197; *Certain Children v Minister for Families and Children (No 2)* [2017] VSC 251 [177]; *Castles v Secretary of the Department of Justice* (2010) 28 VR 141; [2010] VSC 310.

compulsory treatment. The Alliance also supports VMIAC's recommendations around defining 'last resort'.

Principle 7: Recognise and respond to the medical and other health needs (including any related to the use of alcohol and other drugs) of people living with mental illness or psychological distress and consider and respond to the ways in which these needs may affect their mental health and wellbeing and use of services.

The Alliance supports this principle. We also note the bi-directional relationship between physical and mental health and the impact that some mental health treatments can have on women's physical health, including weight gain, diabetes, sexual health and infertility.²² **We recommend that this principle be expanded to require mental health services and decision-makers to take into account – and ensure women are fully informed about – the impacts of mental health treatment on physical health.**

Principle 8: Recognise that people receiving mental health and wellbeing services may have specific diversity-related needs and experiences (as to age, disability, neurodiversity, culture, language, communication, religion, race, gender, gender identity, sexual orientation or other matters) and ensure that services are provided in a manner that is safe, sensitive and responsive to these needs and experiences and upholds people's rights.

The Alliance supports this principle, but reiterates the importance of recognising that inequities of need, access, experience and outcome arise not from a person's social identity or 'diversity-related needs', but from structural inequalities and experiences of discrimination. **The Alliance recommends that this principle be amended to recognise the impacts of inequality and discrimination on mental health – and in addition to ensuring services are provided in a manner that is safe, sensitive and responsive to people's needs and experiences – also addresses the structural and systemic inequalities, assumptions and biases that influence individuals' mental health and access to and experiences of the mental health system.** We also note that trauma history has been included in this list of 'diversity-related needs and experiences' on page 30 of the consultation paper, but has not been included in the proposed principle itself. The Alliance supports the inclusion of trauma history in this principle as well as recommending trauma-informed practice be included as a stand-alone principle.

The Alliance supports Tandem's recommendation that this principle be expanded to include family, carers and supporters.

Principle 9: Recognise that people receiving mental health and wellbeing services may have specific gender-related safety needs and experiences and ensure that services are provided in a manner that: is safe and responsive to histories of family violence and trauma; recognises how gender

²² See, for example, Frankenburg, F. R., & Zanarini, M. C. (2006), Obesity and obesity-related illnesses in borderline patients. *Journal of Personality Disorders*, 20, 71–80.

dynamics can affect service use, treatment and recovery; and recognises how gender intersects with other types of discrimination and disadvantage.

The Alliance welcomes and strongly supports the inclusion of a principle on gender-responsive services. It is clear from the evidence that the prevalence, risk factors and experience of mental ill-health among women and girls are different from those of men and boys,²³ resulting in different treatment, care and support needs and experiences.²⁴ Trans and gender diverse people also have specific needs and experiences to which mental health services must be responsive in order to provide safe and effective treatment and support.²⁵ The inclusion of this principle is important to set the expectation for gender-responsive approaches, noting that this will need to be supported by workforce- and system capability-building in gender- and cultural-responsiveness.

We recommend the following amendments to strengthen this principle:

- While gender safety within mental health services is essential, the current wording - 'gender-related *safety* needs and experiences' - is too narrow. In this instance, **we recommend that the word 'safety' be removed to reflect the fact that women and girls have a broad range of gender-related needs and experiences beyond safety** (for example, caring roles, higher prevalence of trauma, dismissive treatment by mental health professionals), to which the mental health system needs to be responsive.
- **We recommend that the reference to 'family violence' be broadened to 'gendered violence, including family and sexual violence'** to reflect the high rates at which women, girls and LGBTIQ people experience of a range of different forms of gendered violence²⁶ and the impacts of this violence on their mental health and interactions with the mental health service system.²⁷
- The principle should include a reference to the gendered social determinants and risk factors of mental ill-health among women, girls and gender diverse people,²⁸ as well as the ways in which gender can influence diagnosis and experience of mental health services. **We recommend the wording be amended to: 'recognises how gender dynamics can affect *risk factors, diagnosis, service use and experience, treatment and recovery; and recognises how gender inequality intersects with other types of discrimination and disadvantage*'.**

²³ Women's Mental Health Alliance (2021), [Snapshot of Australian women's mental health](#).

²⁴ Women's Health Victoria (2020), [Spotlight on women and gender-responsive mental healthcare](#).

²⁵ Hill AO et al (2020), [Private Lives 3: The health and wellbeing of LGBTIQ people in Australia](#), Australian Research Centre in Sex, Health and Society Monograph Series No. 122; Hill AO et al (2021), [Writing Themselves In 4: The health and wellbeing of LGBTQA+ young people in Australia](#). Australian Research Centre in Sex, Health and Society Monograph Series No.122.

²⁶ Our Watch (2021) [Quick Facts \[Webpage\]](#).

²⁷ Australia's National Research Organisation for Women's Safety. (2020). [Violence against women and mental health](#) (ANROWS Insights, 04/2020).

²⁸ Women's Health Victoria (2019), [Royal Commission into Victoria's Mental Health System – Submission prepared by Women's Health Victoria](#), pp 7-14.

- **The principle should be expanded to include consideration of the gender-related needs and experiences of family, carers and supporters.**

The Alliance supports the reference to trauma in the gender-responsiveness principle, and **strongly recommends that trauma-informed practice also be included as an additional stand-alone principle in the Act.** Trauma is a key social determinant of women's mental health,²⁹ but also prevalent in the aetiology of a broad range of mental health conditions affecting men, women and gender diverse people. As noted above, it will be important to ensure that the proposed principle for trauma-informed care applies not just to mental health practice but to all aspects of mental health service delivery.

Principle 10: Recognise and respond to the range of circumstances that influence mental health and wellbeing including relationships, accommodation, education, financial circumstances and employment status.

The Alliance supports this principle and **recommends it be broadened to ensure the full range of circumstances influencing mental health are included to avoid this list becoming prescriptive. This could be achieved through reference to the social, environmental, structural/political, economic, cultural, biomedical and commercial determinants of mental health, as set out in the draft *National Preventive Health Strategy 2021-30*.**³⁰

The Alliance notes that guidance will be needed for mental health services outlining expectations and approaches/options for responding to these circumstances, for example, where a person is experiencing family violence or homelessness.

Principle 12: Recognise and promote the best interests of children and young people receiving mental health and wellbeing services, including providing treatment and support in age and developmentally appropriate settings and ways.

Young women aged 16 to 24 report the highest rates of mental disorder of *any* population group (30%) and are presenting to mental health services with self-harm and suicidal behaviours at increasing rates.³¹

Recognising the high and increasing rates of mental ill-health among young women and girls, **the Alliance suggests this principle be strengthened through the inclusion of 'gender-responsiveness', for example: 'providing treatment and supported in age and developmentally appropriate *and gender-responsive settings and ways*'.** At a minimum, any statutory guidance should make clear that the principles must be 'read together' to ensure that other principles – such as gender-responsiveness – are also applied when supporting children and young people.

²⁹ Mental Health Complaints Commissioner (2018), [The right to be safe: Ensuring sexual safety in mental health inpatient units – sexual safety project report](#), pp 50-51.

