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| Non-legal mental health advocacy service and opt-out register |
| Protocol for the primary non-legal mental health advocacy service provider |
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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 the primary independent non-legal mental health advocacy service provider, Independent Mental Health Advocacy (IMHA) on their role, responsibilities and processes in relation to opt-out non-legal advocacy.

The department will review and reissue this protocol in collaboration with consumers, families, carers, mental health services, and IMHA in early 2024.

Katherine Whetton

**Chief Officer for Mental Health and Wellbeing**

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# Background

## The Mental Health and Wellbeing Act 2022

The Actwas passed by the Parliament of Victoria on 30 August 2022 to 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 into Victoria’s Mental Health System (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​.

The Act requires the Chief Officer[[1]](#footnote-2) to prepare written protocols for the primary non-legal mental health advocacy service in relation to any information or records to be maintained and reported; how additional non-legal advocacy providers are to work together (when applicable); provision of non-legal mental health advocacy services for children and young persons; and management of the opt-out register.

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

* 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
* providing 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 person 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 mental health 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, including establishing 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 historical 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, IMHA, as the primary opt-out non legal mental health advocacy provider, must be notified 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 can choose to opt-out of the service at the time of being contacted by IMHA or before a notification is made. Consumers who decide to opt-out of receiving non-legal advocacy are able to opt back in at any stage by contacting IMHA.

### Alternative non-legal mental health advocacy service providers

Whilst IMHA is the primary provider of the opt-out non-legal advocacy service, consumers who do not want IMHA to provide them with non-legal advocacy will be offered Victorian Mental Illness Awareness Council (VMIAC) as an alternative provider. VMIAC and IMHA will have an arrangement in place to inform working together. With the consumer’s consent, a warm referral will be sent from IMHA to VMIAC, and consumers will be informed that VMIAC will be informed of any future notifications, unless the consumer contacts IMHA and requests that IMHA ceases sending this information to VMIAC.

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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. |

### The role of advocates

The role of mental health advocates is enshrined in legislation. 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 the consumer and 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 legislation and, similar to other rights promoting and safeguarding bodies, cannot be restricted. Section 45 of the Act outlines the role of a mental health advocate and section 47 outlines what a mental health advocate can do (see box below).

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.   **Section 47 of the Act outlines:**  **What can a mental health advocate do?**   1. In accordance with the instructions of a consumer who is at least 16 years of age, a mental health advocate may do any of the following— 2. access the personal information or health information of the consumer, including the consumer's advance statement of preferences, held by a mental health and wellbeing service provider; 3. attend meetings with the consumer and any registered medical practitioner or staff of a mental health and wellbeing service provider involved in the assessment, treatment and care of the consumer; 4. seek information on behalf of the consumer from the staff of a mental health and wellbeing service provider; 5. contact, seek information or provide advice to a consumer's nominated support person, family, carer or supporters; 6. advocate for the rights of a family member, carer or supporter if those rights relate to the treatment, care, support or recovery of the consumer. 7. If a consumer is a patient who is at least 16 years of age and a mental health advocate is unable to obtain instructions from the patient, the mental health advocate may do the following to ensure the rights of the patient are upheld—   (a) attend a relevant designated mental health service to observe and meet the patient;  (b) obtain from the designated mental health service—  (i) information about the patient's treatment and welfare, including accessing the personal information or health information of the patient; and  (ii) any advance statement of preferences made by the person that is known to the designated mental health service; and  (iii) the contact details of any nominated support person of the consumer or other primary support person of the consumer if the consumer does not have a nominated support person;  (c) contact and liaise with the patient's nominated support person or carer to ascertain the patient's views and preferences regarding their treatment and recovery;  (d) represent the likely views and preferences of the patient to the mental health and wellbeing service provider and advocate for those views and preferences to be given effect;  (e) advocate for the rights of the consumer under this Act or any other Act. |

# Mental Health and Wellbeing Act Principles

The primary non-legal mental health advocacy service must give proper consideration to the core mental health and wellbeing principles included in the Act (Appendix 2) in the performance of a function or duty under the Act.

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| **Section 50 of the Act outlines:**  **Consideration of mental health and wellbeing principles**  In the performance of a function or duty under this Act, a non-legal mental health advocacy service provider must give proper consideration to the mental health and wellbeing principles. |

It is important for the primary non-legal mental health advocacy service provider to ensure consumers, along with their families, carers and supporters are aware of these rights-based principles with relation to the care they receive from mental health service providers.

Whilst not described in the Act, advocates play an important role in providing referral pathways to families, carers and supporters to address their own support needs. Advocates should provide referrals to organisations such as Tandem when engaging with families, carers and supporters.

