Mental health and wellbeing principles guidance

From intent to impact

Mental Health and Wellbeing
Commission

Mental Health
and Wellbeing
Commission

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Contents

This includes complaints and our compliance approach and related legislated functions.

This includes who we worked with, definitions, related frameworks and references.

Acknowledgement of Victorian Aboriginal people

The Mental Health and Wellbeing Commission (the Commission) acknowledges with deep respect all Victorian Aboriginal people and Traditional Owners.

We recognise 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.

We acknowledge the devastating impact of colonisation on Aboriginal people, including the displacement, dispossession and ongoing social, emotional, biological and political consequences they experience. We acknowledge that due to historical and current colonial processes, protocols and policies, Indigenous Peoples continue to experience disparities in mental health outcomes. We recognise that many Aboriginal people have experienced and continue to experience trauma when they interact with the mental health system, and we understand that the current structural framework of the system needs to be reformed to address these issues.

We also acknowledge the strengths and resilience of Aboriginal individuals and communities. We are committed to respecting and learning from Aboriginal ways of knowing, being and doing at all times. We trust that this guidance can contribute to a culturally safe mental health and wellbeing system.

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 families, carers and supporters.

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, including the activism and courage instrumental in both bringing about the Royal Commission into Victoria's Mental Health System and in guiding its progress and recommendations.

We are committed to working with an intersectional lens, recognising that individuals embody multiple, interwoven dimensions of identity that shape their experiences and influence the challenges they face. We believe the principles support a service system that honours the complexity of each person's lived and living experience and responds with compassion, inclusivity and effectiveness.

Commitment to lived and living experience

Our functions, commitments and aspirations

Under the *Mental Health and Wellbeing Act 2022* (Vic) (the Act), the Commission has functions to:

- elevate lived experience leadership and support the full and effective participation of people living with mental illness and psychological distress in decision making (s 415(b)
- develop and support lived experience leadership (s 415(c)) and
- promote the role, value and inclusion of families, carers and supporters (s 415(e)).

We are committed to being grounded in lived experience expertise and being an exemplar organisation for lived experience leadership (Mental Health and Wellbeing Commission 2024a).

Our Lived Experience Plan (Mental Health and Wellbeing Commission 2025), shows our aspirations for the mental health and wellbeing sector - including ourselves - to embed inclusive leadership that values lived and living experience and ensures consumers, carers, families, supporters and kin have the power to make decisions that are right for them.

Lived and living experience in action - driving this guidance

This project has been sponsored by our Lived Experience Chair Commissioner - Consumer, Maggie Toko and Lived Experience Commissioner - Carer, Jacqueline Gibson, and led by our Lived Experience team.

At every stage of this project, the Commission has engaged with organisations, advisory groups and individuals with diverse lived and living experiences, to understand and reflect the diverse perspectives and experiences of consumers, carers, families, supporters and kin.

Message from the Lived Experience Commissioners

Maggie Toko
Lived Experience Chair
Commissioner - Consumer

Jacqueline Gibson
Lived Experience
Commissioner - Carer

> This guidance translates lived experience wisdom into practical direction for services. It's a vital step toward creating environments where people feel heard, respected, and empowered to lead their own recovery.

> These principles provide a strong foundation for services to genuinely recognise, include, and value the voices of families, carers, supporters and kin. They will help embed lived experience at the heart of care - ensuring that support is compassionate, collaborative, and guided by real understanding.

Recognition of networks and partners

Our main engagement strategy for this guidance was to create two networks made up of:

- Service representatives including lived and living experience, nursing, medical and allied health workforces, quality managers, and Act implementation leads.
- Sector partners including the Victorian Mental Illness Awareness Council (VMIAC), Tandem, Independent Mental Health Advocacy (IMHA), Victorian Transcultural Mental Health, Safer Care Victoria and the Office of the Chief Psychiatrist.

The service network had representatives from 22 mental health and wellbeing service providers including designated mental health services, community sector organisations and two mental health and wellbeing locals. Each service nominated two representatives, including at least one senior lived and living experience workforce member.

Network members provided input about how they are putting the principles into practice, the barriers and challenges they are experiencing, and how they are monitoring progress. Both services and sector partners reviewed early drafts of the guidance.

We also sought advice from other organisations, advisory bodies and individuals to ensure diverse perspectives were thoroughly reflected (see Appendix One). In this process, we have endeavoured to genuinely and respectfully seek, hear and reflect First Nations voices, lived experiences and expertise.

We are deeply grateful to all network members and consultation partners for generously sharing their lived and living experience and sector expertise.

Note on language

This guidance reflects language and definitions used in the interim and final reports of the Royal Commission into Victoria's Mental Health System, wherever possible.