³⁰ Australian Government Department of Health (2020), [National Preventive Health Strategy \(consultation draft\)](#).

³¹ Women's Health Victoria (2020), [Submission on the Victorian Youth Strategy consultation](#), p 9.

Non-legal advocacy

The Alliance supports the submissions from VMIAC and Victoria Legal Aid in relation to non-legal advocacy, including:

- Support for the current Independent Mental Health Advocacy model coordinated by Victoria Legal Aid in partnership with people with lived experience
- Support for non-legal advocacy to be provided by a service that is independent of mental health services (including because of the risk of conflict of interest)
- Recognising the benefits of the state-wide reach and systemic approach of the current Independent Mental Health Advocacy (IMHA) service

Supported decision-making

The Alliance supports the proposals to promote supported decision-making for all consumers, not just those on compulsory orders. However, the proposals need to be strengthened to meet human rights and disability standards, and align with contemporary best practice models in supported decision-making.

The Alliance is also aware that several projects have been undertaken since the *Mental Health Act 2014* was introduced to define supported decision-making. We recommend that the new Act draw on this work and include a clear definition of supported decision-making that aligns with best practice frameworks.

Advance statements

We support the submission from VMIAC in relation to strengthening the provisions relating to Advance Statements, including:

- Making Advance Statements binding – consistent with international disability standards and the Victorian *Medical Treatment Planning and Decisions Act 2016* – with the only means to overturn an Advance Statement being an independent legal process
- Requiring Advance Statements to be read even when the consumer is voluntary, noting that there is often coercion involved even in voluntary admissions
- Requiring services to document and evidence in writing how they have given all due consideration to an advance statement and how every effort has been made to comply.
- Not permitting services to be excused from adhering to an advance statement because a requested treatment is not 'usually' provided by that service. Services must demonstrate genuine attempts to provide access to that treatment if it is available through another service.

- Storing Advance Statements in a database managed by the Mental Health & Wellbeing Commission.

Nominated persons

The Alliance supports VMIAC's recommendation that nominated persons be required to agree *in writing* to support the person to make their own decisions and help represent the views and preferences of the person.

VMIAC's recommendation that the role of the nominated person be agreed in writing goes some way to mitigating the risk of a nominated person not acting in accordance with the consumer's wishes. However, the Alliance notes that there may be instances – for example, where coercion is present – when a nominated person is appointed against a consumer's wishes or when, despite a written agreement, a nominated person does not comply with the consumer's preferences. **Further consideration needs to be given to ensuring safeguards are in place to address the risk of coercion.**

We note that the current Mental Health Act 2014 provides no ability for a Court or Tribunal to review or revoke an appointment of a nominated person (unlike the provisions in other Victorian legislation that provide for oversight over the appointment of a guardian or an attorney).

The Alliance recognises that there may be a conflict between the role of the nominated person and the role of identified carer and we support clear separation of these roles in the Act, noting however that it may not always be possible for these roles to be assumed by different people.

Second psychiatric opinion

The Alliance supports VMIAC's recommendations regarding second psychiatric opinions.

Information sharing

The Alliance supports the sharing of information with families, carers or supporters at defined points during a consumer's care or treatment, such as admission and discharge, where this **aligns with the MARAM, Family Violence Information Sharing Scheme (FVISS) and Child Information Sharing Scheme (CISS).**

The Alliance supports the proposed requirement that consumers consent to the provision of information but notes that some exceptions will apply under the FVISS and CISS, which allow for information to be shared without consent in certain circumstances to protect the safety of victim-survivors and children.

Information sharing regarding consumers who have used violence

The Alliance supports an exception to the requirement for consent in line with current Victorian legislation and policy regarding information-sharing and family violence. Information sharing about a person who has used family violence can be shared without consent to (1) establish and assess risk, and (2) manage risk. Information can be shared between Information Sharing Entities (ISEs) to increase safety and decrease risk for adult and child victim survivors.

MARAM outlines how significant deterioration in mental health and suicidality are directly related to risk for victim-survivors, including risk of suicide-homicide. This information is critical to keeping victim-survivors safe and is deemed 'risk relevant' under MARAM. If engagement in a mental health service is part of someone's risk management plan or safety plan, then unexpected disengagement may also be risk relevant.³² However, we agree with VMIAC that non-risk relevant details about someone's mental health treatment and service use should never be shared.

Clinicians and practitioners will need clear guidance and support from their organisations in understanding what information is risk relevant. Adequate training and organisational policies will need to be embedded to ensure confident information sharing with other services relating to risk relevant information and promoting the safety victim-survivors.

Information sharing regarding consumers who are victim-survivors of violence

The FVISS requires the consent of the victim-survivor before sharing information (subject to some exceptions as outlined in the Scheme). For example, information about the victim-survivor's mental health treatment and service use can be used against them by the perpetrator (for example, in legal proceedings) or to exert control over them.³³ **It is essential that consumers experiencing family violence consent to – and have the power to exclude – people receiving information from, and providing information to, the service.**

Safeguards will also need to be put in place to ensure information is not inappropriately shared with other services (for example, housing or alcohol and drug services) that puts consumers at risk of harm, in line with the FVISS and CISS.

³² For more detail, please refer to [MARAM practice guides: Guidance for professionals working with adults using family violence](#), Responsibilities 3 and 4.

³³ Australia's National Research Organisation for Women's Safety (2020), [Violence against women and mental health](#) (ANROWS Insights, 04/2020).

Compulsory treatment

The Alliance notes that compulsory treatment infringes consumers' human rights,³⁴ is often traumatising,³⁵ stigmatising and not generally effective.³⁶ We support the inclusion of strong measures and safeguards in the Act to reduce its use and ensure it is only used as a last resort.

The Alliance recommends the Act refer to section 7(2) of the Victorian *Charter of Human Rights and Responsibilities Act 2006*, which provides that rights can only be limited in certain circumstances if it is reasonable, necessary, justified and proportionate. This should be the first test, with the 'last resort' test being secondary.

The Alliance supports the recommendations from VMIAC that the definition of 'last resort' and criteria for compulsory treatment include a requirement that services document that all other treatment and support options have been eliminated before resorting to compulsory treatment. As VMIAC recommends, services should be required to demonstrate that a variety of different treatments and supports has been offered and that the consumer has made a choice either not to use them or has found them to be unhelpful (i.e. their use has been eliminated by the consumer).

The Alliance supports the proposal for decision-makers to consider any distress or harm that compulsory treatment itself may cause to the person receiving it. We support VMIAC's submission that consideration of the impact of compulsory treatment must be based on the consumer's views and not the views of the clinician or service.

The Alliance supports the proposal that factors such as trauma history be considered when decisions are made about restrictive interventions. However, given the prevalence of trauma history among people experiencing mental illness and the fact that a decision-maker may not always know or be able to ascertain a consumer's trauma history (though this), **we recommend that all decisions about use of restrictive interventions should be trauma-informed** and information about trauma history should be sought and considered as part of individualised planning and routine screening. We further note, however, that the use of restrictive interventions is fundamentally incompatible with trauma-informed practice; this proposal must therefore be coupled with an enforceable commitment to eliminating restrictive practices (which needs to be resourced) and be supported by training for all staff in trauma-informed practice and supported decision-making.

