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| Non-legal mental health advocacy service and opt-out register  |
| Protocol for mental health and wellbeing service providers |
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Foreword

The Department of Health (the department) is committed to ensuring consumers of mental health services in Victoria have access to advocacy, legal representation and other supports to enable them to exercise their rights.

The establishment of an opt-out non legal advocacy service and register for consumers receiving compulsory treatment is a key part of ensuring those rights and is embedded in the *Mental Health and Wellbeing Act 2022* (the Act)*.*

This Protocol provides guidance to mental health and wellbeing service providers on their role, responsibilities and processes in relation to opt-out non-legal advocacy.

This Protocol represents significant change for mental health and wellbeing service providers as part of implementing the Act. The department will work with providers to understand the challenges, and solutions and supports, to enable a smooth transition to the new requirements.

The department will review and reissue this Protocol in collaboration with consumers, families, carers, providers and the non-legal mental health advocacy service in early 2024.

Katherine Whetton

**Chief Officer for Mental Health and Wellbeing**

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# Background

## Recommendation 56: Supporting consumers to exercise their rights

The Royal Commission into Victoria’s Mental Health System (the Royal Commission) recommended that the Victorian Government:​

* promote, protect and ensure the rights of people living with mental illness or psychological distress to the enjoyment of the highest attainable standard of mental health and wellbeing without discrimination
* provide in the new Act an opt-out model of access to non-legal advocacy services for consumers who are subject to or at risk of compulsory treatment​
* increase access to legal representation for consumers who appear before the Mental Health Tribunal, particularly when consecutive compulsory treatment orders in the community are being sought​
* align mental health laws over time with other decision-making laws with a view to promoting supported decision-making principles and practices.

## The Mental Health and Wellbeing Act 2022

The Mental Health and Wellbeing Actwas passed by the Parliament on 30 August 2022 and will commence on 1 September 2023.​ The Act provides a framework for the development of opt-out non-legal mental health advocacy services as recommended by the Royal Commission. It identifies trigger points where compulsory notifications are to be sent to the non-legal mental health advocacy service provider.​

Victoria Legal Aid has been designated as the primary non-legal mental health advocacy provider and will carry out this work through Independent Mental Health Advocacy (IMHA), a service it has delivered since 2015​. Further information about IMHA can be found at **Appendix 1**.

The Act requires the Chief Officer[[1]](#footnote-2) to prepare written protocols for mental health and wellbeing service providers for the making, and form, of notifications to the primary non-legal mental health advocacy service provider (IMHA).

The Act also builds on protections that were available under the *Mental Health Act 2014*, including:

* enhanced obligations to provide appropriate support to people to understand information communicated to them and to make or participate in decisions about their treatment, care and support
* requirements to provide consumers with statements of rights at defined points of their treatment and care
* supports for people to have their views and preferences considered in the event that they receive compulsory assessment or treatment including by appointing a nominated support persons and making an advance statement of preferences
* processes for making complaints about mental health and wellbeing services to the independent Mental Health and Wellbeing Commission.

## Opt-out non-legal advocacy

Non-legal advocacy is an important human rights protection.​ It can reduce feelings of disempowerment in consumers and is well regarded by consumers, even when they do not achieve their desired outcome. Despite this, access to non-legal advocacy has been limited (Royal Commission final report, vol. 4 p.396).​

The Act includes safeguards that promote supported decision-making and the agency and autonomy of people living with mental illness, establishes in legislation an opt-out non-legal mental health advocacy service. The service employs advocates that act on the instruction of a consumer to provide non-legal assistance regarding their assessment, treatment and care; participate in the making of decisions about assessment, treatment and care; and to understand and exercise their rights.

IMHA currently provides non-legal advocacy services. There are difficulties with access presented by the current opt-in model, which puts the onus on the individual to seek out advocacy services. The opt-out model will address these issues. ​

From 1 September 2023, mental health and wellbeing service providers must notify IMHA at defined points, such as when a person is made subject to a temporary treatment order or treatment order. This will allow IMHA to contact the person and discuss the opt-out model and provide information to the person about their rights and options.

Consumers who decide to opt-out of receiving non-legal advocacy will be able to opt back in at any stage by contacting IMHA.

