Mental health and wellbeing principles guidance summary

From intent to impact

Mental Health
and Wellbeing
Commission

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and Wellbeing
Commission

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Contents

Acknowledgement of Victorian Aboriginal people

The Mental Health and Wellbeing Commission (Commission) acknowledges with deep respect all Victorian Aboriginal people and Traditional Owners, recognising their enduring connections to Country, Culture and Kin, a connection that has been nurtured for over 60,000 years. We pay our deepest respects to Elders both past and present, recognising their ongoing resilience, wisdom, and leadership. We acknowledge that this land was, is and always will be Aboriginal land.

Recognition of diverse lived experiences

The Commission recognises the strength and diverse identities, experiences and backgrounds of people living with trauma, neurodiversity, mental illness and substance use or addiction, and their carers, families, supporters and kin. We remember those who have been lost to suicide. We stand on the shoulders of giants - those who went before us to advocate for choice and dignity for all people.

Note on language[1]

At times, this guidance uses language that we acknowledge is not preferred by some people. We use 'consumer', and 'person' wherever possible. However, when discussing requirements for compulsory treatment under the Act, we may use the word 'patient', meaning a person receiving compulsory mental health treatment.

We use the term 'carers, families, supporters and kin' to mean people who support people accessing, or trying to access, mental health and wellbeing services. At times, to reflect the language of the Act, we may also use 'carer', 'parent', or 'guardian', or the phrase 'family, carer or supporter'.

We acknowledge that the terms Aboriginal, Indigenous, and First Nations or First Peoples are used interchangeably in this document and do not capture the unique language groups of many within the community. We respect everyone's right to self-identification.

The Act includes other principles including the decision making principles, the information sharing principles and the health-led response principles. Any reference to 'the principles', if not otherwise specified, means the mental health and wellbeing principles.

References to legislation are to the *Mental Health and Wellbeing Act 2022* (Vic) unless otherwise specified.

References to 'service providers' mean mental health and wellbeing service providers.

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[1] Please see the full mental health and wellbeing principles guidance for detailed notes on language.

1. Purpose

In line with our functions under the *Mental Health and Wellbeing Act 2022* (the Act), the Commission has prepared guidance to support mental health and wellbeing services to apply the mental health and wellbeing principles to actions and decisions under the Act.

This summary is primarily intended to support clinicians to understand the actions they can and must take in daily practice to comply with the principles. Some of these are Act requirements and indicated with an 📖 icon. The summary also gives a very brief overview of leadership responsibilities to embed the principles in service design and delivery. Leaders, the quality improvement and education workforces, and any staff seeking a deeper understanding of the principles should read the Commission's full guidance, which includes more detailed explanations. The full guidance has been developed together with lived and living experience, medical, nursing and allied health staff in services, as well as sector partners. Many of the examples and actions in the full guidance are drawn from their input and we thank them for generously sharing their expertise.

2. A human rights approach to mental health and wellbeing

A human rights approach is about embedding rights in practice. In Victoria, this approach is enshrined in the *Charter of Human Rights and Responsibilities Act 2006* (the Charter).

Public authorities, including mental health and wellbeing service providers, can uphold human rights by applying the Charter and building a human rights culture within their service and workforce. For mental health and wellbeing service providers, this involves connecting human rights with work done to apply the principles, as well as other specific requirements of the Act.

3. Legal obligations

3.1 Overview

Mental health and wellbeing service providers' responsibilities to enact the principles are set out in section 29 of the Act (see below).

Section 29: Mental health and wellbeing service providers to make all reasonable efforts

A mental health and wellbeing service provider must:

a) when exercising a function to which this Act applies, make all reasonable efforts to comply with the mental health and wellbeing principles; and

b) when making a decision under this Act, give proper consideration to the mental health and wellbeing principles; and

c) provide safe, person-centered mental health and wellbeing services; and

d) foster continuous improvement in the quality and safety of the care and mental health and wellbeing services they provide.

The standard of all reasonable efforts applies to actions and proper consideration applies to decisions. As decisions often lead to actions the two requirements are closely linked.

Proper consideration in decision making can lead to actions that are compatible with the mental health and wellbeing principles.

Interpreting the Act

The principles also guide how the Act is interpreted. When the Act has more than one possible meaning, preference is to be given to an interpretation that promotes the principles (s 10(1) of the Act). See the full guidance for further information about other obligations in the Act.

3.2 Making all reasonable efforts

Mental health and wellbeing service providers are expected to act compatibly with the principles in practice by embedding the principles into their actions at all levels. For example, incorporating the principles into decision making, policies, practices and service delivery in a way that is consistent with their aims.

How can service providers show they have made reasonable efforts to comply with the principles?

Meeting this standard involves service providers and/or practitioners being able to show how they have:

- taken **proactive** and **meaningful** steps
- to **act compatibly** with the mental health and wellbeing principles.

Proportionality approach

This involves a *proportionality approach* that takes into account:

- the **relevance** of the principle proportionate to the action being taken
- the **impact** the proposed action will have on any rights or entitlements arising from the relevant principles.

The greater the relevance of a principle and the impact of not meeting the outcomes that should arise from that principle, the greater the effort that will usually be required.

The phrase 'all reasonable efforts' allows for some flexibility in how compliance with the principles can be achieved.

When does it apply?

Mental health and wellbeing service providers must make all reasonable efforts to comply with the principles when exercising a function under the Act. In short, exercising a function generally refers to taking actions.

To exercise a function means to act in a way that is authorised, required or permitted by the Act. This understanding is similar to the way the Charter defines the functions of public authorities.

Some mental health and wellbeing service providers have functions that are outlined in the Act, such as the Victorian Institute of Forensic Mental Health ('Forensicare'). For most other mental health and wellbeing service providers, functions are not always expressly outlined in the Act. Generally, the functions of a mental health and wellbeing service may include:

- the provision of mental health care, treatment and support
- education, training and research undertaken by a service in relation to mental health and wellbeing
- quality, safety and innovation activities and obligations undertaken by a service in relation to mental health and wellbeing
- administrative obligations such as reporting (for example, to the Minister and/or Health Secretary) and
- other requirements that may be part of a funding arrangement.

3.3 Giving proper consideration to the principles

When making a decision under the Act, mental health and wellbeing service providers must give proper consideration to the mental health and wellbeing principles.

How can service providers show they have given proper consideration to the principles?

Proper consideration is a mandatory process of deliberation when making a decision under the Act. The standard is the same as what is required under the Charter.

Giving proper consideration to the principles involves being able to:

1. Understand in general terms what principles may be relevant to the decision and what they mean.
2. Identify different and opposing interests or obligations that will be affected by the decision.
3. Consider the impact of the proposed decision on any interests or rights arising from the relevant principles.
4. Apply a proportionality approach to balance these factors and justify the decision being made.

When does it apply?

All decisions made under the Act require proper consideration of the principles. They include:

- decisions that are expressly authorised, required or permitted by the Act, and
- decisions which are made in the process of exercising a function under the Act.

Decisions requiring proper consideration of the principles include decisions that involve:

- the rights of consumers, carers, family members or supporters
- granting, denying, suspending or altering a privilege
- giving, suspending, revoking or refusing to give a direction, approval, consent or permission or
- imposing any other condition or restriction.

A decision not to perform a duty or exercise a power under the Act is also a decision that must involve proper consideration of the principles.

Decision making in context

The context within which a decision is being made will be relevant when giving proper consideration.

In urgent situations, proper consideration may look different from situations where there is more time to make a decision or where the decision is especially significant.