The Alliance supports in principle the proposed replacement of the criterion 'preventing serious deterioration in the person's mental or physical health' with 'the person experiencing serious

³⁴ Royal Commission into Victoria's Mental Health System (2021), Final report, Summary and recommendations, pp 4-5.

³⁵ Royal Commission into Victoria's Mental Health System (2021), Final report, Volume 4, p 372.

³⁶ Daniel Maughan et al (2014), A systematic review of the effect of community treatment orders on service use, *Social Psychiatry and Psychiatric Epidemiology*, 49(4): 651-663; Lisa Brophy & David Ring (2004), The efficacy of involuntary treatment in the community: Consumer and service provider perspectives, *Social Work in Mental Health*, 2(2-3): 157-174.

distress'. **However, we recommend that close consideration be given to any unintended consequences of removing the 'serious deterioration' criterion in relation to consumers who are severely unwell due to an eating disorder.** While retention of the criterion of 'preventing serious harm to the person or another person' may be sufficient to permit compulsory treatment where required (noting this should still be used as a last resort), **the Alliance recommends that the Department undertake targeted consultation with people with lived experience of eating disorders, their families and carers, and clinicians and service providers with expertise in this area, to ensure sufficient safeguards are in place to protect the lives and health of consumers who are severely unwell with an eating disorder.** Eating disorders have the highest mortality rate of any mental illness,³⁷ and there is a strong interplay between the physical and mental health of people with severe eating disorders, with consumers often moved back and forth between medical and psychiatric wards. While there may be scope to utilise the *Medical Treatment Planning and Decisions Act (2016)* where a consumer with an eating disorder does not have capacity to consent (for example, having lost decision-making capacity due to starvation) since both the harm to be avoided and the required treatment (feeding) relate to their physical health, in practice it is mental health legislation that has historically been used where intervention is required as a last resort.

The Alliance supports VMIAC's recommendation that there be a requirement that if a compulsory treatment order negatively impacts on a person's physical health or personal recovery it must be immediately stopped, within medical safety guidelines.

The Alliance supports in principle the proposal to expand the range of people who are authorised to make a temporary treatment order (for example, to include social workers and nurse practitioners), noting that it requires further development and co-design. We understand this proposal is based on a UK model which allows the decision-maker more time with the consumer (with the potential to reduce the use of compulsory treatment) and separates the therapeutic relationship (the treating psychiatrist) from the coercive relationship (the person who makes the order) which has potential therapeutic benefits. However, we note that the UK legislation provides for a range of supports and safeguards for this process, including mandatory training and accreditation for decision-makers and an appeals process, which have not been outlined in the consultation paper.

The Alliance echoes VMIAC's concerns about the lack of attention to community treatment orders in the proposed changes and the underdeveloped proposal for a conference ahead of the Mental Health Tribunal considering a treatment order extension.

The Alliance supports annual targets to reduce the use and duration of compulsory treatment and the publication of service-level and system-wide data. Further recommendations for monitoring and enforcing compliance with requirements related to compulsory treatment are detailed under 'Governance and oversight' below.

³⁷ Chesney E, Goodwin GM, Fazel S (2014). [Risks of all-cause and suicide mortality in mental disorders: a meta-review](#). *World Psychiatry*.13(2):153-60.

Seclusion and restraint

The Royal Commission was critical of the high rates of seclusion and restraint use in Victoria.³⁸ It acknowledged the scope and severity of the potential harms of seclusion and restraint use, including the distress, trauma, injury, pain, humiliation, anger, fear and loss of dignity they can cause to consumers, and the potential of these practices to adversely affect family, carers, supporters and staff and to undermine the therapeutic relationship.³⁹ The Royal Commission characterised the reduction and elimination of seclusion and restraint as non-negotiable goals due to the human rights implications of these practices and their incompatibility with 'a system that is safe for both consumers and staff, and that provides the highest standard of treatment, care and support'.⁴⁰

The Royal Commission's recommendation that these practices be reduced and eventually eliminated stands to benefit women and people of all genders. Seclusion and restraint risks retraumatising women and girls who have previously been subject to trauma, including abuse and sexual violence.⁴¹ While the Royal Commission did not mention the gendered aspects of these risks, it did acknowledge the role of seclusion and restraint in creating and perpetuating consumers' trauma and recommend its elimination on this basis.⁴²

The Alliance supports the proposals that the new Act will:

- acknowledge the harm caused by restrictive interventions and the shared responsibility for their elimination.
- require clinicians to balance consideration of the harm likely to be caused by a restrictive intervention with the harm sought to be prevented by it when contemplating its use/intent of the clinician – including consideration of gender and trauma history in line with the principles, noting the Alliance's view that use of restrictive interventions is incompatible with human rights and trauma-informed practice.
- require clinicians to document the alternative treatments and supports that were tried or considered and the reasons why they were found unsuitable. As noted above in relation to the use of compulsory treatment as a last resort, it is the consumer who should determine that alternative treatments and supports are 'unsuitable'. We note that these requirements will need to be balanced with the rights of mental health workers to protect themselves from harm in emergency situations.

³⁸ Royal Commission into Victoria's Mental Health System (2021), Final Report, Volume 4, pp 315-317.

³⁹ Royal Commission into Victoria's Mental Health System (2021), Final Report, Volume 4, pp 298-9, 304-6, 322-326.

⁴⁰ Royal Commission into Victoria's Mental Health System (2021), Final Report, Volume 4, p 300.

⁴¹ Juliet Watson et al (2020), [Preventing Gender-based Violence in Mental Health Inpatient Units](#) (ANROWS).

⁴² For example: Royal Commission into Victoria's Mental Health System (2021), Final Report, Volume 4, p 304.

The Alliance submits that the 10 year timeframe for the elimination of seclusion and restraint – though consistent with the Royal Commission’s recommendations – is too long and should be shortened. While we acknowledge the wide range of measures that must be implemented before seclusion and restraint can be eliminated, and the cultural change that must accompany these measures, the Alliance is concerned that 10 years is a long time for these harmful practices to be tolerated and perpetrated on women, girls and other consumers. Although the Royal Commission acknowledged that reducing and eliminating seclusion and restraint will be challenging, it characterised the barriers as structural and surmountable.⁴³ Significant reductions have been achieved in other jurisdictions. **The Alliance supports VMIAC’s suggestion that the timeline be shortened to align with the review of the new Act; we would suggest this be a maximum of five years.**⁴⁴

The Alliance supports chemical restraint being clearly defined and more strongly regulated. **We support VMIAC’s recommendation that the definition of chemical restraint be based on the impact on the consumer (including impact on decision-making capacity and ability to participate in community life) rather than the intent of the clinician, and that it should only be used as a last resort.**

The Alliance notes that much of the systems and culture change required to eliminate seclusion and restraint will sit outside legislation, and will need to be supported by policy guidance, workforce development and resourcing. In this context, **the Alliance wishes to highlight the importance of applying an intersectional gender lens to any measures implemented to reduce the use of seclusion and restraint.** The Royal Commission did not discuss the importance of ensuring that evidence-based alternatives to seclusion and restraint are gender-sensitive. However, there is a valuable body of evidence on the implementation of alternatives, although further information is needed about whether these alternatives meet the needs and perspectives of all consumer cohorts, including women, girls and gender diverse consumers. Attention to these gaps is necessary to ensure that the reduction and elimination goals are appropriate for people of all genders.⁴⁵

⁴³ Women’s Mental Health Alliance (2021), [Gender analysis of Recommendation 54: Towards the elimination of seclusion and restraint](#).