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| **Section 44 of the Act outlines:****Role of non-legal mental health advocacy service providers** 1. The primary non-legal mental health advocacy service provider is responsible for—
	1. receiving notifications or requests for support from or on behalf of consumers; and
	2. receiving notifications from entities required to notify the primary non-legal mental health advocacy service provider of matters relating to consumers under this Act; and
	3. coordinating the provision of non-legal mental health advocacy services by any non-legal mental health advocacy service providers designated under section 41(1)(b); and
	4. maintaining the opt-out register.
2. The primary non-legal mental health advocacy service provider and any non-legal mental health advocacy service provider designated under section 41(1)(b) is expected to—
	1. employ, contract or otherwise engage persons to be mental health advocates; and
	2. provide services to consumers in accordance with the protocols issued by the Chief Officer under section 42; and
	3. provide information to, and educate consumers and the community generally about—
		1. the role of non-legal mental health advocacy service providers and mental health advocates; and
		2. the operation of this Act including the mental health and wellbeing principles and the rights and safeguards for people under this Act; and
		3. other relevant Acts including the Charter of Human Rights and Responsibilities Act 2006 and how they apply to this Act.
 |

# Summary of events requiring notifications

From 1 September 2023, IMHA must be notified at any of the following trigger events as identified in the Act. A summary of these events can be found in the Table 1 below.

Where the Client Management Interface (CMI) is indicated as the mechanism for notification, an automated notification will be made from data entered into CMI. There will be a new CMI release to support the Act requirements. Services should engage their CMI coordinator for further information. CMI data will be automatically transferred to IMHA daily from the department’s CMI data. Services need to ensure data is entered into CMI to enable notification to occur within the required timeframe.

Relevant data must be entered into CMI as soon as practicable, no later than 48 hours after the relevant event unless otherwise stated in Table 1.

Table 1: Summary of events requiring notifications

The below table summarise notifications that must be made to the non-legal advocacy service provider. Where the CMI is indicated as the mechanism for notification, an automated notification will be made from data entered into CMI.

Please note, mental health and wellbeing service providers are not required to provide notice of Mental Health Tribunal (MHT) hearings. These will be provided by MHT to IMHA.

