the Australian College of Mental Health Nurses Inc.

Victorian Mental Health and Wellbeing Act: Update and engagement paper

ACMHN SUBMISSION

30 July 2021

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Introduction

The Australian College of Mental Health Nurses (ACMHN) is the peak professional organisation representing mental health nurses in Australia. A primary objective of the ACMHN is to enhance the mental health of the community through the pursuit of excellence in mental health nursing, and by supporting improvement of services and care delivery to people affected by mental ill-health, their families, carers and communities. The ACMHN also sets standards of practice for the profession, is the Credentialing body for Mental Health Nurses and promotes best practice of mental health nursing in Australia.

The ACMHN has a growing and active membership in Victoria working across a diverse range of settings including public bed based and community mental health services, hospital consultation and liaison, alcohol and other drug services, Forensicare, prisons and correctional health services, Headspace centres, private mental health services, psychotherapy practices, specialist organisations including family violence, refugee and multicultural services, transcultural health, LGBTQIA+ services, general health and community care services, primary health care and medical settings, schools and other educational settings, academic roles including teaching and research positions in higher education institutions throughout the state, infant and maternal health services, women's health, family services, child and youth healthcare, aged care services and within the public service.

The ACMHN welcomes the opportunity to make a submission to the engagement paper pertaining to the Victorian Mental Health and Wellbeing Act. We note the unusually short timeframe set for consideration of the major legislative changes and are curious as to why it has been determined that extensive consultation is not warranted?

The focus of our submission is to reflect the experiences of those in the mental health nursing workforce in relation to their professional practice when working alongside people with lived experience of mental ill-health and psychological distress, their families, carers and other supporters. ACMHN emphasizes that mental health nurses are working within a sector that has been severely under-resourced and many of our members continue to work within environments that are dated and often not designed or built to address the requirements of contemporary mental health care. We are mindful that at this particular time, there are also increasing reports of high levels of fatigue and distress amongst the Victorian specialist mental health workforce that do not appear to have been responded to. If left unaddressed, this poses a serious threat to any successful implementation of changes intended to realise the objective "to achieve the highest attainable standard of mental health and wellbeing for the people of Victoria" (State of Victoria, 2021).

The ACMHN identifies the following key points:

1. People with experiences of mental ill-health, their families, carers, other supporters and communities have a right to receive nursing care and treatment from suitably qualified and experienced mental health nurses. ACMHN seeks that access to a nationally regulated clinical workforce who are qualified in mental health, be added to the Principle's within the proposed legislation.

2. Consistent with Royal Commission Recommendation 42.2e which states '*The government should also ensure the Mental Health and Wellbeing Act specifies measures to reduce rates and negative impacts of compulsory assessment and treatment, seclusion and restraint'* (State of Victoria, 2021, p. 11); the ACMHN proposes as essential and necessary requirements specific inclusion of legislative obligations for building workforce capability and ongoing professional development. This would include, but not be limited to provisions within the Act mandating co-designed and co-delivered core competencies in cultural safety, gender and sexual safety, supported decision making, advance statements, trauma informed care, family violence, working with families/carers/support people, upholding human rights, reducing restrictive interventions, SAFEWARDS and clinical supervision. It could also include a mandate that encourages and supports innovation in mental health nursing practice models.

3. Consistent with Royal Commission Recommendation 42.2a which states '*The government should also ensure the Mental Health and Wellbeing Act provides a diverse range of comprehensive, safe and high-quality mental health and wellbeing services'* (State of Victoria, 2021, p. 11); the ACMHN proposes inclusion of legislative obligations mandating for all mental health bed-based environment budgets to include clear and adequate provisions for funded resources to enable the workforce to work therapeutically with people including, but not be limited to, purchasing and replenishing SAFEWARDS resources, purchasing and replenishing sensory modulation equipment, providing resources for group therapies and activities every day and evening and adequate IT devices for access to advocates. It has already been demonstrated that it is insufficient for these requirements to be articulated in guidelines or departmental policy, given these have not been sufficiently influential to effect sustainable implementation.