⁴⁴ Royal Commission into Victoria’s Mental Health System (2021), Final Report, Recommendation 43.

⁴⁵ Women’s Mental Health Alliance (2021), [Gender analysis of Recommendation 54: Towards the elimination of seclusion and restraint](#).

Governance and oversight

All the elements of the new Mental Health & Wellbeing Act will need to work together in order to create a mental health system that upholds the human rights of consumers, and delivers on the objectives and principles, including reduction in the use of compulsory treatment and elimination of restrictive interventions. An integrated system of regulation and oversight that recognises and manages the relationships between different parts of the Act is needed to ensure that the failings of the *Mental Health Act 2014* (Vic) are not repeated.

The Alliance sees the Mental Health & Wellbeing Commission as playing a central role in this regard, and supports VMIAC's recommendation that the Mental Health & Wellbeing Commission's functions should include a responsibility to promote, support and ensure compliance with the Act and to protect the rights of consumers.

Unfortunately, the proposals contained in the consultation paper do not coalesce into a coherent regulatory system; services will be required to report on different matters to different regulatory and oversight bodies, with significant variation in standards and requirements. For example, compliance with the principles is only to be publicly reported in an annual report, while there is no clear goal, standard or reporting mechanism for compulsory treatment.⁴⁶

The Alliance points to the six thematic changes identified by Katterl as required for an effective regulatory and oversight system in Victoria⁴⁷ and highlights in particular the importance of:

- improved disclosure and transparency of data;
- increased enforcement activities;
- a shift towards more preventative actions; and
- the promotion of consumer leadership.

Improved disclosure and transparency of data

The Royal Commission called for the publication of service-level and system-wide data on the use and duration of compulsory treatment and the use of seclusion and restraint, and that this data be used to monitor variations between services and to understand where additional efforts to reduce use are required.⁴⁸ It noted that reporting of data on seclusion and restraint should be

⁴⁶ Simon Katterl (2021), [Making it fit: ensuring our regulatory infrastructure achieves the Royal Commission's ambitions](#) [webpage].

⁴⁷ Simon Katterl (2021), Regulatory Oversight, Mental Health and Human Rights, *Alternative Law Journal* 46(2): 149.

⁴⁸ Royal Commission into Victoria's Mental Health System (2021), Final Report, Volume 4, Recommendation 55 and p 301.

‘comprehensive, accessible and timely’,⁴⁹ and recommended developing and reporting on a ‘suite of measures’ for this purpose.⁵⁰

It will be critical to ensure that all data collected, analysed and published on use of compulsory treatment, seclusion and restraint is disaggregated by gender and ideally other demographic characteristics, including age and cultural background. Such data is essential for understanding the experiences and needs of women and gender diverse consumers, among others, and will be valuable in assessing whether reduction and elimination efforts are adequately tailored to these groups.

Increased enforcement activities

The current *Mental Health Act 2014* lacks sufficient regulatory power, and what enforcement powers it contains have not been effectively utilised. As Katterl argues, ‘effective regulatory oversight that prevents, minimises and rectifies human rights violations will require the visible use of a full range of enforcement activities.’⁵¹ Regulation can still be responsive – supporting mental health services to improve compliance on a voluntary basis where possible – but requires the backing of stronger enforcement powers to instil public confidence.

As the Royal Commission observed, ‘transparency about [how services are being held to account] allows consumers and their advocates to engage in a more meaningful way with the various oversight and improvement arrangements, and hold those charged with these functions to – in turn – be held to account. In contrast, the lack of information about how the Department of Health, the Chief Psychiatrist and other bodies are responding to quality and safety concerns can leave consumers feeling disempowered and distrustful.’⁵²

Supporting compliance with objectives and principles

The Royal Commission highlighted the need for the principles in the Act to be accompanied by compliance mechanisms.⁵³ It noted that although it is a requirement for mental health service providers and other decision makers to have regard to the principles in the current Act in their work, the principles are not widely embedded in treatment, care and support.⁵⁴

The fact that much of the work required to achieve the objectives of the Act will sit outside legislation means the principles will play a critical role in setting expectations and requirements for service providers. The Alliance is concerned that there is no means proposed in the consultation paper for holding service providers accountable for their compliance with the objectives and principles in the Act and no consequences for non-compliance. **The Alliance submits that the**

⁴⁹ Royal Commission into Victoria’s Mental Health System (2021), Final Report, p 330.

⁵⁰ Royal Commission into Victoria’s Mental Health System (2021), Final Report, p 345.

⁵¹ Simon Katterl (2021), Regulatory Oversight, Mental Health and Human Rights, *Alternative Law Journal* 46(2): 149, p 154.

⁵² Royal Commission into Victoria’s Mental Health System (2021), Final Report, Volume 4, p 263.

⁵³ Royal Commission into Victoria’s Mental Health System (2021), Final Report, Volume 4, p 39.

⁵⁴ Royal Commission into Victoria’s Mental Health System (2021), Final Report, Volume 4, p 41.

proposed mechanisms for promoting compliance with the objectives and principles, such as public reporting and individual complaints, are insufficient to achieve the intent of the Royal Commission.

The Alliance recommends that requirements for reporting on compliance with the principles be strengthened so that mental health services are required to make 'reasonable and material progress' against the principles, consistent with the test used in the *Gender Equality Act 2020 (Vic)*, not simply 'all reasonable efforts'. This is discussed in more detail below.

Strengthening accountability for reductions in compulsory treatment, seclusion and restraint

The potential for infringement of the human rights of consumers within the mental health system is high and it is therefore essential that the Mental Health & Wellbeing Commission can hold mental health services accountable where these rights are infringed.

The Alliance strongly supports the development of system-wide targets for reducing the use and duration of compulsory treatment and eliminating seclusion and restraint. **We recommend that mental health services be required to make 'reasonable and material progress' against these targets – and publicly report on their progress.**

In addition to reporting by individual services, **the Alliance supports the Mental Health & Wellbeing Commission publicly reporting annually at system-wide and service level on:**

- Non-compliance with *Victorian Charter of Human Rights and Responsibilities (2006)* and the Mental Health & Wellbeing Act
- Analysis of reductions in seclusion and restraint
- Analysis of reductions in compulsory treatment
- Analysis of grounds for compulsory treatment
- **Analysis of incidents of gender-based violence**
- Analysis of decisions made relating to capacity and use of supported decision-making, including compliance with advance care directives
- Analysis of complaints received by services, including services' responses to complaints
- Any investigations, including recommendations and outcomes
- Sector-wide and individual service compliance with the principles and objectives of the Act.

The Alliance notes that the important role of the Mental Health & Wellbeing Commission in monitoring the incidence of gender-based violence in mental health facilities, recommended by the Royal Commission, is not proposed to be explicitly included in the new Act. As outlined above, **the Alliance recommends that the role/function of the Mental Health & Wellbeing Commission in monitoring and reporting on gender-based violence be explicitly included in the new Act. Recognising that gender-based violence would (or should) be in breach of the principles of the Act,**

we also recommend the Mental Health & Wellbeing Commission be empowered to act on and penalise services for non-compliance with the principles, as outlined below.