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

The Commission prefers to use the term 'carers, family, supporters and kin' to represent people who support those who are accessing, or trying to access, mental health and wellbeing services, to reflect the breadth of people's support networks. Where needed to reflect the language of the Act, we may also use 'carer', 'parent' or 'guardian', or the phrase 'family, carer or supporter'. Family includes family of birth and family of choice. We recognise Tandem's definition of family as 'the significant people who play a supporting role in someone's life' and that family can look different for everyone.

We also acknowledge the terms Aboriginal, Indigenous, and First Nations or First Peoples are used interchangeably and do not capture the unique language groups of many within the community. The Commission does not favour one approach. We respect everyone's right to self-identification.

Throughout this guidance, we use the term 'mental illness', usually where this word is used in the Act. We recognise the Victorian Mental Illness Awareness Council Declaration (2019), which notes that people with lived experience can have varying ways of understanding the experiences that are often called 'mental illness'. It acknowledges that mental illness can be described using terms such as 'neurodiversity', 'emotional distress', 'trauma' and 'mental health challenges'.

We also use the term 'lived and living experience' to refer to the diverse experiences of people who are living with (or have lived with) mental illness or psychological distress, or someone who is caring for or otherwise supporting (or has cared for or otherwise supported) a person who is living with (or has lived with) mental illness or psychological distress. People with lived and living experience are sometimes referred to as 'consumers' or 'carers'. The Commission acknowledges the experiences of consumers and carers are different. 'Lived and living experience' reflects that people's experiences may be past or ongoing. At times, we use 'lived experience' where this reflects the language of the Act, job titles, or when referencing another document that uses that term.

When communicating with an individual, family or community, it is good practice to respectfully ask about the terminology they prefer for any of the above terms, and to be guided by their preferences.

We acknowledge the term 'restrictive interventions' is not preferred by many people with lived and living experience. In this guidance, we use the term 'restrictive practices' wherever possible and only use 'restrictive interventions' when making a direct reference to Act requirements.

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.

The Act contains three sets of principles - the mental health and wellbeing principles, the decision making principles, and the information sharing principles. Any references to 'the principles' in this document that are not further specified, are references to the mental health and wellbeing principles.

Appendix Two contains definitions used in this guidance.

Part One: Introduction, legal requirements and leadership

1. Purpose and background

1.1 Purpose

The Commission has prepared this guidance in accordance with our function under s 415(g) of the Act to issue guidance materials about how the mental health and wellbeing principles (principles) should be applied in relation to actions and decisions under the Act. The intent of this guidance is to support services to translate the principles into practice by clarifying service obligations, highlighting good practices and supporting ongoing cultural change that prioritises the dignity, autonomy, rights and diverse needs and preferences of people living with mental illness and psychological distress, and recognises the role of their families, carers and supporters.

Part One of this document explains the background to this guidance, and what it means to give proper consideration to, and make all reasonable efforts to comply with the principles. It also contains a summary of actions that service leaders should take to ensure the principles are strongly embedded into services.

Part Two contains detailed advice about each principle, including requirements to comply with the principle. Actions described as requirements are required by the Act, national standards, or Chief Psychiatrist or other guidance, and should be well established in services. We acknowledge that for community mental health and wellbeing services (non-designated mental health services), standards are voluntary, rather than mandatory as for clinical mental health and wellbeing services.

Guidance on individual principles also includes good practice suggestions shared by members of the mental health and wellbeing service provider and sector partner networks.

The Commission also intends to release implementation tools including scenarios, checklists and other supports, that will be published separately on our website. We are committed to working with consumers, families, carers and mental health and wellbeing service providers to continue to gather and share good practices, support cross-service learning and improvement, and strengthen how the principles are translated into practice.

Note on audience

This guidance is intended for all mental health and wellbeing service providers. This includes designated mental health services, community sector mental health and wellbeing services, Mental Health and Wellbeing Locals and Mental Health and Wellbeing Connect Centres[1].

Some requirements outlined in the guidance are about complying with the Act. These are marked with a 📖 icon. All service types should be aware of Act requirements, as all may be involved in supporting people who are receiving or may receive compulsory treatment. Some actions will only apply to designated mental health services, because they relate to the provision of compulsory treatment.

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We are committed to working with consumers, families, carers and mental health and wellbeing service providers to continue to gather and share good practices, support cross-service learning and improvement, and strengthen how the principles are translated into practice.

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[1] Some mental health and wellbeing connect centres may not meet legislative criteria to be mental health and wellbeing service providers.