| **Description**  | **Mechanism for notification**  | **Timeframe for data entry\*** | **Responsibility\*\*** | **Definitions (if applicable)** |
| --- | --- | --- | --- | --- |
| Use of a restrictive intervention - seclusion, chemical restraint, bodily restraint | CMI | 24 hours | An authorised psychiatrist must ensure that, as soon as practicable after the commencement of the use of a restrictive intervention on a person, IMHA is notified of its use, the nature of the restrictive intervention and the reason for using it. | **Seclusion** means the sole confinement of a person to a room or any other enclosed space from which it is not within the control of the person confined to leave.**Chemical restraint** means the giving of a drug to a person for the primary purpose of controlling the person's behaviour by restricting their freedom of movement but does not include the giving of a drug to a person for the purpose of treatment or medical treatment.**Bodily restraint** means physical restraint, or mechanical restraint, of a person. |
| Making a Temporary Treatment Order (TTO) | CMI  | 24 hours | As soon as practicable after an authorised psychiatrist makes a temporary treatment order, the authorised psychiatrist must ensure that IMHA is notified of the making of the order. |  |
| Making a Treatment Order (TO) | CMI  | 24 hours | As soon as practicable after a treatment order is made, an authorised psychiatrist for the responsible designated mental health service must ensure that IMHA is notified of the making of the order. |  |
| Variation of TTO or TO - community to inpatient AND inpatient to community | CMI | 48 hours | As soon as practicable after an authorised psychiatrist varies an order under section 200 or 201, the authorised psychiatrist must ensure that IMHA is notified that the order has been varied. |  |
| Revocation of a TTO or TO | CMI  | 48 hours | As soon as practicable after a temporary treatment order or treatment order is revoked, an authorised psychiatrist for the responsible designated mental health service must ensure that IMHA is notified that the order has been revoked. |  |
| When a security patient subject to a Secure TO is received at a Designated Mental Health Service (DMHS) | CMI | 48 hours | When a security patient who is subject to a secure treatment order is received at a designated mental health service, the designated mental health service must ensure IMHA is notified as soon as practicable after the security patient is received. | **Security patient** means a person who is not subject to an assessment order, a court assessment order, a temporary treatment order or a treatment order but is - (a) detained in a designated mental health service irrespective of whether the person is absent with or without leave from the designated mental health service; and (b) subject to a court secure treatment order or a secure treatment order. |
| When a security patient who is subject to a Court Secure TO is received at a DMHS  | CMI | 48 hours | When a security patient who is subject to a court secure treatment order is received at a designated mental health service, the designated mental health service must ensure IMHA is notified as soon as practicable after the security patient is received. |  |
| When a security patient is being transported to another designated mental health service  | CMI | 24 hours | As soon as practicable after making a direction under section 555 or receiving a direction under section 556, the authorised psychiatrist must ensure reasonable steps are taken to notify IMHA. |  |
| When a security patient subject to a court secure TO or a secure TO is discharged  | CMI | 48 hours | An authorised psychiatrist who has discharged a person as a security patient must ensure reasonable steps are taken to notify IMHA. |  |
| When a forensic patient is transported to a designated mental health service excluding where a direction is involved below or if there is a Forensic Leave Panel review of decision to transport the forensic patient to another DMHS  | CMI | 48 hours | The designated mental health service must ensure that IMHA is notified as soon as practicable after the forensic patient is received at the receiving designated mental health service. |  |
| If an authorised psychiatrist directs a forensic patient to be transported to another DMHS; or if the Chief Psychiatrist directs that a forensic patient is transported to another DMHS  | CMI | 48 hours | As soon as practicable after making a direction under section 571 or receiving a direction under section 572, the authorised psychiatrist must ensure IMHA is notified in relation to direction for the forensic patient. |  |
| When Forensicare applies to the MHT for an intensive monitored supervision order  | CMI | 48 hours | The Victorian Institute of Forensic Mental Health (Forensicare) must notify IMHA of the making of the application. |  |
| After an intensive monitored supervision order is made | CMI | 48 hours | Forensicare must ensure all reasonable steps are taken to notify IMHA. |  |
| When an order is varied to allow treatment at another designated mental health service (transfer of a patient). | CMI | 24 hours | The authorised psychiatrist who varies the order to specify treatment of a patient will be provided by another designated mental health service (either because the authorised psychiatrist is satisfied that the variation is necessary or because the authorised psychiatrist is directed by the Chief Psychiatrist to make the variation) must notify IMHA as soon as practicable, but no later than 24 hours after the order is made. |  |
| Restriction of an inpatient’s right to communicate  | Upload of data to the department monthly  | 5th of each month commencing 5 October 2023 for events occurring 1-30 September 2023 | An authorised psychiatrist who makes a direction under section 54 to restrict an inpatient's right to communicate must ensure that reasonable steps are taken to inform IMHA about the restriction and the reason for it. | **Communicate**, in relation to an inpatient, means – (a) sending from, or receiving at, a designated mental health service uncensored private communication which may include communication by letter, telephone or electronic communication; or (b) receiving visitors at a designated mental health service at reasonable times, including an Australian legal practitioner, mental health advocate or nominated support person of the inpatient.**Right to communicate** means an inpatient has a right to communicate lawfully with any person, including by electronic communication. An inpatient has a right to communicate with any person for the purpose of - (a) seeking legal advice or legal representation; or (b) seeking the services of a mental health advocate. Members of staff of a designated mental health service must ensure that reasonable steps are taken to assist an inpatient to communicate lawfully with any person.An authorised psychiatrist in writing may direct staff at a designated mental health service to restrict an inpatient's right to communicate (see section 54 of Act). A direction that restricts an inpatient’s right to communicate cannot restrict an inpatient’s right to communicate with a legal representative or a non-legal mental health advocacy service provider or a mental health advocate.  |
| Mental Health Tribunal hearing | MHT – IMHAdata transfer | 24 hours | The MHT must list a matter for hearing and give written notice of that hearing as soon as practicable to the primary non-legal advocacy service provider. |  |

\*Note that for some events data entry is not able to occur until after the event has concluded. In this circumstance, timeframe for data entry is no more than 24 hours after the event has concluded.