The Royal Commission proposed that accountability requirements for decision makers under the Mental Health & Wellbeing Act should be in line with *Gender Equality Act 2020*.⁵⁵ However, the proposals in the consultation paper are not consistent with this. **The Alliance recommends that – at a minimum – mental health services and decision-makers be subject to similar requirements to defined entities under the *Gender Equality Act 2020 (Vic)*.**

A compliance regime that mirrors the *Gender Equality Act 2020* should:

- Require mental health services to prepare a co-designed annual action plan outlining the steps they are taking to meet the requirements of the Act – including the objectives and principles and any targets for reduction of compulsory treatment, seclusion and restraint – and report on progress annually. The plan and progress report should be available publicly.
- Require mental health services to make ‘reasonable and material progress’ towards the objectives and principles, and any indicators or targets for the reduction of compulsory treatment, seclusion and restraint (not just ‘all reasonable efforts’), taking into account a range of factors specific to the service.

The Alliance further recommends that the Mental Health & Wellbeing Commission be granted powers similar to those of the Commissioner for Gender Equality in the Public Sector under the *Gender Equality Act 2020 (Vic)*. These powers would include:

- Issuing compliance notices where a service fails to submit its annual plan or progress report or fails to make reasonable and material progress against relevant indicators, targets, objectives and principles
- Where a service fails to comply with a compliance notice, taking a range of actions including accepting an enforceable undertaking from the service, naming the service on its website, recommending appropriate action to the Minister, or seeking an order from VCAT to compel compliance.

The Alliance also supports empowering the Mental Health & Wellbeing Commission to impose or recommend more severe penalties in cases of serious or repeated breaches of the Act, including deregistration and/or defunding of services.

A shift towards more preventative actions

The Alliance is pleased that the Mental Health & Wellbeing Commission will have power to receive complaints related to non-compliance with the principles, ‘inquire into system-wide quality and safety challenges or concerns’ and ‘advise government on system-wide challenges and concerns’.

⁵⁵ Royal Commission into Victoria’s Mental Health System (2021), Final Report, Volume 4, p 44.

However, we are concerned that the Act remains over-reliant on individual complaints. This fails to address the barriers consumers and carers face to making complaints.⁵⁶ There also appears to be no proposal to grant the Commission power to take corrective action when a complaint is substantiated.

In the six years since the Mental Health Complaints Commissioner was established, there has been no known use of compliance orders to require services to act compatibly with the *Mental Health Act 2014*.⁵⁷ We note with dismay, for example, that three years after the publication of what has been perhaps the most significant review of complaints undertaken by the Mental Health Complaints Commissioner – the review of complaints regarding ‘sexual safety breaches’ in mental health inpatient units (published as *The Right to be Safe* report, 2018) – little if any action has been taken at a statewide or systemic level to address the findings and recommendations of the report.

The Alliance is of the view that the Mental Health & Wellbeing Commission should have stronger powers to initiate systemic reviews and take effective action to address breaches of the Act identified through those reviews, including through enforceable undertakings. This would reduce reliance on individual complaints. **The Commission should also have the power to intervene where there is evidence of imminent or ongoing breaches of the Act.** As Katterl observes, ‘unlike other areas of regulatory oversight, including general health complaints bodies, many complaints represent current and/or impending human rights violations. This is evidenced by the high rates of oral complaints made to the MHCC, which often present a different level of urgency and focus than traditional written complaints: rather than achieving ‘justice’ for past harms, these complaints often reflect a plea for assistance regarding ongoing violations and/or future or imminent breaches of mental health and human rights laws.’⁵⁸

Governance and promotion of consumer leadership and gender equality

The Royal Commission has recognised the central role of lived experience in systems change, and that ‘placing the patient (or consumer), their experience and wellbeing at the heart of system reform is the “most crucial” lesson of successful healthcare reform in recent times’.⁵⁹ It is therefore essential that all new regulatory and oversight bodies established or with powers under the Act involve people with lived experience of mental illness and psychological distress and as carers at every level.

The Royal Commission recommended that the new Mental Health & Wellbeing Commission be led by a Chair Commissioner supported by a ‘small group of Commissioners’, including ‘at least’ one

⁵⁶ Royal Commission into Victoria’s Mental Health System (2021), Final Report, Volume 4, p 258.

⁵⁷ Simon Katterl (2021), Regulatory Oversight, Mental Health and Human Rights, *Alternative Law Journal* 46(2): 149, p 151.

⁵⁸ Simon Katterl (2021), Regulatory Oversight, Mental Health and Human Rights, *Alternative Law Journal* 46(2): 149, p 154.

⁵⁹ Royal Commission into Victoria’s Mental Health System (2021), Final Report, Volume 1 p 66.

Commissioner with lived experience of mental illness or psychological distress and one Commissioner with lived experience as a family member or carer.⁶⁰

VMIAC has previously argued that more than one person with lived experience of mental ill-health or caring should be included on any governance body;⁶¹ this better redresses power imbalances, enables people with lived experience to support each other and reduces the expectation that they should/are able to 'represent' the diversity of people with lived experience. The Alliance supports VMIAC's recommendation that **at least 50% of the Commissioners have lived experience of mental illness or psychological distress**. Having a minimum of four Commissioners would support this approach.

In keeping with the Victorian Government's commitment that women will make up 50% of appointments to paid government boards, **the Alliance expects that the Boards and senior management of the Mental Health & Wellbeing Commission and other key regulatory, oversight and research bodies – including Regional Boards and the Collaborative Centre – will comprise at least 50% women, with provision also made for representation of gender diverse and non-binary people**. This quota should apply across all roles – including lived experience – to ensure that women with lived experience of mental ill-health and/or psychological distress are adequately represented.⁶² We expect that these bodies will also become defined entities under the *Gender Equality Act 2020* which will require them to undertake workplace gender audits, including in relation to the gender composition of their workforces.

The Alliance also supports inclusion of carers and wellbeing/psychosocial support workers, who play an important role in supporting people experiencing mental ill-health outside the clinical mental health system, within the governance arrangements for regulatory and oversight bodies.

Mental Health & Wellbeing Promotion Office

The Royal Commission considered 'promoting good mental health and wellbeing' to be the 'primary objective' of the new Act,⁶³ and emphasised that the new Act will 'rebalance the legal framework and broaden the focus beyond compulsory treatment towards the attainment of good mental health and wellbeing'.⁶⁴

While this has been recognised in the proposed objectives for the new Act, it is unclear how this will be operationalised and decision-makers held to account. Beyond the objectives, there are no other references in the consultation paper to mental health promotion and primary prevention, and how this will be enabled by the legislation. Because the evidence base for primary prevention is still

⁶⁰ Royal Commission into Victoria's Mental Health System (2021), Final Report, Recommendation 44.

⁶¹ Victorian Mental Illness Awareness Council (2021), [Summary response to the Royal Commission report](#), p 4.

⁶² Given the overrepresentation of women as carers, there is a risk that a requirement for gender equal representation that applies across both types of lived experience roles could result in the involvement of a disproportionate number of men with lived experience of mental illness.

⁶³ Royal Commission into Victoria's Mental Health System (2021), Final Report, Volume 4, p 49.