In urgent circumstances (for example, where necessary to avoid a serious risk to the consumer or another person), it may be necessary to rely on known information and existing procedures. This underscores the importance of ensuring that procedures are informed by the principles and that all reasonable efforts are made to understand and document a consumer's views and preferences at all points in care. If a decision is made in an urgent situation, it should be revisited in more detail later in the person's care and treatment, when the urgency has passed.

It is important to remember that the obligation to give proper consideration still exists in situations of urgency. The context of a decision is a matter to be given weight when giving proper consideration. It must not be used as a justification to avoid proper consideration.

All decisions, including the reasons for decisions, actions taken and how the person's views and preferences have informed the decision and actions, must be documented.

4. Putting the principles into practice - a framework

This section outlines the steps involved in giving proper consideration to and making all reasonable efforts to comply with the principles. It includes a 5 step process flowchart, a scenario applying the process, and an example flowchart showing how this process can be applied to a consumer journey and a systemic change. This process can also be used to assess whether service providers' actions or decisions complied with their obligations.

Flowchart 1: Process for giving proper consideration and making all reasonable efforts

Step 1: Identify and understand the relevant principles	What principles are relevant to this decision or action? Do I understand what the relevant principles mean in general terms?
Step 2: Consider impacts of the decision or action	Who will be affected by this decision or action? Will any rights or entitlements be limited?
Step 3: Identify competing or other interests or obligations	What competing or other interests or obligations might be affected by the proposed decision or action? How do they intersect or conflict?
Step 4: Balance and weigh (proportionality approach)	What is the relevance of the principle proportionate to the action or decision? For any rights or entitlements that might be limited, what will be the likely impact on persons affected? How have I worked with the person to understand the impacts of different options?
Step 5: Decide or act	Am I ready to make the decision and/or take the action? Have I shown how proper consideration has been given and/or reasonable efforts made? Have I documented the reasons for my decision or action?

A scenario applying proper consideration and reasonable effort: Alex

Alex is 28 years old. He is a part time student who lives at home with his parents Julia and Gary and his dog Zorro. He also lives with a mental illness. Sometimes, he hears voices that tell him to harm himself. When this happens, Alex feels very distressed.

Alex has had periods of compulsory treatment within inpatient settings. During his last admission, Alex also experienced restrictive practices. He found the experience traumatising and does not want it repeated. After that admission, Alex worked with his treating team to develop an advance statement of preferences, which says that:

- He wants to avoid inpatient treatment in the future.
- He is willing to receive intensive support in the community.
- It is important for his mental health and wellbeing to continue his studies, take walks with Zorro, and see nearby friends.
- His parents, Julia and Gary, give him daily support. Alex is happy for them to be involved in his treatment and care and for them to receive information.

For most of the last year, Alex has received mental health treatment in the community on a voluntary basis. Recently, Alex told his case manager, Tamara, that he was hearing voices telling him to harm himself again. Alex said he felt it was ‘getting worse’ and that he had not felt this bad since the time before his last inpatient admission.

Alex has been reluctant to tell anyone about his symptoms as he does not want to go to hospital.

Step 1: Identify and understand the relevant principles

Tamara talks with Alex further to understand how he is feeling and to explore options to provide him with treatment, care and support. Tamara explains that after they have talked, she will need to discuss with her colleagues, including the team’s consultant psychiatrist, whether and how the service can meet Alex’s preferences. Tamara asks Alex if he would like to be part of that discussion, and asks if he would like Julia and Gary to be part of that meeting to support him. Alex agrees. While talking with Alex, his treating team:

- identify the following principles as relevant to any action or decision in relation to Alex’s treatment and care: the least restrictive; dignity and autonomy; supported decision making; family and carers; dignity of risk; lived experience; and diversity of care principles.
- show their understanding of the principles throughout the conversation.

☆ **Tip:** It is sufficient to show an understanding of what the relevant principles mean in a general sense. Detailed analysis or reference to legislation is not needed, but it must be done in a way that is not tokenistic.

In this meeting, the treating team, including the consultant psychiatrist, show that they turned their mind to what the supported decision making principle means by listening to Alex’s past experience of compulsory treatment and seeking to understand his views and preferences while exploring and explaining options with him and his parents.

Step 2: Consider impacts of the decision or action

Alex's team identify the following:

- Alex is entitled to receive treatment with the least possible restriction to his rights, dignity and autonomy. This includes being given the dignity of risk to make decisions. He is also entitled to have his preferences about his care responded to wherever possible. The team understand that during his last inpatient admission restrictive practices were used and that this was traumatic for him.
- His preference is not to go to hospital. He has been very engaged with his voluntary community-based treatment. He has expressed his views and preferences in an advance statement of preferences, and verbally. Alex is likely to be distressed by an admission especially if the admission is not voluntary.
- Alex's interests that may be impacted by a compulsory treatment decision include his academic studies, his ability to go walking with his dog and see friends.
- The possible impacts of community-based treatment may include greater risk of self-harm to Alex.

Considering these impacts is central to the process of decision making and engagement with Alex and his family.

☆ **Tip:** consider the impact of a potential decision in a broad sense.

Step 3: Identify competing or other interests or obligations

There are competing interests between Alex's wish to decline inpatient treatment, which he considers is best for his long-term wellbeing (avoiding trauma, maintaining connection to his community and his studies) and his parents and the treating team's concern about his immediate safety given concerns about self-harm. Julia and Gary have concerns about their ability to support Alex's safety in the community, and also need support in their caring role.

The treating team also identify that while they can increase their community support to visit him at home every three days with phone contact in between, they do not currently have resources to offer intensive community support (for example, Hospital in the Home).

The treating team identify that other relevant obligations in this instance include the decision making principles for treatment and intervention, Alex's advance statement of preferences, and privacy obligations.

Step 4: Balance and weigh - proportionality approach

The treating team considers how they can support Alex's decisions wherever possible. They talk with him about his preferences to stay at home and his parents' concerns about his safety and their ability to support him. The treating team, including the consultant psychiatrist, considers this tension through the lens of the relevant principles including: least restrictive, dignity of risk and family and carers.

In partnership with Alex, and with his agreement, his parents' involvement, the treating team explore how Alex is experiencing his voices, what type of support he would find helpful, what options are available, what support Julia and Gary feel they can provide Alex at home, and what each option may mean for his wellbeing and safety. Options include:

- increased support to Alex at home. This includes exploring Julia and Gary's concerns and whether there are ways the service can support them in their caring role. This may include helping them to identify where they can ask for help from others - for example, could Alex's close friends spend time with him during the day, and identifying supports required to meet their own needs.
- admission to Prevention and Recovery Care (PARC) for short-term increased support - explaining the PARC model to Alex and exploring whether it is something he might agree to, including explaining how it would be different from an inpatient admission and may make it easier to continue his engagement in his studies.
- either separately or with either of the above options, exploring whether Alex would be interested in attending a peer support group (for example, Hearing Voices) as an additional strategy to help him manage his voices.

Both options could include discussion with Alex, Julia and Gary about what to do if his symptoms do not improve, or worsen, or if Julia and Gary feel they can no longer safely support Alex at home. For example, ensuring there is a clear crisis plan so that Alex, Julia and Gary are all clear about how to contact the service at any time, if needed. The treating team could continue to talk with Alex about what may help to make an inpatient admission a safe option for him and what they could do to minimise disruption to his daily life, if they considered the risk to Alex and/or others was no longer reasonable. For example, clear strategies to avoid the use of restrictive interventions, considering what leave arrangements may be possible including to attend university or do other valued activities, visiting arrangements for Julia and Gary, other ways to support Alex's continuing education while he is an inpatient including any support to request extensions or special consideration with his university.