1.2 Background

Royal Commission

The Royal Commission into Victoria's Mental Health System laid bare the experiences of consumers, families and carers with our mental health system. People described being unheard, experiencing highly restrictive treatment, and not being able to access recovery-centred treatment, care and support. The Act and these principles are one outcome of the Royal Commission, which supports the aim to achieve the highest attainable standard of mental health and wellbeing for Victorians.

Legislative background

In addition to our function to prepare guidance, the Commission must also give proper consideration to the principles in performing a function or duty or when exercising powers under the Act (s 414(a)).

Under s 29 of the Act, mental health and wellbeing service providers must:

- make all reasonable efforts to comply with the principles when exercising a function under the Act
- give proper consideration to the mental health and wellbeing principles when making a decision under the Act
- provide safe, person-centred mental health and wellbeing services
- foster continuous improvement in the quality and safety of the care and mental health and wellbeing services they provide.

Under s 431-433 of the Act, consumers, family members and supporters can make a complaint to the Commission about a failure by a mental health and wellbeing service provider to make all reasonable efforts to comply with the principles when delivering their services (see section 3.1 of this guidance for detail).

1.3 Related frameworks, guidance and training

This guidance aims to support the implementation of the principles and continuous improvement of Victoria's public mental health and wellbeing services, and in doing so, to improve the experiences of people accessing them. However, it is only one part of the efforts underway across Victoria to support the principles being fully embedded in mental health and wellbeing services. Other key pieces of work include:

- Interim Chief Psychiatrist's guidance - decision making principles for treatment and interventions (see page 29 for further discussion of this)
- Principles in practice project Centre for Mental Health Learning (CMHL) and IMHA
- IMHA's plain language guide to the principles
- Tandem's plain language information kit
- Our workforce our future: A capability framework for Victoria's mental health and wellbeing workforce and its associated implementation guide
- Lived and living experience workforce frameworks
- Mental health and wellbeing outcomes and performance framework
- National Safety and Quality Health Service Standards
- National Safety and Quality Mental Health Standards for Community Managed Organisations

A brief description of these, and full references, are included at Appendix Three.

2. A human rights approach to mental health and wellbeing

2.1 What is a human rights approach?

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* (Vic) 2006 (the Charter). The Charter sets out the human rights to be promoted and protected; ensures that laws are interpreted, so far as is possible, in a way that is compatible with human rights; and obliges all public authorities to give proper consideration to human rights in decision making and to act in a way that is compatible with those rights.

Public authorities, including mental health and wellbeing service providers, can uphold human rights by building a human rights culture within the workforce. This can start with 'connecting human rights with existing work, such as diversity and inclusion plans, disability access frameworks, Aboriginal engagement strategies and gender equality initiatives' (VEOHRC 2021, p 9). For mental health and wellbeing service providers this includes connecting human rights with work done to give effect to the mental health and wellbeing principles in the Act.

2.2 Human rights and the Mental Health and Wellbeing Act

The Act was enacted with the goal of better protecting and upholding human rights in practice for people receiving mental health treatment, care and support, as well as their families, carers and supporters. It was intended to reflect contemporary human rights practice and thinking.

Key objectives of the Act include:

- providing comprehensive, compassionate, safe and high-quality mental health and wellbeing services and
- protecting and promoting the human rights and dignity of people living with mental illness by providing treatment in the least restrictive way possible.

The principles complement these objectives. Many of the principles reflect established human rights laws and norms, such as the principle of dignity and autonomy.

The Act also deals with 'rights' through:

- **specific requirements** such as the obligation to provide a statement of rights, the right to communicate and the right to access to mental health advocacy.
- the **objectives** of the Act, which include the protection and promotion of human rights and provide guidance for how the law should be interpreted.
- the **mental health and wellbeing principles** to which services must give proper consideration and make all reasonable efforts to comply with when exercising a function or making a decision under the Act.
- the **decision making principles for treatment and intervention** to which people with authority to make a decision or exercise a power in respect of the care or treatment of a patient, must give proper consideration.
- the **information sharing principles** to which any entity that makes a decision, performs a function, or exercises a power related to the disclosure, use or collection of health information or personal information under this Act must give proper consideration.

The Royal Commission into Victoria's Mental Health System emphasised the importance of drafting this legislation with the Charter and other human rights instruments in mind. The final report highlighted the concepts of 'dignity, equality and freedom' from the Charter's Preamble and the concepts of 'participation, independence, inclusion and services that are available, accessible and acceptable' embraced by the *Convention on the Rights of Persons with Disabilities* (Final Report, Volume 3, page 36).