\*\*Local policies and procedures should address how the Authorised Psychiatrist can ensure required notifications are made. It is expected that other staff (for example Authorised Mental Health Practitioners) may be given responsibilities for ensuring that appropriate actions are taken and that administrative staff will be responsible for necessary data entry.

## Timeframes for data entry

Where timeframes for data entry are not able to be achieved, for example within 24 hours on a weekend when there are no or limited administrative staff, data should be entered as soon as practically possible ideally no more than 48 hours. Consumers should be told at the time of the event that there is likely to be a delay in IMHA getting a notification and they should be provided with IMHA contact details and a way to contact IMHA, including an option for IMHA to be contacted on their behalf.

## Restriction of an inpatient’s right to communicate

For most trigger events requiring notification, the required data will automatically transfer to IMHA when it is entered into CMI. The exception to this is restriction of an inpatient’s right to communicate.

Restriction of the right to communicate includes any restraint placed on a consumer’s ability to contact others including family, friends, carers, advocates or other supporters, via any, or a combination of, mobile phone, ward phones or internet. Restriction to an inpatient’s right to communicate also includes restrictions placed on when an inpatient can utilise communication devices.

The process for notifying IMHA of these events is as follows:

* When the restriction of an inpatient’s right to communicate occurs, providers are to record this including the inpatients UR number, full name and primary reason for the restriction of communication (from the following options):
	+ Harm to self
	+ Harm to others
	+ Excessive contact (for example to family or emergency services)
	+ Parent/guardian request
	+ Service policy
	+ Maintaining integrity of the program
	+ Privacy concerns for others
	+ Other
* If services do not already have a methodology for recording this data and need to create a new record management system, services will need to ensure data security requirements are met. Seek advice from health information managers if needed.
* A consolidated list of these events and the above information is to be provided to the department no later than the 5th of each month, commencing 5 October 2023 for events occurring 1-30 September 2023.
* This file must be uploaded to a designated secure folder established and managed by the department. Services must provide the department with an email address for access to the secure folder. This should be provided to mhwd.data@health.vic.gov.au
* The department will facilitate the secure provision of this information to IMHA on a monthly basis.
* If there are no instances of this event during the reporting period services should upload a nil report. Where there is no report provided by a service, a department representative will be in touch with service’s nominated key contact to follow up.

This reporting process is temporary until required changes to CMI can be made to facilitate an automated transfer. The department is working to facilitate this as soon as possible.

When a consumer is subject to restriction of their right communicate, they must be informed at the time that a notification will be made to IMHA, but that this may not be for some time after the event. The consumer should be provided with IMHA contact details and a way to contact IMHA, as soon as practicable, including an option for staff to contact IMHA on behalf of the consumer.

## Children and young people subject to trigger events

The requirement for notification of trigger events also applies to children and young people experiencing these events. Consideration should be given to age-appropriate information and communication being provided to these consumers. IMHA are employing a small number of child and youth advocates.

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| **Section 46 of the Act outlines:****Role of a mental health advocates in relation to a child or young person** 1. If a consumer is 15 years of age or younger, the role of a mental health advocate is—
	1. to promote the views and preferences of the consumer; and
	2. to work with the family, carers and supporters of the consumer to ensure that the consumer's best interests are protected.
2. In performing the role under subsection (1), a mental health advocate must—
	1. provide advocacy services in accordance with the protocols issued under section 42(1)(c); and
	2. if the DFFH Secretary has parental responsibility for a consumer under a relevant child protection order, consult that Secretary.
 |

# Facilitating consumer access to advocacy

Under Section 49 of the Act, mental health and wellbeing service providers must give any reasonable assistance to any mental health advocate for the purposes of enabling the advocate to perform and carry out their functions, duties and responsibilities with respect to a consumer. To adequately support consumers to exercise their rights, advocates must be able to speak with consumers within 24 hours of receiving notification of a trigger event.

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| **Section 49 of the Act outlines:****Mental health and wellbeing service provider to give reasonable assistance** A mental health and wellbeing service provider must give any reasonable assistance to any mental health advocate for the purposes of enabling the advocate to perform and carry out their functions, duties and responsibilities with respect to a consumer. |

Examples of reasonable assistance include providing a phone to a consumer if advocates cannot reach them on a shared service phone or assisting advocates to access a high dependency unit.