⁶⁴ Royal Commission into Victoria's Mental Health System (2021), Final Report, Volume 4, p 34.

emerging and it takes time for the impacts to be realised, there is a risk that it will be deprioritised in favour of reforms in the acute/response system. However, if we do not prioritise and invest in primary prevention, we will neither optimise Victorians' mental wellbeing, nor make significant inroads in reducing demand for treatment, care and support services.

To ensure that primary prevention and mental health promotion is prioritised in line with the Royal Commission's recommendations, the Alliance recommends that the establishment of the new Mental Health and Wellbeing Promotion Office and its key functions be enshrined in the new Act. Facilitation of whole-of-government, whole-of-community and place-based approaches to mental health promotion should be included as a key function of the Office, as well as monitoring and evaluation of primary prevention and mental health efforts against outcome indicators framed around the social and other determinants of mental health.

Regional Mental Health & Wellbeing Boards

Regional Boards will play a central role in the future Victorian mental health system, making key decisions about the way mental health services will be planned, resourced, delivered and monitored.

The Royal Commission's recommendation that Regional Boards be skills-based does not obviate the need for the bodies to be informed by a diversity of experience and deeply engaged with their communities. It is possible – and indeed desirable – for governance arrangements to be both skills-based and incorporate a breadth of experience and diversity. The reforms recommended by the Royal Commission present an opportunity to rethink traditional governance models to ensure that Victoria's new mental health system is governed by people with fresh insights and perspectives.

Drawing on advice previously provided to the Deputy Secretary, Mental Health, in relation to interim bodies, **the Alliance makes the following recommendations for inclusion in the Act in relation to Regional Boards:**

- each Regional Board include more than one consumer and one carer;
- each Regional Board comprise at least 50% women, with provision also made for representation of gender diverse and non-binary people, and that this gender quota apply across all roles on the Boards – including lived experience;
- each Regional Board include a breadth of experience and reflect the diversity of their communities, and involve young people with lived experience of mental illness, people with expertise in gendered violence, people with expertise in primary prevention/ mental health promotion, and people with both clinical and non-clinical expertise (including psychosocial support/wellbeing workers);
- the functions of the Mental Health & Wellbeing Commission include oversight of Regional Boards.

The Alliance supports VMIAC's recommendation that the regions for which Regional Boards have responsibility not have strict boundaries or catchments in order to support greater consumer choice and service flexibility.

To support lived experience members to participate effectively on Regional Boards, the Alliance recommends that (outside legislation):

- the Department create mechanisms for members with lived experience to share, collaborate and support each other across the eight Boards;
- the Department ensure members with lived experience receive the support they need to participate effectively on the Regional Boards, including but not limited to adequate remuneration;
- the Department put in place measures to mitigate unequal power relations among members of Regional Boards, as well as ensuring members are trained in trauma-informed practice and co-design;
- the Department put in place measures to build the skills and capacity of a diversity of people with lived experience to take on further governance roles.

The Alliance has attached advice previously provided to the Deputy Secretary on interim regional bodies as an appendix to this submission.

Collaborative Centre

As for the Mental Health & Wellbeing Commission and Regional Boards, the Alliance submits that the Collaborative Centre should include people with lived experience as carers and consumers at every level, and that the Board should have more than one representative with lived experience as a consumer. The Alliance also expects that the Board and senior management will comprise at least 50% women, with provision also made for representation of gender diverse and non-binary people.

The Alliance notes that the consultation paper flags that the Collaborative Centre will be the subject of separate legislation and requests the opportunity to be consulted on this legislation.

The Alliance has attached advice previously provided to Mental Health Reform Victoria on gendered considerations for the establishment of the Collaborative Centre as an appendix to this submission.

Appendices

Appendix A: Women's Mental Health Alliance letter to Katherine Whetton re interim regional bodies

8 June 2021

Katherine Whetton
Deputy Secretary, Mental Health
Department of Health
By email: Katherine.Whetton@dhhs.vic.gov.au

Dear Katherine,

Re: ESTABLISHMENT OF INTERIM REGIONAL BODIES

I am writing to you on behalf of the Women's Mental Health Alliance regarding the establishment of interim regional bodies – which will function as pre-cursors to Regional Boards – as recommended by the Royal Commission into Victoria's Mental Health System (Recommendation 4).

The interim bodies will play an important role in supporting the establishment of Regional Boards,⁶⁵ which will in turn be the lynchpins of the future Victorian mental health system, making key decisions about the way mental health services will be planned, resourced, delivered and monitored.

The Alliance supports the establishment of these regional governance arrangements, which are intended to ensure services are more responsive to the needs of their local communities, as well as addressing service gaps and fragmentation and facilitating service integration, in a way which is centred on the needs of the individual.

We are aware that work is well under way to establish the interim bodies by mid-2021, in line with the Royal Commission's recommended timeline. Recognising the Department of Health's broad scope of work and the tight timelines for delivery, the Alliance is endeavouring to provide constructive advice to support implementation of the reforms.

⁶⁵ The Alliance understand the role of interim bodies includes (pp 272-273):

- laying the groundwork to support the establishment of Regional Boards, including undertaking needs assessment and planning, building relationships with service providers, and establishing strong community participation processes; and
- providing advice to the Department of Health – which will perform the functions of the Regional Boards until the Boards are established – to ensure decisions are informed by local perspectives. This may in turn include:
 - determining the way in which funds will flow from the department to the Board and then onto service providers, and associated accountability arrangements; and
 - establishing the broad parameters for how the Regional Boards will work with other entities such as the new Mental Health & Wellbeing Commission.

The Royal Commission recommended that interim regional bodies comprise 'a chair and five members who are appointed based on their skills and understanding of community needs in their respective regions' (p 273).

Given their important role, it is essential that the interim bodies are equipped with the appropriate expertise to fulfil their roles. The recommendation that interim bodies (and ultimately Regional Boards) be skills-based does not obviate the need for the bodies to be informed by a diversity of experience and deeply engaged with their communities. It is possible – and indeed desirable – for governance arrangements to be both skills-based *and* incorporate a breadth of experience and diversity. The reforms recommended by the Royal Commission present an opportunity to rethink traditional governance models to ensure that Victoria's new mental health system is governed by people with fresh insights and perspectives.

We know, for example, that many skills-based corporate and not-for-profit boards are seeking to diversify their representation to ensure they are better able to understand and meet the needs of the communities they serve.

In summary, the Alliance makes the following recommendations in relation to the interim bodies:

- each interim body include at least one consumer and one carer;
- the Department create mechanisms for members with lived experience to share, collaborate and support each other across the eight interim bodies;
- the Department ensure members with lived experience receive the support they need to participate effectively on the interim bodies, including but not limited to adequate remuneration;
- the Department put in place measures to mitigate unequal power relations among members of interim bodies, as well as ensuring members are trained in trauma-informed practice and co-design;
- the Department put in place measures to build the skills and capacity of a diversity of people with lived experience to take on further governance roles in the future, including as part of Regional Boards;
- each interim body comprise at least 50% women, with provision also made for representation of gender diverse and non-binary people, and that this gender quota apply across all roles on the interim bodies – including lived experience;
- the Department strive to ensure the interim bodies include a breadth of experience and reflect the diversity of their communities, and involve young people with lived experience of mental illness, people with expertise in gendered violence, people with expertise in primary prevention/ mental health promotion, and people with both clinical and non-clinical expertise;
- the Department consider funding the development of a framework to support decision-makers to apply an intersectional lens to the reforms;
- regional women's health services and experts in family and sexual violence response be included on community advisory committees; and
- services that support women and other victim/survivors of gendered violence be included within regional multi-agency panels.