4. It is essential to ensure proposed legislative changes don't result in detrimental impacts on the capacity of those in the mental health nursing workforce to utilise their clinical judgment, including further consideration and responses to the frequent contexts where health practitioners already juggle tensions associated with a person's risk to self or others against their professional preferences to support self-determination and recovery.

5. There are risks associated with the lack of definitional clarity for some elements within the 'engagement paper' which result in practices based on interpretations. For example, 'distress'.

6. Some of the proposed changes may unintentionally delay people accessing specialist mental health care.

7. There will need to be adequate resources and programs of learning and development to uphold the stated provisions for families, carers and supporters. We noted that nowhere in the engagement paper is there reference to The Carers Recognition Act 2012.

8. Safety for all is a significant issue and this impacts on our members and all people involved. Enhancing the actual and perceived safety of mental health nurses is essential to achieving further reductions in the use of seclusion and restraint in mental health settings.

9. It is possible that the proposed mandated requirements to provide written clinical judgements to people accessing care, has the potential to subject the health practitioner who writes the reasons to an increased level of legal scrutiny; we believe this requires further consultation.

10. Clinicians involved in potential complaint processes have industrial rights, including being afforded natural justice and procedural fairness. It is unclear how this would be adhered to under the proposed broadened functions of the new Mental Health and Wellbeing Commission and broadening of the related roles and responsibilities.

11. It may assist for any guidance developed for health services and the workforce regarding implementation and adherence with the proposed legislation to include template policy, procedures and plans. We suggest that this would reduce the potential for interpretation inconsistencies (and therefore practices) and minimise inefficiencies associated with each organisation needing to independently create these.

12. ACMHN supports the intentions stated throughout the engagement paper for the new Mental Health Improvement Unit (MHIU). Further, we strongly believe that the establishment of, and focus of MHIU needs to be recognised within the proposed new Act. Legislation is the appropriate mechanism to ensure that the Royal Commissions clarity about the MHIU establishment and focus are fully enacted. We note the engagement paper outlines that the MHIU intended functions are to be inclusive of:
    i. Offering education and training programs on safeguards and supported decision making for consumers, families, carers and supporters, as well as the mental health workforce,

ii. Provide for advance statements and nominated persons registers,
iii. Support service providers to ensure consumers receive a statement of rights on entry to the service and to ensure the statement is provided in a range of languages and formats,
iv. Increase consumer leadership and participation in all activities to reduce compulsory treatment,
v. Support the design and implementation of local programs, informed by data, to reduce compulsory treatment,
vi. Make available workforce training on non-coercive options for treatment that is underpinned by human rights, safety and supported decision-making principles,
vii. Practice improvement and support to providers of acute mental health inpatient services to work towards elimination of seclusion and restraint, and to embed trauma-informed care as part of practice,
viii. Royal Commission Recommendation 54.4: Co-design with mental health and wellbeing services and people with lived experience a range of programs and supports aligned with the strategy that focuses on:
    a. Working with each mental health and wellbeing service to investigate local data and practices in order to identify priority areas for change;
    b. Making workforce training available for services, and
    c. Continuing to support services to embed Safewards.

ACMHN also propose that these responsibilities would be enriched by having a MHIU clinical advisory established to inform its work, which must include mental health nurses from the clinical workforce, mental health nurses in leadership positions and mental health nurses in learning and development/education positions alongside other workforce representatives. Providing for the establishment of the MHIC and its functions within this legislation is the only way to provide certainty to people with lived experiences of mental ill-health, their families, carers and supporters, the workforce and service providers.

13. There is concern about the proposals to change the criteria for use of restrictive interventions, specifically, that this will contribute to further physical harm and assaults to other people admitted, as well as the workforce, and also risk people needing to deteriorate further before specialist care is mandated.

14. We seek that the department urgently commit to specific consultations related to the definition and provisions for chemical restraint, ensuring that adequate time is afforded to enable further discussions with our members. We suggest that it is possible to progress the drafting work of a revised bill whilst proper consultation occurs concurrently on this component.

15. In relation to seclusion, ACMHN proposes that the absence of legal requirements for 1:1 nursing care for a person placed in seclusion is detrimental and that this needs to

be amended in the revised Act. It is already provided for bodily restraint. It is unacceptable for a person to be detained in a room on their own without mandated continuous access to psychological care from a mental health nurse. We also seek for the legislation to mandate that a standardised post event protocol for the person who is subject to the intervention is to be implemented.