Services should not make decisions as to whether a consumer has the capacity to speak to an advocate. Advocates will work with the consumer to support them to understand the opt-out non legal advocacy register and services so they can decide if they would like to opt-out or opt-in.

To facilitate consumer access to advocacy, mental health and wellbeing service providers should ensure they have:

* dedicated phones, phone lines or devices for virtual meetings within services to be used by consumers for access to advocacy services. Please note, provision must be made for consumers who may require video contact if they need visual cues to support communication
* staff with the capacity to support consumers to access a phone or devices for the purposes of contacting an advocate
* policies and procedures in place to ensure consumers are provided with this support and phone and/or device access
* devices available to provide to consumers who do not have a device that will allow them to speak/meet virtually with an advocate
* support to access the Translating and Interpreting Service (TIS National) or Auslan to facilitate communication with an advocate as required
* appropriate confidential spaces allocated within inpatient units for advocates to meet with consumers in person or when meeting with them virtually or speaking on the phone. This room may be used daily in some services
* key contacts in units who can assist with advocates having in-person access to consumers
* facilitated access to Aboriginal and Torres Strait Islander designated roles, where available in the health service to assist with access to IMHA, if the consumer wants this.

If any one method of contact (for example telephone access or in-person visits) is unable to be facilitated, alternative ways to connect with advocates should be put in place.

## Sharing consumer information with IMHA advocates

Section 47 of the Act sets out what a mental health advocate can do which includes accessing the personal and health information of the consumer and seeking information on behalf of the consumer from the service providers. Section 49 requires a service provider to give reasonable assistance to any mental health advocate. There is no requirement under the Act that consumer consent has to be in writing.

Under the Act, a mental health and wellbeing service provider is not required to disclose the health information of a consumer to family, a carer, or a support person despite consent being given by the consumer if the provider holds the view that the disclosure:

* poses a threat to the life or health of any person
* could unreasonably impact on the privacy of other persons
* is unlawful or is inconsistent with a requirement or authorisation by or under law
* may prejudice an investigation of unlawful activity or a law enforcement function by or on behalf of law enforcement agency
* is likely to cause damage to the security of Australia in the course of a law enforcement agency performing a function.

Further, a person must also not give information to another person if he or she reasonably believes that by doing so there is a risk that a person may be subjected to family violence or other serious harm. This applies even if the person has consented to the providing of information. However, this provision should not be used as a blanket provision not to share information with IMHA.

# Provision of information about the opt-out non- legal advocacy service

Service providers must display information about the opt-out non-legal advocacy service throughout inpatient units, community clinics and other service locations. Posters to support this will be provided by IMHA. Services can contact IMHA for copies of these.

Service providers should provide one or both of the following when a trigger event occurs:

* Factsheets (available in English and 20 other languages, available from IMHA)
* Video to help consumers, families, carers and supporters understand what happens with consumer information and how and when a consumer can opt-out and opt-in. This could be provided via a link if the recipient has access to the internet.

Service providers must ensure that mental health practitioners are able to enact the Act, and staff that support consumers, families, carers, supporters and kin are aware of the opt-out non legal advocacy service and understand their responsibilities.

Service providers should facilitate connection to an Aboriginal Liaison Officer or other designated Aboriginal role such as Social and Emotional Wellbeing officers for Aboriginal and Torres Strait Islander people.

IMHA will be meeting with services to inform staff about the changes and will provide service providers with written information and information sessions that can be recorded for all staff.

## Providing information to consumers

Whenever a consumer is subject to a trigger notification event, service providers are to advise the consumer and provide information about receiving services through IMHA, including information about their rights and options for enacting these rights, for example supported decision making mechanisms, self-advocacy and advocacy.

A range of resources are available and should be provided according to the consumer’s preference, including translated materials or access to an interpreter if needed.

## Providing information to families, carers and supporters

Service providers must only share general information (such as the information resources detailed above) about the opt-out non legal advocacy register and service available to consumers from IMHA. Service providers can only share specific information with families, carers, kin, and supporters if there is consumer consent.