Step 5: Decide or act

Alex agrees that PARC is a suitable option for him at this point. He agrees to a week-long stay in the first instance to review medications and see how that goes. He will be able to take Zorro for walks, and this option makes it easier for him to engage in his studies and maintain his connection to the community.

The treating team offers to link Alex's parents with a carer peer support worker and to provide a warm referral to the nearest Connect Centre.

After this discussion, the treating team documents:

- how the principles have been identified and considered in options for Alex's treatment
- how the options respond to Alex's known views and preferences
- the reasons for the decision taken.

Flowchart 2: Applying proper consideration and all reasonable efforts - a consumer journey and systemic example

		● **Consumer journey example**	● **Systemic example**
		Decision about Alex's treatment pathway (see scenario pages 7-9)	*A service provider considering changing their visiting hours*
Step 1: Identify and understand the relevant principles	**What principles are relevant to this decision or action?**	● Least restrictive, dignity and autonomy, supported decision making, family and carers, dignity of risk, lived experience and diversity of care principles.	● Dignity and autonomy, family and carers, wellbeing of dependents, cultural safety and diversity principles.
	Do I understand what the relevant principles mean in general terms?	● For example, the supported decision making principle requires listening to Alex's past experience of compulsory treatment, seeking to understand his views and preferences, and exploring and explaining options with him and his parents, Julia and Gary.	● For example, the dignity and autonomy principle requires rights to be upheld, including the right to communicate. Wellbeing of dependents requires consideration of how dependents maintain contact with a caregiver receiving inpatient treatment.
Step 2: Consider impacts of the decision or action	**Who will be affected by this decision or action?**	● Alex ● Alex's parents, Julia and Gary	● Consumers, their families, children, visiting Elders, pastors, community leaders, friends or supporters.
	Will any rights or entitlements be limited?	Limited **rights** could include: ● Least restrictive treatment and supported decision making - Alex is entitled to have his preferences, including those in his advance statement of preferences, followed wherever possible. ● Dignity of risk - Alex is entitled to take reasonable risks in order to achieve personal growth, self-esteem and quality of life. ● Alex's interests that may be impacted by a compulsory treatment decision include his academic studies, his ability to go on walks with his dog, and see friends. ● The possible impacts of community-based treatment may include greater risk of self-harm.	Limited **rights** could include: ● The right to communicate, for example, having visitors while receiving inpatient treatment. ● Cultural safety - being supported by community, kin and Elders whenever needed. ● Wellbeing of dependents - maintaining connection with caregivers who are receiving treatment.

● **Consumer journey example**

Decision about Alex's treatment pathway

● **Systemic example**

A service provider considering changing their visiting hours

Step 3: Identify competing or other interests or obligations

What competing or other interests or obligations might be affected by the proposed decision or action?

● The treating team can increase their support to visits once every three days with phone contact in between but they do not currently have resources to offer intensive community support.

● Other relevant obligations may include the decision making principles for treatment and interventions, and privacy obligations.

● Julia and Gary are concerned about their ability to support Alex's safety in the community. They also need support for themselves and to maintain their caring role.

● Staffing, the need to have dedicated time for therapeutic engagement, need for quiet times on the unit.

● Possible public health requirements (for example, consider past COVID restrictions).

How do they intersect or conflict?

● There may be competing interests between Alex's wish to be treated in the community which he considers is best for his long-term wellbeing, and his parents and the treating team's concern about his immediate safety given concerns about self-harm.

● Consumers' rights to receive visitors and maintain connection with their families, carers and dependents' may intersect with service requirements, for example, maintaining adequate staffing to support visits, staff limitations overnight.

● Consumer journey example	● Systemic example
Decision about Alex's treatment pathway	*A service provider considering changing their visiting hours*

Step 4: Balance and weigh (proportionality approach)

How relevant is the principle proportionate to the action or decision?

● All of the principles mentioned are very strongly related to a decision about Alex's care and treatment - his views and preferences define what is least restrictive for him.	● For example, the families and carers principle is directly related as contact with families and carers will be supported or limited by the policy.

For any rights or entitlements that might be limited, what will be the likely impact on persons affected? *Impact can only be understood by seeking the views and preferences of those affected.*

How preferences shape the choice	How preferences shape the choice
● Alex's strong preference is not to go to hospital. From speaking with Alex, the treating team understand that an admission, particularly if not voluntary, would create further long-term trauma. The treating team also consider the short-term risk of serious harm arising to Alex and whether he can be adequately supported without a hospital admission.	● The service provider asks consumers, families and carers what the impact on them is and ensures their preferences have weight in decision making.

Step 5: Decide or act

Have I shown and documented how proper consideration has been given and/or reasonable efforts made?

● The treating team documented how they have worked with Alex to understand his views and work through options together with him, being guided at each point by his views and preferences including about what is least restrictive for him.	● The policy is sent for approval with a briefing email noting the process that was followed including how the principles were considered, how consumer and carer feedback was sought and how it informed the final visiting hours policy.

Review point?

● Alex and the treating team agree to review how the chosen option (PARC) is working for him in a week.	● The policy has a planned review date of 12 months and includes advice to staff to remind consumers, carers, and families about how to give feedback or raise concerns about the visiting hours policy in the interim.

5. Service leadership actions to embed the principles

The following is a summary of leadership actions that are required to embed the principles into service design and delivery. See the full guidance and implementation resources for more detail.

Leadership and culture: Embed the principles in policies, procedures and decision making. Strengthen human rights cultures - for example, identify portfolios, committees and/or champions who are responsible for driving human rights, safety, and just cultures. Embed the principles in quality improvement activities including critical incident review and link them to staff reflection and training. Encourage innovation and new approaches, and promote cross-service learning. Have a clear approach to planning for and monitoring principle implementation, including monitoring and reporting on trends and improvements.

Partnering with consumers: Embed lived and living experience in decision making at all levels. Codesign activities with people who are directly impacted by the decision or action, or have relevant lived and living experience. Promote and protect rights, using codesigned materials wherever possible. Welcome feedback and complaints, using culturally safe and trauma informed processes. Theme complaints in line with the principles, with lived and living experience input, to identify, make and test effectiveness of improvements.

Workforce: Embed the principles in recruitment, position descriptions, induction, professional development and performance management processes. Have a clear strategy to ensure the workforce reflects the diversity of the community (for example, First Nations and multicultural staff and staff with diverse gender and sexualities). Develop lived and living experience workforce leadership structures and career pathways. In partnership with lived and living experience, develop and monitor clear plans for training staff about rights and principles and provide opportunities for reflection. Provide ways for staff to seek advice and help to navigate complex situations and reflect on uncertainties, gaps and errors. Support staff at all career stages to learn from lived experience.

Risk management: Have a clear framework for identifying and managing risk that aligns with the principles. Clearly communicate this framework to staff, consumers, carers, families, supporters and kin. Develop consumer, carer and family focused information that aims to create shared understandings of risk and autonomy and explains how taking reasonable risks can contribute to personal growth, self-esteem and quality of life.

Clinical practice: Identify and respond to the diverse needs of the consumers, carers and families who access your service, with particular attention to Aboriginal consumers, carers and families. Ensure existing systems and resources help staff to apply the principles. Support staff to use flexible, creative approaches when applying the principles and encourage learning through continuous improvement, including learning from Safer Care Victoria's Mental Health Improvement Program.

6. Key actions for each principle

The following pages set out core actions to apply the principles in daily practice. For more detail, see the full guidance. The dignity and autonomy and supported decision making principles are foundational to all other principles - people's rights must always be protected, and people must always be supported to make and participate in decisions. For this reason, these two principles are listed first.