# Summary of events requiring notifications

From 1 September 2023, IMHA will receive notifications of trigger events as identified in the Act. A summary of these events can be found in Appendix 1.

Where the Client Management Interface (CMI) is indicated as the mechanism for notification, an automated notification to IMHA will be made from data entered into CMI. There will be a new CMI release to support the Act requirements. 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 ensure the notification occurs within the required timeframe. This is described in more detail in the protocol for mental health and wellbeing services.

Notifications regarding restriction of an inpatient’s right to communicate and information required to be provided by the Mental Health Tribunal (MHT) regarding hearings and orders is not able to be automated at this point in time. Interim measures for the transfer of this information are set out below.

# Notifications and data provided to IMHA

## CMI/ODS to IMHA

The following data fields will be disclosed by the Health Secretary on behalf of the authorised psychiatrist/designated mental health service from CMI/ODS to the non-legal mental health advocacy service when a trigger event occurs:

* Statewide UR number
* Local UR number
* Given name(s) and surname of consumer
* Date of birth
* Gender
* Aboriginal and/or Torres Strait Islander
* Consumer contact details:
  + Mobile phone number
  + Landline (if applicable)
  + Email address
  + Residential address
* Location of an inpatient (designated mental health service name and name of unit where consumer is located)
* If not an inpatient, the treating designated mental health service
* Type of trigger, for example, revocation of order, change of order, MHT hearing
* Date and time of trigger event.

### How and when will data be transferred

Data transfers via CMI will occur daily, with an automated upload of the last 24 hours of data occurring by secure electronic transfer to IMHA. IMHA will not have access to CMI/ODS.

If a person opts-out, the Act still requires notification to IMHA. This notification will be received by the IMHA Service Portal (IMHA database), recognised as ‘opt-out’, and deleted automatically. The only way for someone to opt back in is to contact IMHA and request this.

## IMHA SharePoint portal notification

There are trigger events for which notifications cannot be automatically sent from the Department of Health to IMHA through the CMI system. For the purpose of this Protocol, ‘**unautomated trigger events**’ include ‘restriction of an inpatients right to communicate’ and a Mental Health Tribunal hearing.

As a temporary measure, until automated systems can be implemented, these unautomated trigger events will be notified to IMHA by uploading list/details into specific folders in IMHA’s SharePoint external data sharing portal (**IMHA SharePoint Portal**). The portal will include separate folders for each designated mental health service and for the MHT. Only authorised email addresses can upload information to a folder and only a limited group of IMHA staff who need the information will have access to the IMHA SharePoint Portal (with access rights to be reviewed every 2 months or earlier if an authorised IMHA staff leaves their role). The unautomated trigger events will be notified to IMHA as follows:

1. ***Restriction of inpatient right to communicate notifications*** – The Department of Health will send the relevant information monthly by uploading list/details into a sub-folder in the IMHA SharePoint Portal. In accordance with the non-legal advocacy protocols prepared by the Department of Health’s Chief Officer (section 42 of the Act), designated mental health services must:
   * have a methodology for recording this data in a record management system that ensures data security requirements are met; and
   * send a consolidated list of these events (and the relevant information for each) to the Department of Health monthly, no later than the 5th of each month, commencing 5 October 2023 for events occurring 1-30 September 2023.

IMHA staff are not required to contact a consumer as a result of this notification. IMHA will be asking all consumers if this right has been restricted and provide services, as the notification will not allow timely response given it may be received up to 30 days after the event. This will change when notifications are able to be automated in future changes to CMI.

1. ***MHT hearing notifications*** (under the Act section 371(1)(h)) – The MHT will provide the relevant information by uploading the list/details to a MHT sub-folder of the IMHA SharePoint Portal, with these data uploads to occur daily. IMHA staff are required to contact a consumer a result of this notification.

Pursuant to section 377(4) of the Act, the MHT is required, where reasonably possible, to provide IMHA with a copy of orders made by the MHT. The MHT will provide a copy of orders made by uploading the orders to a MHT sub-folder of the IMHA SharePoint Portal, with these data uploads to occur monthly. This is not a notification for the purposes of the Act and IMHA staff are not required to contact a consumer as result of this.

## Restriction of an inpatient’s right to communicate data

The department will provide IMHA with access to monthly reports about restriction of an inpatient’s right to communicate. Reports will include:

* Service
* Statewide UR number
* Patient name
* Reason for restriction – (to be selected from a drop-down list):
  + 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

## Using data to contacting consumers

IMHA advocates will use the information contained within daily CMI/ODS notifications and daily MHT hearing IMHA SharePoint Portal notifications to contact consumers to inform them of the services available and provide non-legal mental health advocacy services, should the consumer want these. When the unautomated trigger events become daily automated trigger events, IMHA advocates will use the information contained in these notifications in the same way as CMI/ODS notifications. The IMHA advocate will also ‘opt out’ consumers who do not want the service and do not want to be contacted in the future should there be another trigger event that results in a notification. Until automated, IMHA administration staff will go into IMHA SharePoint Portal monthly and delete information for people who have opted out.