16. ACMHN members are dedicated to the people they work alongside and want to see better outcomes, demonstrated by mental health nurses leading Victoria's successful implementation of initiatives such as SAFEWARDS.

17. It will be critical for additional mechanisms to be available prior to the legislative changes being put into effect. ACMHN seeks to contribute further to state-wide discussions and implementation planning that will impact mental health nurses.

Mental Health Nurses provide specialist mental health care

A mental health nurse is a registered or enrolled nurse who holds a recognised specialist qualification in mental health nursing. This also extends to Mental Health Nurse Practitioners who have a regulated advanced scope of practice. Taking a holistic approach, guided by evidence, the mental health nurse works in collaboration with people who are living with mental ill-health, their family, carers and community, towards recovery as defined by the individual (ACMHN, 2010).

The scope of practice of mental health nurses in Australia is:

- nested within a holistic theoretical and clinical framework encompassing the biological, cognitive, cultural, educational, emotional, environmental, functional, mental, occupational, physical, psychological, relational, sexual, social, and spiritual aspects of individuals and communities
- distinguished by person-centred and consumer-focused therapeutic approaches, to deliver specialised, recovery-oriented, evidence-based care to all people, from all cultures, across the lifespan and developmental stages, across diverse settings
- characterised by engagement and relationships with consumers; partnerships and collaboration with carers, families, significant others, other members of the multidisciplinary team, and communities
- underpinned by personal and professional reflection (ACMHN, 2013).

The scope of practice of mental health nurses in Australia encompasses a wide range of nursing roles, functions, responsibilities, accountabilities, activities and creativities, modalities and innovations; and is founded upon ethical decision-making. This diversity is fundamental to promoting optimal physical and mental health; preventing physical and mental illness; and providing therapeutic interventions and treatment to support the physical and mental health preferences and needs of individuals, communities and population groups.

The scope of practice of mental health nurses in Australia is influenced by diverse contextual, cultural, educational, environmental, ethical, financial, informational, political, regulatory and/or legislative, social, technological, and other factors. Consequently, the scope of practice of mental health nurses in Australia is dynamic - responding effectively to change and developing over time.

Mental health consumers, their families and communities have a right to receive nursing care and treatment from suitably qualified and experienced nurses, that is, Mental Health Nurses

The next part of our submission provides reflections on the engagement paper and embedded questions using the four elements of:

- Objectives and principles of the new Act
- Non-legal advocacy, supported decision making and information sharing
- Treatment, care and support and
- Governance and oversight

Objectives and principles of the new Act

Question 1: Do you think the proposals meet the Royal Commission's recommendations about the objective and principles of the new Act? If not, why?

Question 2: How do you think the proposals about objectives and principles could be improved?

Recommendation 42 of The Royal Commission states that the Victorian Government:
"*1. repeal the Mental Health Act 2014 (Vic) and enact a new Mental Health and Wellbeing Act, preferably by the end of 2021 and no later than mid-2022, to:*

a. promote good mental health and wellbeing;
b. reset the legislative foundations underpinning the mental health and wellbeing system; and
c. support the delivery of services that are responsive to the needs and preferences of Victorians" [State of Victoria, 2021, p. 11].

The ACMHN acknowledges this is a significant shift from the current legislation which largely focuses on provisions associated with compulsory treatment, inclusive of some safe guards intended to minimise restrictions to human rights. We welcome the return of inclusion of a mandate for all people accessing the services, whether they are designated as voluntary/informal or subject to compulsory treatment. This aligns with the professional standards and codes for mental health nurses to advocate for and uphold the preferences and rights of all people they care for.

There also appears to be a welcomed move within the proposed legislation to focus on rights, roles and responsibilities of all people accessing services. We note the Royal Commission specified the new Act must not only reset the legislative foundations but also support the delivery of services. Therefore, it is essential for the new legislation to incorporate specific provisions that enable the visions to be implemented, binding all, rather than continuing to rely on departmental guidance and goodwill of employers and the dedication of the mental health workforce. Being specific within the legislation about the enabling mechanisms for the workforce and employers may avoid a future review indicating that whilst people support the principles and objectives, there were simply no resources or consistent learning and development programs to facilitate and sustain the necessary changes.