Dignity and 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.**

Ask if people need support to understand information and rights, and to make and communicate decisions. For example, interpreters, translated information, Easy English resources, cultural supports, communication apps, visual aids, decision support tools and communication boards. Communicate in ways and environments that respond to a person's needs and with consent, involve their families, carers and supporters.

Give and explain statements of rights and compulsory orders to consumers and their nominated support person, guardian, carer, or parent of a consumer aged under 16, as soon as practicable. Use supports to explain rights in ways the person understands, and revisit rights discussions regularly.

Support people to exercise their rights to make complaints, appeal to the Mental Health Tribunal, request a second psychiatric opinion, access IMHA advocacy, and access legal help.

Protect the right to communicate: Support people to communicate by email, phone, letters and visits at reasonable hours. Never restrict communication with a lawyer, advocate, the Chief Psychiatrist, Mental Health Tribunal, Commission or a community visitor. Ensure any restrictions on communication are the least restrictive possible to protect health, safety and wellbeing, are communicated in writing to the person, their nominate support person, guardian, carer, and IMHA, and are regularly reviewed. Recognise that removing mobile phones is a restriction that must not be done unless lawful and justified.

Promote and protect dignity: Ensure inpatients always have access to bedding, clothing, food and water.

Ensure people don't have to repeatedly talk about previous trauma. Always orient people to the service and to the lived and living experience workforce. Respect people's identity (for example, gender, sexuality, culture or religion). Support people to access comforts from home while receiving treatment.

Promote and protect privacy: Support private communication and promote privacy within bedroom and bathroom areas of inpatient or residential environments. Minimise searches by exploring less intrusive alternatives, and considering safety, human rights, trauma history, and gender and cultural needs.

Support the **right to ask for amendment of a health record** or make a **Health Information Statement**. For example, explain to consumers, families, carers and supporters that the consumer has a right to ask for changes to their health information record. Explain that a consumer can make a Health Information Statement (HIS) if a request to change a health information record is refused, and place any such HIS on the person's health information record.

Develop clinical notes together with consumers wherever possible. If there is no agreement about terms or descriptions, document the person's perspectives, including direct quotes if possible.

Promote responsive feedback cultures: Welcome and learn from complaints, provide accessible information about how to give feedback and make complaints (including anonymously). Provide support to make a complaint and share accessible information about service changes and improvements from complaints. Be curious about the underlying issues, concerns or harms at the heart of a person's complaint. Hear and respond to people's feedback including after they have been discharged from the service, including offering consumer advocacy support.

Supported decision making

> 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.

Implementing this principle involves finding ways to maximise a person's choice and control, including when they are receiving compulsory treatment. At times, this will include supporting decisions that are not preferred by the service.

Be curious about people's views, preferences, values and priorities: Ask people what is important to them in their treatment and recovery, and what they need to feel and be safe while at the service. Give people information and options and support their choices wherever possible.

📖 **Always presume capacity to give informed consent:** This includes when a person is a compulsory patient and before starting compulsory treatment. A person has capacity if they can understand, remember, use and weigh information that is relevant to a decision, and can communicate the decision (including with assistance). Capacity can be supported (for example, by providing decision making support), is decision-specific and can change over time. A person can't be assessed not to have capacity only because they make a decision that could be considered unwise - including choosing not to have treatment - or because of their age, appearance, disability, condition or behaviour.

📖 **Assess capacity when and where it can be most accurately assessed:** Consider the environment and time, for example, when the setting is calm and the person has had rest, food and drink.

📖 **Support people to make informed decisions:** Give people adequate information about treatment options (including about purpose, type, method, likely duration, beneficial alternative treatments, advantages and disadvantages of having or not having the treatment, risks and side effects). Give people time, and the opportunity to ask questions and seek support to make decisions. Make sure people aren't under pressure to make decisions and haven't withdrawn consent to a decision.

Check for and follow advance statements of preferences: Offer information and education about advance statements of preferences at key points - for example, intake, treatment planning and discharge. Check that a person's advance statement of preferences remains current whenever treatment is reviewed and at key transition points. 📖 Always check if a person has an advance statement of preferences (for example, ask the person, check the clinical file, ask any known carer, family or supporter) and follow their preferences wherever possible. For example, seek creative solutions to what can be offered within your service, or support the person to access external services or supports. 📖 If preferences can't be followed, explain the reasons why to the person and their support people verbally as soon as practicable, and in writing within 10 business days.

📖 **Check for and involve nominated support persons:** Always check if a person has a nominated support person (for example, ask the person, check the clinical file, ask any known carer, family or supporter). Involve the nominated support person including by contacting them as early as possible, providing information, including them in meetings with the treating team and allowing them to review treatment documents. Recognise that a nominated support person and carer are different roles even if held by the same person, and both roles may need support.

Work with IMHA advocates to support decision making: Encourage the involvement of IMHA advocates. For example, offer to contact IMHA for anyone who is a compulsory patient or at risk of compulsory treatment at admission and key decision points, and display and share information about IMHA advocates in multiple languages and formats. 📖 Give IMHA advocates any reasonable assistance to perform their role - for example, with the consumer's consent, give them information including the consumer's advance statement of preferences, and encourage and support them to attend meetings.

📖 **Involve families, carers, supporters and kin** in treatment and care planning and discussions to support decision making, in line with the consumer's consent and preferences.

Diversity of care

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.

Explore people's preferences and needs: For example, by asking people directly and involving families, carers and supporters in line with the consumer's preferences. Check if a person has an advance statement of preferences or nominated support person that can help to explain their preferences about the kinds of treatment and care that work for them.

Give information about options including different types of care and treatment: This includes access to the lived and living experience workforce such as peer support, as well as allied health services including psychology, social work, physical health or services like dieticians, physiotherapy and exercise physiology.

Connect people to a range of supports that meet their expressed preferences and needs - either within your service or by referring the person to external supports. For example, group therapy, online help, art or music therapy, cultural and spiritual support. Ensure people have adequate community supports in place for after they are discharged from an inpatient unit or from a service.

Promote community participation by linking people with community resources and groups that meet the person's preferences and interests, and support their recovery goals.

Least restrictive

> 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.

Promote autonomy and rights: See dignity and autonomy principle.

Give proper consideration to the decision making principles when making decisions about compulsory assessment and treatment and restrictive interventions.

Make all reasonable efforts to support the person's capacity to make decisions: See supported decision making. Decisions may only be made for the person if they are a compulsory patient who does not have capacity to give (or has not given) informed consent to treatment, the treatment is clinically appropriate, and least restrictive. If a substitute decision is made, explain it clearly to the person.

Prioritise the consumer's views and preferences including as expressed directly, in an advance statement of preferences, or by a nominated support person on the person's behalf - **recognising that least restrictive treatment means treatment that is most in line with what the consumer wants.** Explore beneficial alternative treatments, and the views of any guardian, carer, or parent of a patient aged under 16.

Work with the person to meet their treatment preferences wherever possible, and, with consent, their family, carer, supporters and kin. Consider options like private or voluntary treatment, a range of treatment options including talking therapies and group therapy or adjusting medication type, administration method and dosage. Ask for the person's preferences about treatment environment. Avoid using compulsory treatment as a default pathway to discharge from an inpatient unit and ensure reasons for decisions are clearly documented, including alternatives that were considered.

Promote leave from inpatient units in line with the person's preferences and risk and safety assessments.

Reduce and eliminate restrictive practices: Gather information from the point of admission, from the person, any advance statement of preferences or nominated support person and their carer, family or supporters, about strategies, strengths, preferences and protective factors that can be built on to avoid using restrictive practices at an individual level.