# Involvement of families, kin, carers and supporters

Upon meeting with the consumer, IMHA and the consumer will decide the degree to which the consumer wishes for family, kin, carer and supporter involvement.

Service providers are encouraged to promote opt-out advocacy services with families, kin, carers and supporters for the purpose of education and supporting the consumer to access services. This provides the ability for families, carers and supporters to remind the consumer of their right to contact an advocate.

Where a family member, kin, carer or supporter believes that the consumer is at risk of compulsory treatment, they can contact IMHA directly with the consumer’s consent and ask that the consumer is contacted via their preferred means at their preferred days/times.

# Queries and complaints

Consumers that have queries about the opt-out register should be directed to IMHA. Details are provided on the IMHA information resources.

**Telephone 1300 947 820 between 9.30 am and 4.30 pm seven days a week.**

**Email** imhacontact@imha.vic.gov.au

**Website:** [www.imha.vic.gov.au](http://www.imha.vic.gov.au)

If a consumer would like to opt-out so they are not contact by IMHA if they are subject to a notification event they can:

* call 03 9093 3701
* visit [www.imha.vic.gov.au/optout](http://www.imha.vic.gov.au/optout) to fill in the opt-out form
* complete the following form and send it to imhaadmin@imha.vic.gov.au or via post to:

Independent Mental Health Advocacy

GPO Box 4380

Melbourne VIC 3001

Services can raise issues with their IMHA key contact or IMHA administration via phone (03) 9093 3701.

# Appendix 1. Independent Mental Health Advocacy

### Overview of Independent Mental Health Advocacy

Independent Mental Health Advocacy (IMHA) was established in 2015 as part of the Victorian Government’s commitment to a human rights-based mental health system, funded by the then Department of Health and Human Services (DHHS) as part of the implementation of the Mental Health Act 2014 (Vic). IMHA was created through a co-design process involving DHHS, the Victorian Mental Illness Awareness Council (VMIAC), Tandem, clinicians and independent consumers. IMHA is the first and currently the only non-legal advocacy service of this kind in Victoria (similar services exist in Western Australia and the UK). IMHA’s work continues to be informed by a permanent senior consumer consultant role and consumer advisory group, Speaking from Experience.

IMHA supports people receiving or at risk of compulsory mental health treatment to make decisions and have as much say as possible about their assessment, treatment, and recovery. To do this, IMHA advocates regularly visit every public mental health service in Victoria to advocate, promote human rights and supported decision-making, provide information and support to navigate the mental health system, support self-advocacy, and actively refer consumers to services they request to support their recovery.

IMHA reaches thousands of consumers each year from diverse backgrounds, including Aboriginal and Torres Strait Islander people, culturally and linguistically diverse people, LGBTIQA+ people, younger and older people, and people with a disability or disabilities.

### The role of advocates

The role of mental health advocates is enshrined in legislation. This includes, in accordance with a consumer’s instructions, to assist a consumer to:

* understand and exercise their rights
* access supported decision making mechanisms such as Advance Statement of Preferences, Nominate Support Persons, seek legal advice or a second psychiatric opinion or make a complaint
* make decisions about their assessment, treatment and care
* express their decisions, views and preferences and/or to represent the consumer’s views to mental health and wellbeing service staff.

The *Mental Health and Wellbeing Act 2022* (the Act) provides clarity about the authority that advocates have when acting on instructions of the consumer, including to access information about the consumer, attend meetings with staff involved in the consumer’s assessment, treatment and care and seek information on the consumer’s behalf from the mental health and wellbeing service provider. The right of a consumer to communicate with a non-legal advocate is also protected in the legislation and, similar to other rights promoting and safeguarding bodies, cannot be restricted.

Importantly, the Act also establishes, for the first time in Victoria, a legislative obligation for mental health service providers to give any reasonable assistance to any mental health advocate, to enable them to perform their functions and responsibilities for consumers.