It is not evident how the proposed principles and objectives as stated will achieve these outcomes.

ACMHN suggests that this part of the legislation must incorporate clear and specific actions or criteria under each of the stated principles.

For example, in relation to Principles 4, 5, 9 & 11, specific criteria for the workforce may include:

a) Demonstrate attendance at co-designed and co-delivered core competencies in:
    - cultural safety,
    - gender and sexual safety,
    - supported decision making,
    - advance statements,
    - trauma informed care,
    - family violence,
    - working with families/carers/support people,
    - human rights,
    - reducing restrictive interventions,
    - SAFEWARDS and
    - Clinical supervision.
b) Demonstrate annual attendance at state-wide funded learning and development programs focussed on developing understanding about the principles and objectives of the Act.

In relation to Principle 10, specific criteria for the workforce may include:

- Participate in forums and other arrangements intended to update and build the workforce's knowledge of other services and associated referral processes.

In relation to Principle 2, the ACMHN proposes specific legislative inclusion of a requirement for all mental health bed-based environment budgets to include clear and adequate provisions for funded resources to enable the workforce to work therapeutically with people including, but not be limited to, purchasing and replenishing Safewards

resources, purchasing and replenishing sensory modulation equipment, providing resources for group therapies and activities every day and evening and adequate IT devices for access to advocates.

More broadly, the ACMHN suggests that there will need to be adequate resources and programs of learning and development to uphold the stated provisions for families, carers and supporters. We also note that nowhere in the engagement paper is there reference to The Carers Recognition Act 2012 and the existing associated legal rights and provisions.

ACMHN notes the engagement paper uses a term 'service provider' which is not included in the glossary. We have interpreted it to mean the employer/organisation. It would be helpful for this to be clarified.

The proposal for the new Mental Health and Wellbeing Commission seems to be very broad and appears to introduce a degree of duplication. We recognise that it is proposed that the current Mental Health Complaints Commissioner and legislated functions will be incorporated into the new entity. What will be prioritised with the new Mental Health and Wellbeing Commission? Issuing statutory guidance, monitoring compulsory treatment or responding to complaints? Will the proposed Mental Health and Wellbeing Commission be adequately resourced to carry out its functions effectively?

In relation to the proposed broadening of functions pertaining to responding to complaints, individual mental health nurses are already regulated by employment agreements and processes of the Nurses and Midwifery Board of Australia which are already legislated. It will be necessary to ensure that the broad scope of the Mental Health and Wellbeing Commission does not introduce unintended ambiguity. Another query raised is whether the consumer's preferences in responding to complaints will always be privileged, and if so, we propose that this be stated in the Act, specifically in situations in which a family or advocate lodges a complaint but the service provider regarded and upheld the consumer's expressed preferences. Perhaps a mechanism could be considered for this scenario to be identified early within any processes developed, and a rapid response provided to ensure that it doesn't result in breakdowns to the connection and relationships between the family and the person with mental ill-health.

Non-legal advocacy, supported decision making and information sharing

Question 3: Do you think the expressed proposals meet the Royal Commission's recommendations about non-legal advocacy? If not, why?

Question 4: How do you think the proposals about non-legal advocacy could be improved?

Question 5: Do you think the proposals meet the Royal Commission's recommendations about supported decision making? If not, why?

Question 6: How do you think the proposals about supported decision making could be improved?

Question 7: Do you think the proposals meet the Royal Commission's recommendations about information collection, use and sharing? If not, why?

Question 8: How do you think the proposals about information collection, use and sharing could be improved?

The Australian Charter of Healthcare Rights (second edition) describes the rights of people using the Australian Health System including access, safety, respect, communication, participation, privacy and feedback (Australian Commission on Safety and Quality in Health Care, 2019). Most health services will have policy and procedures that include the requirement to discuss and provide written information on these and undertake other actions to raise awareness. It may be useful to ensure there is reference to these in the proposed Act, along with the additional mental health and well-being specific actions.