Offer education and resources for consumers, carers, families, supporters and kin about restrictive practices and rights. For example, the need for restrictive practices to be reduced and minimised, the rights outlined in the dignity and autonomy and supported decision making principles, and the right for carers to be involved in care and treatment and to be informed about the use of restrictive practices.

Seek and respond to feedback from consumers, carers and families about what helps people to feel and be safe - for example, sensory rooms and resources, access to comforts from home.

If a restrictive intervention is used:

- cease it as soon as it is no longer needed to prevent imminent and serious harm, or, for bodily restraint, to administer treatment.
- explain to the person what has happened and what would enable the restrictive intervention to stop.
- offer debriefing and support. This could include offering the involvement of lived experience staff to support the person, if possible.

Family and carers

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.**

Consistently and inclusively identify carers, families, supporters and kin including young carers. Recognise that family looks different for everyone, and may include family of origin or choice, extended family, important members of a person's community, and kin. Regularly review and update details.

Explore how the consumer would like to involve their carer, family, supporter or kin in their care. Discuss the benefits of involving carers, families, supporters or kin, what kinds of information the consumer agrees to or prefers not to share, and revisit preferences over time.

Proactively involve families, carers and supporters in care and treatment discussions - for example, family meetings, care planning meetings and discharge planning. Welcome ongoing dialogue. Ask about and use carer, family, supporter and kin insights into the consumer's strengths, history, preferences, communication style, early warning signs, and protective factors.

Explain information sharing, privacy and confidentiality clearly to consumers, families and carers - for example, share Tandem's resources about information sharing with families and carers.

Maintain and support relationships between consumers and their carers, families, supporters and kin where safe and appropriate to do so.

📖 **Share information in accordance with Act requirements:** For example, share information with the consumer's consent, or share general information or information needed to provide care after considering the consumer's views and preferences about sharing that information. Inform and notify carers and give them copies of compulsory orders and statement of rights at key points including when a temporary treatment order is made, varied, revoked or expires, when a treatment order is applied for, or a restrictive intervention is used.

Accept information from carers even if the consumer has not consented to information being shared with the carer. Have clear processes for identifying and protecting any information shared in confidence.

Screen for and respond to family violence: Ask consumers, carers and families sensitively about how they experience key relationships, including what works well and any concerns.

Support family and carer wellbeing: Proactively check in with families and carers about their own wellbeing regularly - not just at crisis points. Ensure their needs are actively considered and addressed in care planning including discharge planning. Refer to carer peer support and practical assistance like respite, system navigation support, and carer support services.

Where there are differences in opinion between a consumer and a carer, uphold the consumer's preferences as far as possible, while respecting and supporting the carer's role. For example, by hearing their views and concerns, providing the information they need to provide care and connecting them with supports. See also dignity of risk principle.

Lived experience

The lived experience of a person with mental illness or psychological distress - and that of 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.

Recognise and value that people are the experts in their own lives: Ask people what they need and want, and provide appropriate supports to enable communication and decision making. See dignity and autonomy principle.

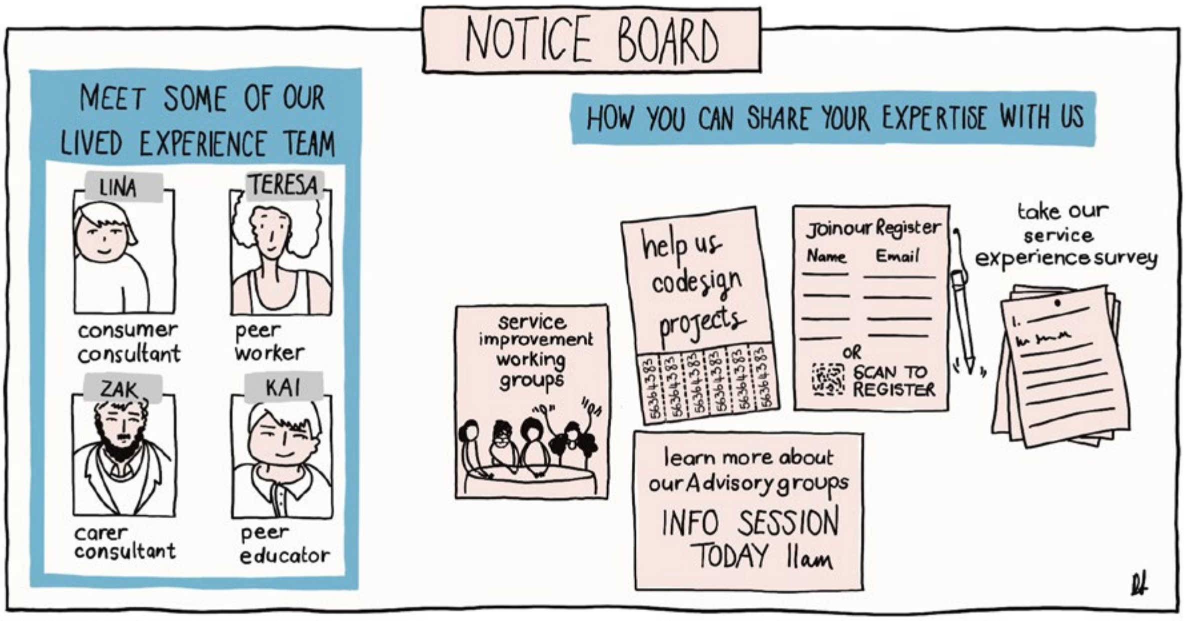
Seek and learn from complaints and feedback: Make sure complaint and feedback processes are culturally safe and trauma informed. Offer as much choice and support as people would like or need - for example, choices to make a complaint to the service or the Commission, to involve support people including lived and living experience or First Nations workforce, or to make anonymous complaints.

Learn from consumers, carers and families: Actively encourage, support and pay current and former service users for their input into service design, delivery and improvement activities. Offer information, orientation and training, and opportunities to develop leadership capabilities.

Ensure systemic improvement activities are safe for First Nations and multicultural consumers, carers and families and people with diverse gender and sexuality. For example, seek advice from relevant organisations or designated roles within your service about how to ensure engagement is safe and respectful. Seek diverse input to make your service as safe and accessible for everyone as possible.

Support and value the lived and living experience workforce: Be curious about what you can learn from the lived and living experience workforce, give time and space for collaboration, and be guided by lived and living experience workforce about how you can support and enable their work. Identify and acknowledge power imbalances and use practical strategies to address these - for example, including more than one lived and living experience staff member in teams, groups or pieces of work.

Share or give up power: Identify who isn't in the room (including whether diverse perspectives are included) and make changes accordingly. **Identify activities and projects that are not currently but could be led by lived and living experience workforce and/or specific perspectives, and where lived and living experience can have decision making power.**



Health needs

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.

Identify physical health concerns by asking the person about their views, preferences and priorities for their physical health. Respect where the person is at - if they are not ready to address an aspect of their health, revisit this later. Ask what is important to them, what they would like to maintain, change or improve, and if there is anything that worries them.

Be aware of and offer tailored support in response to physical health disparities for some communities. For example, develop specific strategies to support the physical health of Aboriginal and Torres Strait Islander consumers. Be mindful of the impact of systemic discrimination on access to services, and that some pe
may prefer to access specialist services
Aboriginal-led services and LGTBIQA+ f
services.

Give relevant information, education and support to identify and explain choices: For example, explain mental health treatment options, and their possible physical health impacts or side effects as well as their expected benefits. Prioritise the person's treatment preferences, including any concerns about previous experiences, side effects, or trauma. In addition, explain options for addressing their physical health priorities.