# Data management

## Opt-Out Register

The opt-out register is generated from IMHA’s database. This database allows recording of minimal identifying information as given to IMHA from CMI/ODS, including a Statewide UR Number (SWURN), name and date of birth for people who opt-out to ensure that future notifications are deleted. This includes people who chose to opt-out before a notification is received by IMHA. It also allows recording of consumers who opt-in and are provided with services as it is part of the IMHA database.

IMHA will ensure there is accessible information about the opt-out system and register on its website and provide written resources to consumers, carers, kin, supporters, families and designated service providers.

A consumer is able to call or submit an online form or send an email to opt-out of the non-legal mental health advocacy service prior to notifications being received. When this occurs, IMHA will receive limited consumer personal and health information to allow IMHA to enter them into the IMHA consumer database and opt the person out. Any future automated notifications will automatically delete for consumers on the opt-out register. The opt-out register will only hold minimal consumer information. It will be reported in accordance with the Act in a de-identified manner as numbers of consumers who have opted out. Where the automated notification has led to consumers opting out, IMHA will report in a de-identified manner the nature of the notifications.

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| **Section 51 of the Act outlines:**  **Opt-out register**   1. The primary non-legal mental health advocacy service provider must establish, maintain and manage a register to be known as the opt-out register—    1. to record the details of consumers who do not wish to be offered or provided with non-legal mental health advocacy services; and    2. to manage notifications made in respect of consumers who have instructed that they do not want to receive non-legal mental health advocacy services. 2. The primary non-legal mental health advocacy service provider must publish on its website information regarding how a consumer may indicate their preferences regarding the provision of non-legal mental health advocacy services. |

Each time a new notification is sent to IMHA, IMHA will contact the consumer (if they have not already chosen to opt-out or have directed IMHA not to contact them in future when receiving certain notifications) to confirm their information and maintain the opt-out register. Ongoing accuracy, completeness and currency of the personal information is ensured by IMHA advocates confirming consumer information each time they contact the consumer when a notification is received.

IMHA will provide consumers with information about their right to exercise their preferences of opting in and out. This information will be displayed in written form, in several languages, and discussed verbally with the consumer.

Consumers will also need to contact IMHA to opt back in, at which time the IMHA staff member will remove their name from the opt-out register.

## Storage of consumer health data

Consumer information received by IMHA through the CMI/ODS notifications will be saved on the IMHA database which is built on Victoria Legal Aid’s enterprise platform located within Australia. The IMHA database information is only accessible to IMHA staff.

IMHA staff have undergone privacy training to understand their confidentiality and privacy obligations, and the limits on use and disclosure of consumer information.

IMHA staff are guided by VLA and IMHA policies and procedures which clearly explain what are and are not legal uses of confidential information, including health and personal information.

Personal and health information will be retained until it is no longer required, and destruction is permitted under the Public Records Act 1973 (Vic). Pursuant to PROS 22/05 Retention and Disposal Authority for Records of the Legal Aid Function, number 1.3, records documenting the management of any matters including non-legal assistance such as non-legal advocacy can be destroyed 25 years after the action has been completed, provided the client has reached 25 years of age.

# Contacting consumers

Advocates will contact consumers by phone. Consumers who have already opted in will be contacted as per their documented preferences in the IMHA database and as per set response times set by IMHA for intake and allocated advocates in the table below.

These are indicative response times for IMHA intake advocates. It is acknowledged that in the initial stages of the opt-out model and expansion of the service, it may not always be possible to meet these times.