Whilst in support of the provision of improved feedback to people when their preferences are not followed/are overridden, who specifically is responsible for this? Clarity is required along with details about the proposed provisions to mitigate against the new workload requirement given this is not currently included within workforce resources. It is possible that the proposed mandated requirements to provide in writing, clinical judgements to people, have the potential to subject the health practitioner who writes the reasons to an increased level of legal scrutiny which requires further consultation.

ACMHN is concerned about detrimental impacts on the nurse-person therapeutic relationship in relation to information being shared without the person's prior consent. We propose that these provisions must privilege the person's consent as a fundamental requirement.

The proposals for automatic non-legal advocacy and the provision for a person to opt out would need to ensure the person's choice to opt-out is respected and to clarify who is permitted to be involved in this conversation. Some of our members report that under the current provisions, when they talk with people who are subject to compulsory treatment under the Act, and do not wish to engage with Independent Mental Health Advocacy (IMHA), they may be met with suspicion from IMHA that staff are somehow influencing the persons decision. We are curious regarding how these mechanisms will specifically reflect provisions that support choice for the person, including facilitating any preferences they have for cultural and potentially religious advocates?

The legislation needs to provide clarity in relation to intersections with other advocates such as community visitors and the expressed views of family, carers and other supporters.

This mechanism also needs to be accompanied by significant infrastructure and resourcing, not just for the organisations undertaking this role but also within mental health and wellbeing service providers. Health services already have policies and procedures in place for people to access medical records, however, these can take time given the involvement across several departments.

ACMHN supports the proposals for people to have the right to communicate with an advocate that cannot be restricted. We would suggest this should include an ability for such conversations to also be in private, wherever possible. There are real design issues in the environments of existing public bed-based settings where this is currently not possible. It may be more realistic to include the words 'wherever possible' with justification being provided in instances in which this may not be possible.

We wonder if it will be confusing if some guidance is issued by the proposed Chief Officer for Mental Health and Wellbeing, and some is issued by the Mental Health and Wellbeing Commission. What is the rationale for having multiple sources of guidance developers and issuers, that specifically relates to the proposed legislation?

ACMHN supports the stated intention for the Mental Health Improvement Unit (MHIU) to:

- offer education and training programs on safeguards and supported decision making,
- continuing to support services to embed Safewards,
- provide advance statements and nominated persons registers and support services to ensure consumers receive statements of rights,
- increase consumer leadership and participation in all activities to reduce compulsory treatment,
- support the design and implementation of local programs, informed by data, to reduce compulsory treatment,
- make available workforce training on non-coercive options for treatment that is underpinned by human rights, safety and supported decision-making principles,
- support practice improvement and support to providers of acute mental health inpatient services to work towards elimination of seclusion and restraint, and
- to embed trauma-informed care as part of practice.

We propose that this responsibility would be enriched by having a mental health clinical advisory unit established to inform this work of the MHIU, which must include mental health nurses from the clinical workforce, mental health nurses in leadership positions and mental health nurses in learning and development/education positions alongside

other workforce representatives. Whilst the engagement paper states the details will be determined in separate processes, it would be helpful for the Act to specifically incorporate the establishment of, and mandate an outline of the responsibilities of the MHIU. Having this specified in the legislation would provide transparency and also ensure people impacted by the legislation are aware of the different entities and their responsibilities in relation to this legislation.

The need for ongoing learning and development programs for the workforce cannot be underestimated. As stated earlier, we seek that such requirements are included in the legislation to ensure the broad vision can be achieved.

Treatment, care and support

Question 9: Do you think the proposals meet the Royal Commission's recommendations about reducing the use and negative impacts of compulsory assessment and treatment? If not, why?

Question 10: How do you think the proposals about compulsory treatment and assessment could be improved?

Question 11: Do you think the proposals meet the Royal Commission's recommendations about reducing the use and negative impacts of seclusion and restraint, and regulation of chemical restraint? If not, why?

Question 12: How do you think the proposals about seclusion and restraint could be improved?