Work with the person to develop a holistic plan that reflects their individual needs and preferences. Recognise the importance of cultural and spiritual activities as part of a person's overall wellbeing and include these as priorities where this is in line with the consumer's preferences.

Address alcohol and drug needs as part of holistic care planning, in line with the person's priorities.

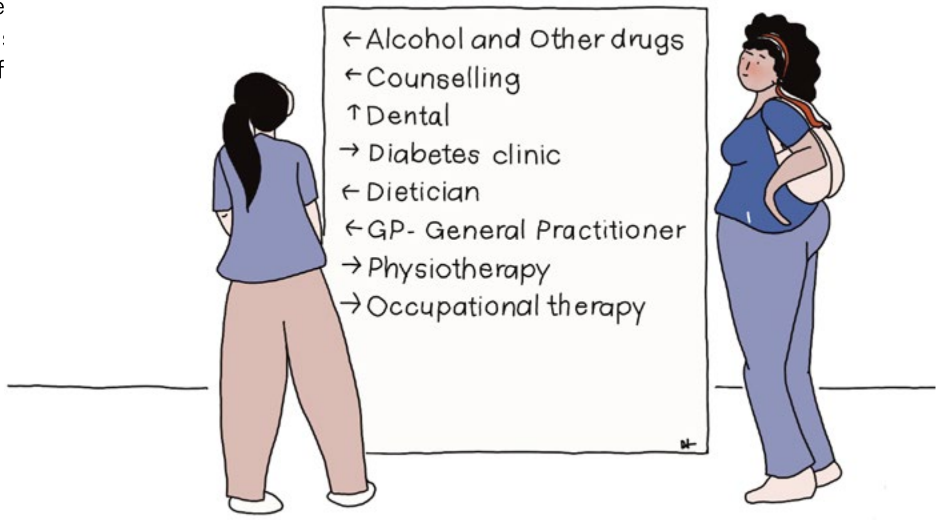
Make referrals to other parts of your service or external services to help the person access the services they need.

Support the person to address barriers to improving their physical health - for example, managing medication side effects, exploring financial support, or finding accessible or inclusive activities that meet their preferences.

Be non-judgmental about any alcohol or drug use - explore the person's reasons for substance use and how it impacts and intersects with their mental health, wellbeing and recovery.

Explore interest in reducing or quitting smoking if the person is a smoker, and offer evidence-based support.

Monitor physical health regularly: Prioritise the person's experiences and views about what is or isn't working well for them and where they would like more support.



Dignity of risk

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.**

This principle is intended to alter the balance of power between medical authority and people with mental illness - to respect people's inherent dignity and human rights, and to weigh against a paternalistic or overprotective approach to service provision.[2]

Explore what personal growth, self-esteem and quality of life mean for the person.

Respect and support the right to make decisions: Presume capacity to give informed consent to decisions - see supported decision making principle. Both voluntary and compulsory patients have a right to make informed decisions involving reasonable risks. What is a reasonable risk may depend in part on the person's current circumstances and supports.

Promote supported decision making practices: See supported decision making principle.

Check if support is required to understand information, rights and options, and to make and communicate decisions. See dignity and autonomy principle.

Support decisions to take reasonable risks, and work together on safety planning: Work together with the consumer, and with consent, their carers, families, supporters and kin. Discuss risks and safety together with consumers, carers, families, supporters and kin to develop a shared understanding of safety, risks and opportunities.

Discuss the benefits and risks of different decisions. This includes considering:

- The consumer's **views, preferences, values and priorities.**
- The **benefits and risks of the person's preferred option** - how does it promote personal growth, self-esteem and quality of life? What general and specific information do you have about the likelihood and seriousness of possible harm to the person or another person?
- The **benefits and risks of options** proposed by the service, or other alternatives. For example, symptom stability or relapse prevention, as well as risks of trauma from compulsory treatment or restrictive interventions, loss of trust with the treating team, medication side-effects, loss of autonomy, or serious distress, disruption to relationships, living arrangements, work and study.
- **Evidence based protective factors** - for example, current mental health, wellbeing and supports.
- Steps that can be taken to **reduce identified risks** - for example, support to access housing, psychological support, or alcohol and drug services, or strengthening community connections.
- What treatment and care options are available and what **less restrictive** ways there may be to meet a person's preferences and respond to their clinical needs.
- Any agreed **reasons to review** the approach to treatment, risk and safety.
- Practical resource **constraints**.

Only intervene if there is a lawful reason: Only make decisions for the person if there is a lawful reason to do so - if all of the following apply: the person is a compulsory patient who does not have capacity to give informed consent to treatment or has refused consent, the treatment is clinically appropriate and there is no less restrictive way to treat the person.

Ensure any decision made for the person is least restrictive - that it is the most consistent with the person's preferences. If a person's decision making is restricted, make plans to move towards decisions that are more in line with the person's preferences. See least restrictive principle.

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[2] Explanatory Memorandum to the Mental Health and Wellbeing Bill 2022, p 22

Wellbeing of young people

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.

Respect and value the diverse and unique identities and experiences of Aboriginal children and young people. Acknowledge and appreciate the strengths of Aboriginal Culture and its role in wellbeing and safety. Encourage and support Aboriginal young people to express their culture and exercise cultural rights. Address racism. See cultural safety principle.

Create a safe, inclusive environment for children and young people to meet diverse needs relating to culture, religion, gender, sexuality, disability, neurodivergence, family violence, sexual safety, education, transport (for example, public transport) and housing. Connect young people with relevant supports.

📖 **Promote and protect rights** including the unique rights of children and young people. For example, explain how children and young people can expect adults at the service to behave and how they can raise concerns for themselves or others (see Child Safe Standards). Be mindful of the importance of online connection for young people and the potential impact of any restriction to their right to communicate. See dignity and autonomy principle.

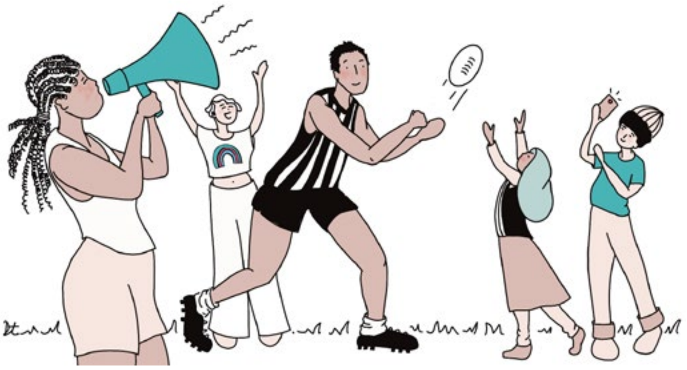
📖 **Promote autonomy and decision making:** Remember the presumption of capacity also applies to young people. Give young people information in ways they can understand it, providing supports if needed. Encourage young people to access IMHA advocacy. See supported decision making and dignity and autonomy principles.

Involve carers, families, supporters and kin in line with the young person's preferences. Be clear with the young person about when the service is required to share information or involve parents. Recognise that family looks different for everyone. Actively support and strengthen important relationships, including when there is disagreement, if safe to do.

Prevent and mitigate risks: Prevent, identify and mitigate risks of child abuse and harm in both physical and online environments within your service. For example, balancing risks with young people and children's rights to privacy, access to information, social connection and learning.

Provide age and developmentally appropriate support: Support young people to make and participate in decisions about their treatment, including the type and setting of treatment that is best for them. If a young person (16+) is treated in an adult service, talk to them about their needs and ensure they are met. For example, cultural and gender safety, and access to outdoor space and meaningful, age-appropriate activities. Hold space for any uncertainty or worry about being in a service, including whether it is a first admission, and how it may affect their routines and supports such as school, family and friends.