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| **Section 45 of the Act outlines:****Role of a mental health advocate** The role of a mental health advocate is— 1. to provide non-legal assistance to a consumer in accordance with any instructions given to the advocate by the consumer, including to assist the consumer—
	1. to understand information regarding their assessment, treatment, care and recovery; or
	2. to make decisions regarding their assessment, treatment and care; or
	3. to understand and exercise their rights under this Act; or
	4. to make an advance statement of preferences; or
	5. to appoint a nominated support person; or
	6. to seek a second psychiatric opinion; or
	7. to seek legal advice; or
	8. to apply to the Mental Health Tribunal; or
	9. to understand and access the mental health and wellbeing service system; or
	10. to express their decisions, views and preferences to a member of the mental health and wellbeing workforce and other relevant parties; or
	11. to make a complaint; and
2. to represent the views of the consumer to staff of a mental health and wellbeing service provider in accordance with any instructions given to the advocate by the consumer.
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# Appendix 2. Mental Health and Wellbeing Act Principles

There are thirteen new rights-based principles underpinning the *Mental Health and Wellbeing Act 2022* (the Act) that promote the values, preferences and views of Victorians with mental illness or psychological distress. The principles place the consumer at the centre of service provision and provide the foundation for how service providers should deliver assessment, treatment, care and support.

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| **No** | **Principle**  | **Description from the Act** |
| 1. | Dignity of autonomy  | The rights, dignity and autonomy of a person living with mental illness or psychological distress is to be promoted and protected and the person is to be supported to exercise those rights. |
| 2. | Diversity of care principle | A person living with mental illness or psychological distress is to be provided with access to a diverse mix of care and support services. This is to be determined, as much as possible, by the needs and preferences of the person living with mental illness or psychological distress including their accessibility requirements, relationships, living situation, any experience of trauma, level of education, financial circumstances and employment status.  |
| 3. | Least restrictive principle  | Mental health and wellbeing services are to be provided to a person living with mental illness or psychological distress with the least possible restriction of their rights, dignity and autonomy with the aim of promoting their recovery and full participation in community life. The views and preferences of the person should be key determinants of the nature of this recovery and participation.  |
| 4. | Supported decision making principle | Supported decision making practices are to be promoted. Persons receiving mental health and wellbeing services are to be supported to make decisions and to be involved in decisions about their assessment, treatment and recovery including when they are receiving compulsory treatment. The views and preferences of the person receiving mental health and wellbeing services are to be given priority.  |
| 5. | Family and carers principle | Families, carers and supporters (including children) of a person receiving mental health and wellbeing services are to be supported in their role in decisions about the person's assessment, treatment and recovery. |
| 6. | Lived experience principle | The lived experience of a person with mental illness or psychological distress and their carers, families and supporters is to be recognised and valued as experience that makes them valuable leaders and active partners in the mental health and wellbeing service system.  |
| 7. | Dignity of risk principle | A person receiving mental health and wellbeing services has the right to take reasonable risks in order to achieve personal growth, self-esteem and overall quality of life. Respecting this right in providing mental health and wellbeing services involves balancing the duty of care owed to all people experiencing mental illness or psychological distress with actions to afford each person the dignity of risk. |
| 8. | Wellbeing of young people principle | The health, wellbeing and autonomy of children and young people receiving mental health and wellbeing services are to be promoted and supported, including by providing treatment and support in age and developmentally appropriate settings and ways. It is recognised that their lived experience makes them valuable leaders and active partners in the mental health and wellbeing service system. |
| 9. | Health needs principle | The medical and other health needs of people living with mental illness or psychological distress are to be identified and responded to, including any medical or health needs that are related to the use of alcohol or other drugs. In doing so, the ways in which a person's physical and mental health needs may intersect should be considered. |
| 10. | Diversity principle | (1) The diverse needs and experiences of a person receiving mental health and wellbeing services are to be actively considered noting that such diversity may be due to a variety of attributes including any of the following— (a) gender identity; (b) sexual orientation; (c) sex; (d) ethnicity; (e) language; (f) race; (g) religion, faith or spirituality; (h) class; (i) socioeconomic status; (j) age; (k) disability; (l) neurodiversity; (m) culture; (n) residency status; (o) geographic disadvantage. (2) Mental health and wellbeing services are to be provided in a manner that (a) is safe, sensitive and responsive to the diverse abilities, needs and experiences of the person including any experience of trauma; and (b) considers how those needs and experiences intersect with each other and with the person's mental health. |
| 11. | Gender safety principle | People receiving mental health and wellbeing services may have specific safety needs or concerns based on their gender. Consideration is therefore to be given to these needs and concerns and access is to be provided to services that (a) are safe; and (b) are responsive to any current experience of family violence and trauma or any history of family violence and trauma; and (c) recognise and respond to the ways gender dynamics may affect service delivery, treatment and recovery; and (d) recognise and respond to the ways in which gender intersects with other types of discrimination and disadvantage. |
| 12. | Cultural safety principle | (1) Mental health and wellbeing services are to be culturally safe and responsive to people of all racial, ethnic, faith-based and cultural backgrounds. (2) Treatment and care is to be appropriate for, and consistent with, the cultural and spiritual beliefs and practices of a person living with mental illness or psychological distress. Regard is to be given to the views of the person's family and, to the extent that it is practicable and appropriate to do so, the views of significant members of the person's community. Regard is to be given to Aboriginal and Torres Strait Islander people's unique culture and identity, including connections to family and kinship, community, Country and waters. (3) Treatment and care for Aboriginal and Torres Strait Islander people is, to the extent that it is practicable and appropriate to do so, to be decided and given having regard to the views of Elders, traditional healers and Aboriginal and Torres Strait Islander mental health workers. |
| 13. | Wellbeing of dependents principle | The needs, wellbeing and safety of children, young people and other dependents of people receiving mental health and wellbeing services are to be protected. |