Whilst ACMHN is supportive of the aspiration to 'move away from a crisis-driven model to a more balanced mental health and wellbeing system' we are concerned that the content of the engagement paper doesn't reflect the significant suite of actions and resources that are required to move from the current to the future. In relation to the very real experiences of all people within the acute mental health wards currently, these are busy, noisy and sometimes very distressing places. Many of our members working in the acute wards really want the sector to change for the better. They have for years been advocating for improvements, adequate funding and resources to provide the evidence-based specialist care they signed up for, talking about the ongoing and increased pressures and impacts on all who find themselves admitted to or working in these environments. Our members are currently experiencing greater levels of fatigue, possibly from the ongoing COVID-19 pandemic and feel that no-one is hearing their cries for assistance in the wards. Mental health nurses remain dedicated to the people they work alongside and want to see better outcomes and have led the way to successfully implement new initiatives such as Safewards within Victoria.

There is concern about the proposals to change the criteria for use of restrictive interventions, specifically, that this will contribute to further physical harm and assaults to other people admitted as well as staff. This by no-means is intended to indicate they are unwilling to keep trying to do better and reduce restrictive interventions, it is simply a reflection of the realities of the services people work in at present.

Perhaps what might assist is to see current provisions fully enacted? For example, s 107 of the MHA 2014 clearly specifies the responsibilities for notifications about the use of a restrictive intervention. Importantly, what else was tried or considered and was not successful? How is this monitored now? Is it possible that the lack of monitoring would simply be replicated through new provisions?

Recent Australian research suggests nurses have concerns and can experience fear associated with managing aggressive or violent patients without restrictive measures[1]. The issue of fear at work as a feature of clinical practice in mental health nursing is as yet not fully elucidated, though there is a need to explore this more comprehensively particularly given findings reported by Bigwood and Crowe (2008), Muir-Cochrane et al. (2018) and others.

That fear is an issue for mental health nurses is perhaps not surprising given that mental health nurses experience a higher rate of physical aggression than nurses in any other health care settings and other professionals within the mental health environment (Muir-Cochrane et al, 2018, p. 1511). The lifetime risk of assault for nurses in mental health settings is estimated to be 'approaching 100%' (Renwick et al, 2019, p. 269). This high risk of assault is known to negatively influence emotional, social and psychological well-being in nurses and can generate a range of physical injuries such as open wounds, bruising and sprains and emotional injuries including self-doubt, confusion, anger, guilt, shame and an increased risk of developing post-traumatic stress disorder.

Fear of assault has also been shown to influence clinical decision-making in relation to management of aggression, seclusion and restraint (Muir-Cochrane et al, 2018 & Renwick et al, 2019). Staff feelings and perceptions of their own personal safety have been associated with use of coercive containment methods such as seclusion and restraint in mental health settings.

Workplace safety for nurses is a significant issue in achieving organisational and professional goals around reduced incidence of seclusion and restraint. Accordingly, addressing the work environment to enhance actual and perceived safety of nurses is essential to achieving further reductions in seclusion and restraint in mental health setting

In honouring the commitment to ensure best possible care for people admitted and aiming to reduce seclusion and restraint reduction in Australian mental health settings, it has become clear that increasing safety in care and enhancing safety for the workforce, particularly nursing staff, is a crucial aspect of achieving further reductions in the use of seclusion and restraint.

ACMHN believes the actions that will increase safety in care and safety at work should be reflected in this legislation and include:

1. A continued and sustained focus on improving safety for all within Australian mental health services, including the provision of appropriate funding for safety-related activities.
2. The provision of sufficient inpatient and community mental health facilities to meet the demand.
3. Ensuring vacant mental health nursing positions are filled.
4. Ensuring all nurses working in mental health services are appropriately qualified and supported to engage in continuous professional development.
5. Ensuring the skill mix of personnel recruited to mental health services includes leadership from experienced mental health nurses and that less experienced nurses are supported to develop their knowledge and practice skills.
6. Inexperienced nurses with limited mental health knowledge should not be promoted to senior nursing positions (nurse manager, team leader).
7. Ensuring nurse-to-patient ratios and skill mix across all shifts appropriately reflect consumer needs and clinical acuity.
8. Ensuring service funding models reflect clinical realities.
9. Exploring and implementing innovative models focused on improving safety in care, such as the *Scottish Patient Safety Program – Improving Observation Practice* which reflects a shift in mind-set based on emerging good practice within mental health inpatient culture and practice, utilising a proactive intervention based approach to care, treatment and safety based on prevention, early recognition and early response strategies to address potential or actual patient deterioration of health, wellbeing or risk. This approach applies proactively to all patients in the ward. This represents a move away from centralising the use of observation status to determine and describe the nature and extent of care, treatment and safety planning and associated intervention and interaction an individual requires. Instead, care, treatment and safety planning are guided by the identified specific clinical needs of the individual.