We have provided further detail to support these recommendations in the attached advice on the establishment of interim regional bodies.

In the spirit of collaboration, we would welcome the opportunity to discuss our recommendations. My EA can be contacted on (03) 9664 9300 or at georgie.saggers@whv.org.au.

We look forward to continuing to work with the Department to ensure these historic reforms meet the needs of everyone in our community, including women and girls.

Yours sincerely,



Dianne Hill

Chief Executive Officer, Women's Health Victoria

On behalf of the **Women's Mental Health Alliance**

Appendix to letter: Advice on the establishment of interim regional bodies from the Women's Mental Health Alliance

The following advice provides further detail to support the Women's Mental Health Alliance's recommendations for the establishment of interim regional bodies.

Lived experience

The Royal Commission made no recommendation regarding involvement on the interim bodies of people with lived experience as mental health consumers or carers,⁶⁶ and the Alliance believes this is a fundamental omission.

The Royal Commission has recognised the central role of lived experience in systems change, and that 'placing the patient (or consumer), their experience and wellbeing at the heart of system reform is the "most crucial" lesson of successful healthcare reform in recent times' (p 66). Guiding Principle Six for Victoria's mental health and wellbeing system emphasises the centrality of lived experience to the planning and delivery of mental health treatment, care and support services (p 19).

It is therefore essential that this first step towards establishing new governance arrangements for Victoria's mental health system be informed by people with lived experience, through inclusion of consumers and carers as members of the interim regional bodies.

The Victorian Mental Illness Awareness Council (VMIAC) has previously argued that more than one person with lived experience of mental ill-health or caring should be included on any governance body;⁶⁷ this enables people with lived experience to support each other and reduces the expectation that they should/are able to 'represent' the diversity of people with lived experience.

⁶⁶ The Royal Commission recommended that Regional Boards include people with lived experience of mental illness or psychological distress, and people with lived experience as a carer, but was silent on the involvement of people with lived experience on interim regional bodies.

⁶⁷ Victorian Mental Illness Awareness Council (2021), Summary response to the Royal Commission report, p 4. Available at [URL](#).

Given it may not be feasible to have two people with lived experience of mental illness and two people with experience as mental health carers on each interim body (each with a total of six members), the Alliance recommends that each interim body include at least one consumer and one carer, and that the Department create mechanisms for members with lived experience to share, collaborate and support each other across the eight interim bodies. A network of lived experience members could be facilitated by the Victorian Mental Illness Awareness Council. Lived experience members could be further informed and supported by a consumer advisory group.

Alternatively, the Department of Health (the Department) may wish to consider expanding the size of the interim bodies; this would strengthen governance by accommodating a broader range of skills and diversity, and allow for greater participation by people with lived experience.

It will be important to ensure that members with lived experience receive the support they need to participate effectively on the interim bodies, including – but not limited to – adequate remuneration, which takes account of the fact that consumers are unlikely to be able to rely on institutional support for their participation. Recognising the diversity of skills and experience that members will bring to the interim bodies, and acknowledging that participation by members with lived experience may be retraumatising, it will also be critical to ensure that measures are in place to mitigate unequal power relations, and that all members are trained in trauma-informed practice and co-design.

Recognising there may be a shortage of people with lived experience with the necessary governance skills and experience, the Alliance also recommends that the Department put in place measures to build the skills and capacity of a diversity of people with lived experience to take on more of these roles in the future, including on Regional Boards.

Gender equal composition

In keeping with the Victorian Government's commitment that women will make up 50% of appointments to paid government boards, the Alliance expects that each interim body will comprise at least 50% women, with provision also made for representation of gender diverse and non-binary people.

This quota should apply across all roles on the interim bodies – including lived experience – to ensure that women with lived experience of mental ill-health and/or psychological distress are adequately represented. (Given the overrepresentation of women as carers, there is a risk that a requirement for gender equal representation that applies across both types of lived experience roles could result in the involvement of a disproportionate number of men with lived experience of mental illness.)

While the lack of publicly available gender-disaggregated data limits our understanding, we know that overall women experience poorer mental health than men,⁶⁸ and that women and men demonstrate different patterns of mental health service usage across all levels of acuity. At a national level, females are both significantly more likely to access Medicare-subsidised mental

⁶⁸ Yu S. (2018). *Uncovering the hidden impacts of inequality on mental health: a global study*. *Translat Psychiatr.* 2018;8: 98.

health services,⁶⁹ and more likely to be attended by an ambulance for suicide attempt and self-injury.⁷⁰ In Victoria, females are also more likely to access residential mental health services.⁷¹

Of course, population-level data do not account for differences within gendered cohorts. For example, the higher overall rate of mental health-related admissions to emergency departments among males obscures the fact that emergency department admissions are increasing at a higher rate for females aged 12-24 years than for males in this age group.⁷² The absence of disaggregated data means we are unable to account for gendered differences across other demographic characteristics such as Aboriginality, country of birth or LGBTIQ+ identity.

In undertaking needs assessments and planning, it will be critical for interim bodies – and subsequently Regional Boards – to have a thorough understanding of the gendered and other differences in service demand, usage and experiences in their regions.

Reflecting their communities

The Alliance recognises that, given the size of each interim body (six members), it will not be possible for each body to reflect the full diversity of the Victorian community. However, we believe the Department should still strive to ensure the interim bodies include a breadth of experience and reflect the diversity of their communities.

In particular, in addition to the inclusion of people with lived experience as consumers and carers and gender equal representation, we highlight the importance of ensuring the interim bodies are informed by the expertise of the following groups:

- **Young people** with lived experience of mental ill-health, noting both the high prevalence of mental ill-health among young people and the importance of intervening early in life and early in onset;
- People with expertise in (and ideally lived experience of) the **impacts of gendered violence** on mental health, noting the prevalence of violence against women in our community and its significant mental health impacts;
- People with expertise in **primary prevention/ mental health promotion** and an understanding of the social determinants of mental health, noting the significant risk that primary prevention could be deprioritised and/or rolled together with early intervention, from which it is distinct;
- People with both **clinical and non-clinical** mental health expertise, noting the preference among women in particular for holistic approaches to mental health treatment, care and support.

As noted above, the overall composition of the interim bodies should be gender equal. The Department should also aim to ensure that people with a diversity of backgrounds and experiences –

⁶⁹ Females made up just over 60% of users of Medicare-subsidised mental health services in 2019-20: Australian Institute of Health & Welfare, *Mental Health Services in Australia* [Website], Table MBS.2. Accessed 31 May 2021. Available at [URL](#).

⁷⁰ Australian Institute of Health & Welfare, *Suicide & self-harm monitoring* [Website], Ambulance attendances, self-harm behaviours & mental health. Available at: [URL](#). Accessed 31 May 2021.

⁷¹ Females made up 57% of residential mental health care episodes in Victoria in 2018-19, though this is not the case in other states and territories: Australian Institute of Health & Welfare, *Mental Health Services in Australia*, Table RMHC.4. Available at [URL](#). Accessed 31 May 2021.