# Appendix 3. Definition of terms used in this protocol

* **At risk of compulsory treatment** means the consumer has concerns they may be made subject to compulsory treatment. This can be for any reason but may be because they have been placed on an assessment order or may be as result of comments or suggestions made to them by their treating team.
* **Authorised mental health practitioner** means — (a) a person who is employed or engaged by a designated mental health service as a — (i) registered psychologist; or (ii) registered nurse; or (iii) social worker; or (iv) registered occupational therapist; or (b) a member of a prescribed class of person.
* **Consumer** means a person who — (a) has received mental health and wellbeing services from a mental health and wellbeing service provider; or (b) is receiving mental health and wellbeing services from a mental health and wellbeing service provider; or (c) was assessed by an authorised psychiatrist and was not provided with treatment; or (d) sought or is seeking mental health and wellbeing services from a mental health and wellbeing service provider and was not or is not provided with those services.
* **Department** means the Department of Health.
* **Inpatient** means a patient who is detained in a designated mental health service.
* **Non-legal mental health advocacy services** means services provided by a non-legal mental health advocacy service provider.
* **Non-legal mental health advocacy service provider** includes — (a) the primary non-legal mental health advocacy service provider; and (b) any non-legal mental health advocacy service provider designated under section 41(1)(b).
* **Opt-out register** means the register of consumers who have opted-out of contact with advocacy services, established and maintained by the primary non-legal mental health advocacy service provider under section 51.
* **Patient** means — (a) an assessment patient; or (b) a court assessment patient; or (c) a temporary treatment patient; or (d) a treatment patient; or (e) a security patient; or (f) a forensic patient.
* **Primary non-legal mental health advocacy service provider** means the non-legal mental health advocacy service provider designated by the Health Secretary under section 41(1)(a).
* **Psychiatrist** means a person who is registered under the Health Practitioner Regulation National Law as a medical practitioner in the specialty of psychiatry (other than as a student).
* **Responsible designated mental health service** means a designated mental health service that is specified in — (a) an assessment order as being responsible for assessing the person who is subject to the order; or (b) a temporary treatment order as being responsible for treating the person who is subject to the order; or (c) a treatment order as being responsible for treating the person who is subject to the order.
* **Security patient** means a person who is not subject to an assessment order, a court assessment order, a temporary treatment order or a treatment order but is — (a) detained in a designated mental health service irrespective of whether the person is absent with or without leave from the designated mental health service; and (b) subject to — (i) a court secure treatment order; or (ii) a secure treatment order.
1. Katherine Whetton was appointed as Chief Officer for Mental Health and Wellbeing in accordance with part 6.2 of the *Mental Health and Wellbeing Act 2022* on 6 August 2023. Victoria’s Chief Officer for Mental Health and Wellbeing is responsible for performing statutory functions and powers specified under part 6.2 of the Act. [↑](#footnote-ref-2)