Value young people's lived and living experience and include them in service design. See lived experience principle.



Diversity

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:

- gender identity
- sexual orientation
- sex
- ethnicity
- language
- race
- religion, faith or spirituality
- class
- socioeconomic status
- age
- disability
- neurodiversity
- culture
- residency status
- geographic disadvantage.

Mental health and wellbeing services are to be provided in a manner that:

- is **safe, sensitive and responsive** to the diverse abilities, needs and experiences of the person including any experience of trauma
- **considers how those needs and experiences intersect** with each other and with the person's mental health.

Communicate in ways that respond to the diversity of consumers, carers, families, supporters and kin and share information in ways that meet their needs - for example, provide supports to understand information and rights, and to make and communicate decisions.

Routinely ask about people's cultural, religious, communication, accessibility, or identity-based needs and act on what they share. For example, be guided by the person about who is important in their life - including extended family, community leaders and faith leaders. Respect what the person tells you about their identity. Ensure people can access their usual disability supports including while receiving inpatient treatment (for example, mobility aids).

Recognise that intersecting aspects of identity can affect a person's experiences, including access to care, experiences of stigma, or trauma.

Provide trauma-informed and responsive care to all consumers. For example, always ask people what they need to feel and be safe and welcomed in the service, give as much choice as possible, support people's capacity to make decisions about treatment and care, and take least restrictive approaches.

Be mindful of trauma: People with diverse identities may be more likely to have experienced compounded traumas - including racism, discrimination, targeted violence, trauma associated with refugee or migrant experiences - which can impact their mental and physical health, and their access to services.

Increase responsiveness to intersecting needs: Create ways to make services more accessible and responsive to intersecting needs - for example, spaces or programs for multicultural women, girls and gender diverse people.

Gender safety

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:

- are **safe**
- are responsive to any current experience of **family violence and trauma** or any history of family violence and trauma
- recognise and respond to the ways **gender dynamics** may affect service delivery, treatment and recovery
- recognise and respond to the ways in which **gender intersects** with other types of discrimination and disadvantage.

Ask what a person needs to feel safe and dignified: Reassure them they do not need to explain why. Incorporate their needs into their care and treatment. Promote autonomy and choice. For example, ask whether a person prefers to be treated by staff of a particular gender, or for bed-based services, accommodation in a gender-sensitive area of the unit.

Be responsive to trauma: Understand that certain incidents, environments or practices - such as inpatient settings, compulsory treatment, and experiencing or witnessing restrictive practices - may have an additional impact on people based on their prior life experiences, including trauma.

Create safety with and for people with diverse gender identities: Seek training and be guided by lived and living experience advice wherever possible. For example, to help people feel safe - ask what they need to feel safe and supported, follow what the person tells you about their name and gender, respect choices about disclosing sex, gender identity or sexuality in certain settings or circumstances and ask about and respect preferences to be treated by staff of a particular gender where possible.

Recognise and respond to family violence: Comply with the MARAM Framework's requirements, for example, screen for family violence risk using approved tools, provide information, make referrals, and escalate concerns as needed. Practical steps in a bed-based environment include asking consumers sensitively about relationships - exploring strengths and concerns - and clarifying who they would like to be able to visit them or who they do not want to receive visits from.

Do not share information if you reasonably believe doing so would place someone at risk of family violence: This applies even if sharing the information is allowed by the Act or agreed to by the person whose information it is.

Recognise how gender and other types of discrimination and disadvantage intersect: Identify barriers that may prevent people from accessing or having their needs met in mental health and wellbeing services. For example, for women and gender diverse people who are also multicultural, Aboriginal, have a disability, are LGBTIQA+, or have migrant or refugee backgrounds.

Recognise how different life stages (for example, adolescence, parenthood) may impact mental health.

Recognise how gendered medical conditions or experiences may impact the mental health of girls, women and gender-diverse people[3]. Explore physical health symptoms thoroughly.

Promote and protect sexual safety in line with the Chief Psychiatrist's guidance.

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[3] Department of Health (2025) *Bridging the gender pain gap inquiry report*.

Cultural safety

Mental health and wellbeing services are to be **culturally safe and responsive** to people of all racial, ethnic, faith-based and cultural backgrounds.

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.

Treatment and care for Aboriginal and Torres Strait Islander peoples 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.

This principle refers to cultural safety for people of all racial, ethnic, faith-based and cultural backgrounds, as well as specific obligations for providing treatment and care to Aboriginal and Torres Strait Islander peoples. This means that there are two aspects to cultural safety - a clear focus on cultural safety for First Nations peoples, and a universal approach that promotes cultural safety for all.

Approaches to implementing the cultural safety principle must recognise and respond to the distinct cultural rights and ways of knowing and being of First Nations peoples and not conflate these with universal approaches.

Learn from the social and emotional wellbeing model of health, including connection to physical wellbeing, mental and emotional wellbeing, and connection to family and kinship, spirituality and ancestors, community, Culture and land.

Work with Aboriginal workforce and organisations to support culturally safe treatment and care.

Acknowledge and actively address the impacts of racism, discrimination and colonisation.

Ensure treatment and care is responsive to Aboriginal and Torres Strait Islander peoples' unique Culture and identity. Involve the people the consumer identifies as important in their life or treatment - including Kin, Elders and Aboriginal workforce. Ask what is important to the consumer, their carer, family, supporters and kin and prioritise treatment that supports social and emotional wellbeing. Offer engagement with traditional healers, ensure connections to family, kinship, community, Country and waters are respected and considered as part of care and treatment. For example, prioritise these connections in decisions about community or inpatient treatment or leave.

Actively ask about culture, and respect cultural and spiritual beliefs and practices. For example, ask what is important to the consumer and their family - such as spirituality, faith or religious requirements - and how you can support these by enabling access to prayer rooms, meeting dietary needs and making space for ceremony such as breaking a fast.

Respect the cultural and spiritual significance of clothing or belongings. In high-risk environments, this may include items that pose safety risks. Where items cannot safely be permitted, consider how to offer safe, culturally appropriate alternatives, seek support from cultural/multicultural liaison offers to navigate conversations, and involve carers, families, supporters, kin and community.

Be guided by the person about who they would like to involve in their treatment and care: In addition to carers, family, and nominated support persons, this may include kin, extended family, community leaders, or faith leaders.

Wellbeing of dependents

The **needs, wellbeing and safety of children, young people** and other dependents of people receiving mental health and wellbeing services are to be **protected**.

Identify and record information about dependents as early as possible - ask consumers carefully and sensitively about their lives and family connections. Revisit and update this information regularly.

Identify young carers: Recognise they may have key support responsibilities, and with consumer consent, involve them in treatment and care discussions according to their preferences and capacity.

Regularly discuss the consumer's parenting and caregiving role as part of assessment and treatment planning. For example, work with the consumer and, with their consent, their carer, family, supporters and kin to identify strengths, and help them access any services and supports that will help them to maintain their caring role and to meet the needs of their children or other dependents.

Co-create and embed plans for dependents' wellbeing: Promote safety and wellbeing for children, young people and dependents including by co-creating and embedding plans. Ensure plans include who will care for dependents (encourage consumers to state this is an advance statement of preferences) and how connection between the parent or caregiver and child, young person or dependent will be maintained during treatment. For example, visits, phone or video calls, emails, letters or shared online activities. Use available care plan templates to prompt thinking about the specific and diverse needs and experiences of dependents (including based on their age and developmental stage) and the information, resources, networks and supports that may be available.

Be aware of and comply with, for example, the Child Safe Standards, mandatory reporting requirements and other information sharing requirements (such as the Child Information Sharing Scheme).