⁷² Australian Institute for Health & Welfare, *Mental Health Services in Australia*, Table ED.9. Available at [URL](#). Accessed 31 May 2021.

representative of the communities they serve – are also included on the interim bodies. There may be opportunities for the eight interim bodies to collaborate to share some of this experience and expertise.

The challenges associated with ensuring that the interim bodies are informed by the experience of all service users and population groups highlights the need for a framework that will support the Department – and the various bodies responsible for implementing the Royal Commission's recommendations – to apply an intersectional lens to the reforms. This involves thinking beyond individual identities and social factors, and focuses on people's experiences of discrimination and the ways in which power inequalities shape people's experiences of mental illness and interactions with the mental health system.

The Alliance is currently in conversation with Victorian Transcultural Mental Health about preparing a proposal for the Department to develop such a tool, in collaboration with other organisations representing different population groups.

Community advisory committees

The proposed establishment of community advisory committees (p 269) does not diminish the importance of including a breadth of experience on the interim bodies themselves. The Alliance does, however, see a role for these committees in ensuring that the bodies are informed by the perspectives and experiences of community members.

The Alliance recommends that Victoria's network of women's health services (four metropolitan and five regional) – which have a deep understanding of the needs and experiences of women in their local areas – be represented on these committees. Women's health services also bring extensive expertise in regional approaches to primary prevention – drawing on a decade's experience implementing a collective impact model for the primary prevention of violence against women.

We also recommend the inclusion of experts and/or service providers from the family and sexual violence response sector/s.

Regional multi-agency panels

The Alliance notes that the interim bodies will also play a role in establishing Regional Multi-Agency Panels, which are intended to bring different service providers together to support collaboration and accountability in providing services to consumers, and to coordinate services for those who may need intensive ongoing treatment and support (pp 270, 274).

The need for collaboration and integration of services is at the heart of the Royal Commission's proposed reforms. The Alliance notes that the Royal Commission has drawn on the Orange Door model in making its recommendations for the regional panels. Given the prevalence and mental health impacts of gendered violence, collaboration between mental health services and services that support women and other victim/survivors of gendered violence will be critical, and the Alliance argues that these services must be considered 'important non-government organisations in the area' which will form part of the regional panels (p 277).

Appendix B: Advice from the Women's Mental Health Alliance to Mental Health Reform Victoria regarding the Collaborative Centre, August 2020

What should MHRV consider in its early thinking about the design of the Collaborative Centre?

A purpose-built collaborative centre centred around consumer and family/carer lived experience would be a world first and contribute to Victoria reclaiming its reputation as a world leader in mental health.

True collaboration starts with a **shared vision for change** and agreement on outcomes. Currently, different stakeholders are at odds in terms of their vision for the mental health system. Agreed outcomes should be centred on those prioritised by people with lived experience as consumers and carers.

From a gender-sensitive perspective, the Collaborative Centre should:

- Have a clear **gender equity policy** including a dedicated focus on and investment in sex- and gender-sensitive research to address the current lack of understanding of how sex and gender impact on mental health and wellbeing. We recommend establishing a **dedicated research unit focusing on women's mental health** – this would be a world-first! Research should include:
 - Analysis of sex- and gender-specific symptoms and experiences
 - Analysis and evaluation of sex- and gender-specific therapies and treatments
 - Sex- and gender-disaggregated data collection and reporting, including disaggregation for other population groups wherever possible, for all mental health research
- Take a **biopsychosocial approach** – recognising the interplay between biological, socio-political and environmental factors in influencing women's mental health, including events such as experiences of domestic violence and sexual assault, migration and war
- Take a **whole-of-life/life course** approach, rather than being designed around adult mental health
- Take an **intersectional** approach – addressing the intersecting gendered structural, social and economic inequalities that impact on mental health
- In its research, cover the **full spectrum** from social determinants/prevention/mental health promotion through to response/treatment and recovery
 - In particular, it is important that research is undertaken into a gendered approach to **mental health promotion**, focusing on the gendered drivers of poor mental health and how best to promote mental health and wellbeing among women and girls
- Undertake all types of research, including:
 - **Biomedical**: focusing on new treatment approaches for women, particularly to improve side effects and desired impacts for women e.g. medication type and dosing to take female biomarkers into account to prevent unwanted effects.
 - **Psychosocial**: focusing on social supports (including peer support, walking groups, brief interventions) and therapies
 - **Psychoeducation and support** programs for family/carers

- Be **multi-disciplinary**. For example, the evidence shows women (e.g. with PTSD) require social support, but there is little interaction currently between psychiatrists, psychologists, social workers, family violence response practitioners, health promotion workers and other specialists. The CC should promote interdisciplinary collaboration.
- Be open to **innovative forms of research** (not purely clinical) e.g. consultative action research models
- All research and data should be **gender-disaggregated** (and by other population characteristics where possible).
 - All research undertaken or commissioned by the Centre should include women, including **clinical trials**.
- Be **trauma-informed** in research and all levels of care provided
- Incorporate the **perspectives of family/carers** to reflect the relational context within which – the evidence shows – recovery occurs.
- Build the evidence base by **testing** new programmatic approaches and rigorously evaluating
- In its **service delivery**, ensure that the same gender-sensitive, trauma-informed principles are applied as should be applied to all mental health services, including:
 - Separate 'women only' areas in any bed services to ensure safety and privacy
 - Female-focused units/areas with specific groups/treatment approaches tailored for women
 - Provision of physical healthcare along with mental health care with a female focus
 - Ensuring trauma therapy is available for women with early life and later life traumas
 - Recognising that not all people are ready for or want therapy and ensuring inclusion of a continuum of responses – from walking groups/peer support to brief interventions to counselling/therapy
 - Avoiding over-medicalisation or overly focusing on 'disorders' versus resilience
- In its governance and at every level of the organisation, include **representation** from women with lived experience, carers and other experts in women's mental health, putting in place mechanisms to facilitate participation of women from disadvantaged groups

As an example, the UK Women's Mental Health Taskforce (2018) recommended a research and data commissioner be established to improve the evidence-base around women's mental health. It proposed the following principles for ensuring sex and gender are considered in research and data:

- **Study Design:** To improve consideration of sex and gender, research should be informed by involving women and considering gender from the outset.
- **Collect Data:** More should be done by researchers to collect data on topics that are relevant to women and their health, such as violence and abuse, poverty, physical health and the impact of different medications on women of different ages.
- **Data Access:** To make progress in women's mental health research and to understand women's lives and use of services, it is important to be able to access timely, affordable, research-quality data.
- **Data Analysis:** Research gaps must be identified and addressed that currently limit understanding of women's mental health and their service needs.
- **Publish Data:** Statistics and routinely collected data, disaggregated by sex and other characteristics, must be published in meaningful and accessible formats.

In 2016, the European Journal of Psychotraumatology was the first to implement a gender policy i.e. authors are asked to:

- report the sex of research subjects
- justify single-sex studies
- discriminate between sex and gender
- analyse how sex or gender impact the results
- discuss sex and gender issues when relevant.

This should not only apply to the field of psychotrauma, but deserves much broader implementation.⁷³

⁷³ Olf, M (2017). Sex and gender differences in post-traumatic stress disorder: an update. *European Journal of Psychotraumatology*, 8(sup4), 1351204. <https://doi.org/10.1080/20008198.2017.1351204>