| **Type of notification** | **Source** | **Intake Advocate response time** |
| --- | --- | --- |
| Placed on temporary treatment order or treatment order (*incl if forensic or security patient*) | CMI | 24 hrs (1 day) |
| Right to communicate has been restricted  *Note:* *Sent to IMHA monthly. While unautomated, Intake will ask consumers if their right to communicate has been restricted* | DH via SharePoint | Intake ask this. If yes, Allocated Advocate to respond as per consumer instructions previously noted |
| Temporary treatment order, or treatment order, has been varied from community to inpatient or inpatient to community | CMI | *Inpatient*  24 hrs (1 day) |
| *Community* 48 hrs (2 days) |
| Temporary treatment order, or treatment order, has been revoked or cancelled | CMI | 72 hours (3 days) |
| Mental Health Tribunal hearing scheduled  *Note: (i) Daily CT notifications are currently unautomated. They are manually added to the Portal Contact Screen by IMHA administration staff*  *(ii) Rarely, there are MHT urgent hearings on the weekend. IMHA does not receive CT notifications for these hearings. If scheduled, the MHT will notify the health service to tell the consumer that they have a right to speak to IMHA*  *(iii) MHT orders also sent to IMHA (monthly), but these are not CT notifications* | MHT via SharePoint | 24 hrs (1 day) |
| A restrictive intervention is used, for example, put in seclusion, or physically or chemically restrained | CMI | 24 hrs (1 day) |
| Transferred to another designated mental health service such as to a Secure Extended Care Unit | CMI | 24 hrs (1 day) |
| **Security patient** received, or transported to, a designated mental health service | CMI | 48 hrs (2 days) |
| Security patient discharged back to prison | CMI | 72 hrs (3 days) |
| **Forensic patient** transported to a designated mental health service (*except* if the Forensic Leave Panel approves the transport or is otherwise directed by an authorised body) | CMI | 72 hrs (3 days) |
| Forensic patient psychiatrist or the Chief psychiatrist directs the consumer to be transported to another designated mental health service | CMI | 72 hrs (3 days) |
| Forensicare applies to the MHT for an intensive monitored supervision order, if and when this MHT order is made | CMI | 72 hrs (3 days) |

The intake advocate will contact consumers who have yet to opt-in or opt-out to explain the opt-out register and services offered by non-legal advocates. Intake will also, with consumer consent, provide information on rights, the mental health system, coaching for self-advocacy including assistance to use IMHA self-help tools and resources, and refer to services the consumer has identified they want, including legal services, the Mental Health and Wellbeing Commission to make a complaint, and social welfare services.

# Advocacy for children and young people

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 codesigned with these consumers.

IMHA are employing a small number of child and youth advocates and are expected to support the ongoing development of best practice guidelines for advocates working with children and young people. All IMHA advocates should be provided with training and development aligned with these guidelines.

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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— 3. provide advocacy services in accordance with the protocols issued under section 42(1)(c); and 4. if the DFFH Secretary has parental responsibility for a consumer under a relevant child protection order, consult that Secretary. |

# Alternative non-legal mental health advocacy providers

Consumers may wish to access mental health advocacy from an alternative service provider if requested by the consumer and with their consent, the primary non-legal mental health advocacy service may refer consumers to VMIAC as an alternate non-legal mental health advocacy service. Consumers can decide what personal or health information IMHA will provide to VMIAC for a service referral.

Consumers will also be able to decide if they wish for the primary non-legal mental health advocacy service to provide ongoing referrals to VMIAC when notifications are received and can decide when they want this arrangement to end. VMIAC and IMHA as the primary provider will have a protocol that details referral processes, sharing of information, services to be provided as per the Act and other relevant matters to ensure consumers receive non legal advocacy services as per the Act.

# Information and resources

IMHA should produce a range of information that explain the opt-out non legal advocacy register and non-legal advocacy services for consumers, families, kin, carers and supporters as well as for mental health and wellbeing services.

These should be developed collaboratively with the relevant target audiences and produced in a variety of formats that consider accessibility and diversity.

Information and resources, as well as relevant contact information should be available on IMHAs website.

# Reporting requirements

IMHA will use deidentified information for reporting, evaluating, policy and strategic advocacy purposes to improve their services and the mental health system.

IMHA are required to provide the following reports to the department:

* Three-month implementation report (1 September 2023 to 30 November 2023)
* Regular six-monthly reports (31 May and 30 November each year)

Reports will need to provide the following data:

* Summary of notification events from each mental health service
* Issues/risks
* Number of occasions of service provided and type of service
* Number of consumers opting out.

# Queries and complaints

IMHA will manage queries about the opt-out register. Contact details are to be provided in IMHA information resources.

IMHA should provide a telephone line and email contact and web forms for queries and for consumers that wish to opt-out of non-legal mental health advocacy.

IMHA should also provide methods of contact for mental health and wellbeing services.

**Consumers should be informed that they can complain to Victoria Legal Aid and/or the Victorian Ombudsman. Complaints information should be displayed on the IMHA website and other relevant information sources.**

# Appendix 1. Summary of events requiring notifications

The table below summarises notifications that must be made to the non-legal advocacy service provider. Where 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 services are not required to provide notice of MHT hearings. These will be provided by MHT to IMHA.

**Table 1. Summary of events requiring notifications**

| **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 from designated mental health service | 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. | **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.  The Act defines **communicate** to mean:  (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.  The Act clarifies that receiving visitors includes being visited by Australian legal practitioner, mental health advocate or nominated support person of the inpatient. |
| MHT Hearing | MHT – IMHA  data 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.

# 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)