Clearly explain confidentiality and its limitations to consumers, families, carers, supporters and kin.

Give information resources to consumers and offer support and advice to the consumer, carer, family, supporters and kin about how to talk with children or dependents about mental illness in a way that is safe, supportive and developmentally appropriate.

Give children, young people and dependents age-appropriate information, support and referrals, including to support young carers. This may include:

- Services that can support the needs of children and young people such as the Satellite Foundation, Little Dreamers Wellbeing Hub, child and family health clinics, family counselling, The Orange Door, peer support, other mental health and wellbeing supports or financial support.
- Specific supports for young carers including via the Families where a Parent has a Mental Illness (FaPMI) program.

Share information: With agreement from the child or young person and the consumer, share information with other services including the education system, to ensure their circumstances are accommodated.

7. Short scenarios

The following are two simple scenarios that show the positive impact of complying with the principles. More complex examples are available in the implementation resources on the Commission's website.

1. Supported decision making: upholding an advance statement of preferences

What happened?

Elia, a young woman, was admitted to the inpatient unit on a temporary treatment order, experiencing considerable distress. The treating team considered that antipsychotic medication would help Elia, and suggested injectable medication. This suggestion made Elia more distressed.

What actions did the service take?

The nurse checked the system to see if Elia had an advance statement of preferences. The staff checked with Elia if her statement was still current and if Elia had a nominated support person. Elia's statement said that in the first instance, she would always prefer oral medications because of previous trauma from injectable medication. The nurse alerted the psychiatrist, who changed the treatment plan to offer oral medication.

When the nurse offered Elia oral medication she initially declined, because of anxiety about swallowing medications. Another staff member spent some time speaking to Elia, listening to her concerns and exploring her options and fears. Elia agreed to take oral medication after lunch, in the privacy of her room, and with one staff member present.

Reflections from Commission lived and living experience staff

Saying 'yes you can take it after lunch, in your room with one staff member present' was a simple solution that didn't need a lot of extra resources, and honoured Elia's preferences. Elia started oral medication without any coercion. It was a good outcome for staff as well, who were able to uphold her dignity and autonomy.

What other principles were engaged?

Mental health and wellbeing principles: least restrictive, dignity and autonomy

Decision making principles: autonomy

2. Least restrictive: changing medications

What happened?

Kaden asked to change his medication, as the side effects of his current medication were impacting his quality of life. Kaden felt angry about the impact of his current medication and was extremely worried about side effects from a new medication.

What actions did the service take?

Kaden's psychiatrist sat down with him to explain both medications in detail. They explained things like the benefits and the disadvantages of both, including the side effects Kaden was experiencing from his current medication, and the known side effects of the new medication. Kaden's psychiatrist could see Kaden was still worried, and offered Kaden the opportunity to meet with the community pharmacist to talk more about side effects. This allowed Kaden to speak with someone who was not involved in making decisions about compulsory treatment. After discussing side effects with the pharmacist, Kaden felt supported in his decision to try the new medication.

Reflections from Commission lived and living experience staff

Bringing in the pharmacist showed Kaden that his psychiatrist was deeply listening to his concerns and preferences and trying to give him the best answers he could. Kaden felt heard, that what mattered to him was being taken seriously, and he felt reassured to have the opportunity to ask, and get answers to, his questions, from someone not involved in providing compulsory treatment. From the fact that Kaden's psychiatrist took the time to think about what might help Kaden to make a decision, it sounds like he was approachable and kind, which probably helped significantly.

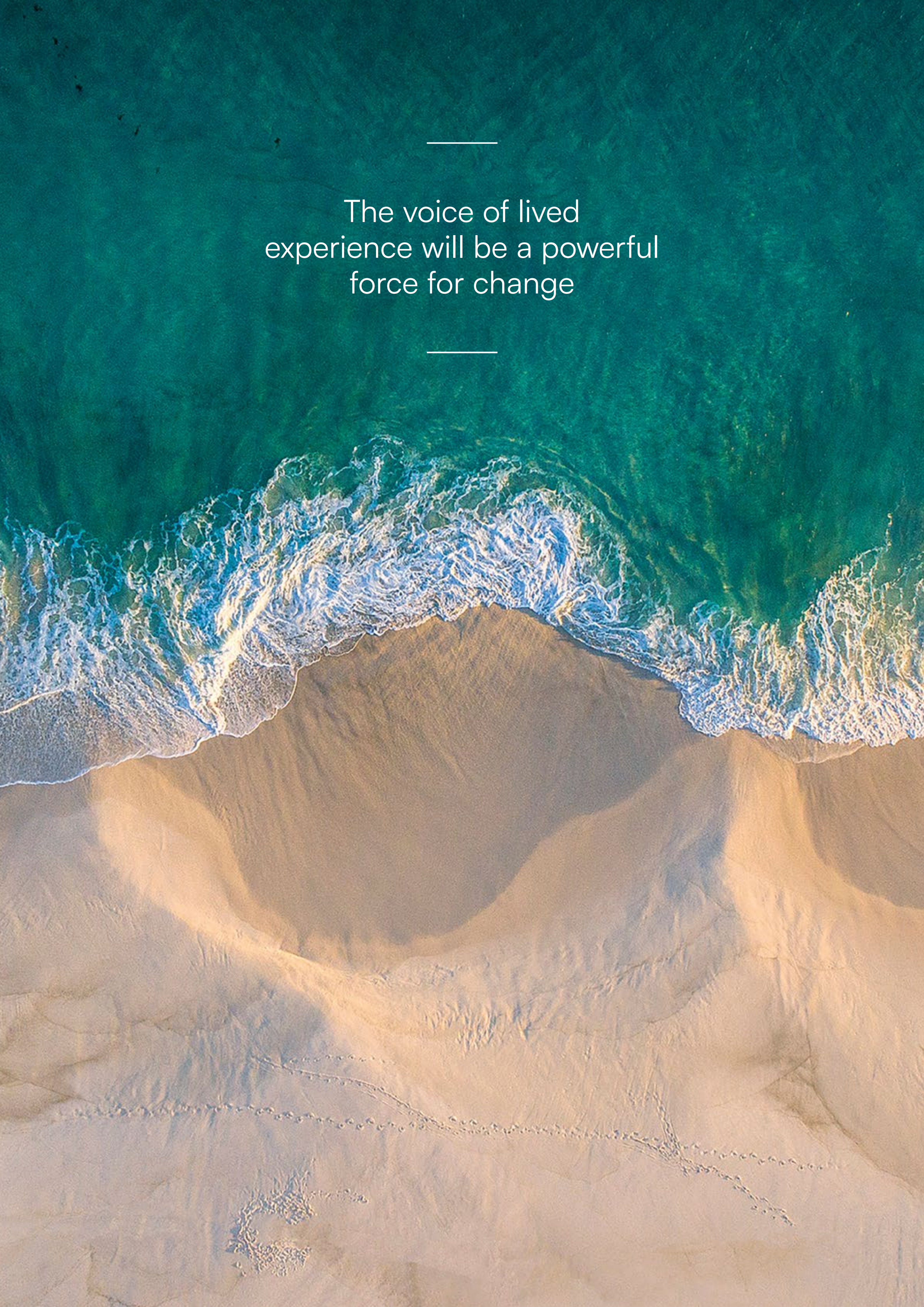
What other principles were engaged?

Mental health and wellbeing principles: supported decision making, health needs

Decision making principles: autonomy

How would you approach this situation?

What might you do differently?



The voice of lived
experience will be a powerful
force for change

Mental Health
and Wellbeing
Commission