With the exception of the proposed inclusion of Mental Health Nurse Practitioners (NPs), ACMHN are uncertain about the proposals to enable health professionals more broadly to make temporary treatment orders. We support including NPs as they hold numerous additional qualifications, often have decades of mental health nursing experience including formalised supervision during their NP candidature and must undertake academic and regulatory assessment to achieve endorsement via national

regulation, which approves advanced scope of practice. Whilst we appreciate the reference to operational issues as a rationale, the past 18 months has demonstrated the ability for consultant psychiatrists to effectively utilise telepsychiatry. ACMHN reminds the department that current provisions actually enable a safety mechanism for people, which should be maintained.

Chemical restraint is also proposed to be included in the new Act. ACMHN is aware of the previous debate on this specific matter in the years leading up to the current Mental Health Act 2014 being developed and passed. As such, we hold concerns that it has been proposed for specific inclusion in the new Act without adequate timeframes for the necessary consultation that this warrants, to ensure definitional clarification. In addition, the consultation could consider clear strategies and resources that will be required to support effective implementation on such a mandate. Whilst we recognise the proposal is to incorporate words from the Tasmanian jurisdiction, our members are not supportive of simply taking these words in their current form. Further, our members have identified the current lack of consultation and potential for interpretations would introduce avoidable and unacceptable risk to all. For example, how does one objectively differentiate behaviours from human functioning and illness? At what point would the prescribing or administering of an antipsychotic medication be considered 'control'. Would the fear of the legal reference contribute to sub-therapeutic treatment for people because of interpretations to do otherwise would be considered a form of restraint?

We suggest that the department commit to specific consultations with adequate time being afforded for such consultations to occur about suitable definition and provisions for chemical restraint. It is possible to progress the drafting work of a revised bill while proper consultation occurs concurrently on this component.

We also welcome the consideration for the legislation to have more rigorous oversight of seclusion and restraint. In relation to seclusion, ACMHN proposes that the absence of legal requirements for 1:1 nursing care for a person placed in seclusion is detrimental and that this needs to be amended in the revised legislation. It is unacceptable for a person to be detained in a room on their own without ongoing access to continuous psychological support from a mental health nurse. This mandate is already specified for bodily restraint in the current Mental Health Act 2014. ACMHN also seeks for the legislation to mandate a standardised post event protocol for the person subjected to the intervention.

Governance and oversight

Question 13: Do you think the proposals meet the Royal Commission's recommendations about governance and oversight? If not, why?

Question 14: How do you think the proposals about governance and oversight could be improved?

Whilst the proposals are clear in relation to the proposed governance structures, they still appear to involve duplications, and more importantly, exclusion of robust legislative provisions that would mandate the essence of the Royal Commission recommendations. For example, the State-wide Multi-Agency Panel is proposed to comprise as Chair the new Chief Officer for Mental Health and Wellbeing and chairs of each of the Regional Multi-Agency Panels. However, this omits key stakeholder groups. ACMHN proposes it must also be inclusive of peak consumer, carer and workforce/professional membership.

The engagement paper partially articulates legislative mechanisms but could be more specific regarding what, where and how improved access and equity will be progressed and reflected in law. The opportunity to specifically address this at the regulatory level is too important to miss. ACMHN recognises that this would provide people with lived experiences on mental ill-health, their families, carers and supporters, the workforce and service providers with legislative mandates instead of reliance on historical approaches of departmental guidance whereby implementation is elective.

This submission by ACMHN outlines possible avenues for improving the proposed legislative revision. We look forward to participating further in the redesign towards a new Victorian Mental Health and Well-Being system.

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