The Charter sets out 20 rights and freedoms that must be protected and upheld. Rights that are particularly relevant in the provision of mental health and wellbeing treatment care and support include:

- recognition and equality before the law
- the right to life
- protection from torture and cruel, inhuman or degrading treatment (including the right not to be subjected to medical treatment without full, free and informed consent)
- freedom of movement
- privacy and reputation
- freedom of thought, conscience, religion and belief
- freedom of expression
- the protection of families and children
- the right to take part in public life
- cultural rights
- liberty and security
- humane treatment when deprived of liberty
- a fair hearing

In this guidance, a human rights framework is applied to each principle.

2.3 What are the 13 mental health and wellbeing principles?

Click a principle below to view detailed guidance in Part Two.

- Dignity and autonomy →
- Diversity of care →
- Least restrictive →
- Supported decision making →
- Family and carers →
- Lived experience →
- Health needs →
- Dignity of risk →
- Wellbeing of young people →
- Diversity →
- Gender safety →
- Cultural safety →
- Wellbeing of dependents →

3. Legal obligations

3.1 Overview

Under the Act, mental health and wellbeing service providers must make all reasonable efforts to comply with the principles in practice and give proper consideration to them in decision making.

Service providers must also provide safe, person-centered mental health and wellbeing services and foster continuous improvement in the quality and safety of the care and mental health and wellbeing services they provide.

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.

This guidance addresses how to comply with sections 29(a) and (b) specifically.

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 might have more than one possible meaning, preference is to be given to an interpretation that promotes the principles (s 10(1)).

Other obligations in the Act

The Act also imposes an obligation on specific bodies, and people in particular roles, to give proper consideration to the principles. Some of those include:

- non-legal mental health advocacy service providers (for example, IMHA, s 50)
- community visitors (s 400(a))
- certain decision makers including the Chief Officer for Mental Health and Wellbeing Victoria, the Chief Psychiatrist and authorised persons (see ss 262(a), 268(a) and 229)
- the Mental Health Tribunal (s 333(a))
- the Health Secretary (s 255(a))
- the Mental Health and Wellbeing Commission (s 414(a))
- the Victorian Institute of Forensic Mental Health (Forensicare) (s 615(a)) and
- the Victorian Collaborative Centre for Mental Health and Wellbeing (s 645(a)).

The Victorian Civil and Administrative Tribunal (VCAT) can also hear and determine applications to review treatment decisions of the Mental Health Tribunal (s 383). When doing so, VCAT assumes the same functions as the Mental Health Tribunal (section 51(1), *Victorian Civil and Administrative Tribunal Act 1998* (Vic)). This means VCAT must also give proper consideration to the mental health and wellbeing principles when making decisions about treatment under the Act.

Annual reporting

Any mental health and wellbeing service provider who is required to publish an annual report must include information in their annual report about what actions were taken to comply with at least one of the principles for that reporting year (s 30).

Complaints relating to the principles

The Commission can receive complaints about mental health and wellbeing service providers failing to make all reasonable efforts to comply with the mental health and wellbeing principles or any other principles or duties in the Act. A complaint can be made by a consumer (s 431(c)) or by another person if certain conditions are met (see ss 432 and 438).

Complaints in this category have two key parts:

1. a failure to make all reasonable efforts to comply with the principles and
2. any matter that arises out of that failure.

Carers, family members or supporters can also make complaints about their own experiences with mental health and wellbeing service providers, including complaints about services failing to make all reasonable efforts to comply with the principles (s 433(b)).

While this guidance is about the mental health and wellbeing principles, other principles in the Act can include those about decision making (Part 1.3), information sharing (Division 1 of Part 17.1) or providing a health led response in specific situations (s 229).

When responding to complaints at a local level, services should identify and understand whether the subject matter of the complaint arises out of a failure to make all reasonable efforts.

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.

What does all reasonable efforts to comply with the principles mean?

Meeting this standard involves being able to:

- take **proactive** and **meaningful** steps
- 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 may 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.

Examples of what acting compatibly with the principles looks like in practice can be found in Part Two of this guidance.

When do mental health and wellbeing services *exercise a function* under the Act?

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 Forensicare. For most other mental health and wellbeing services, functions are not expressly outlined in the Act. Generally, the functions of a mental health and wellbeing service will 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 are 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 principles.

What types of *decisions* require proper consideration of the principles?

Any decision made under the Act requires proper consideration of the principles.

Types of decisions that can arise in this context 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.

What does it mean to give *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 (see explanation of proportionality on page 15).

Decision making in context

The context within which the decision is being made will often be relevant across these factors.

In urgent situations, what constitutes '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. This ensures they can more readily be considered in urgent situations. 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.

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 five 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 services' 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 all reasonable efforts: 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 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 page 18)	*A service 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:	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.	● 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.

Step 3: Identify competing or other interests or obligations

● **Consumer journey example**	● **Systemic example**
Decision about Alex's treatment pathway	*A service considering changing their visiting hours*
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 have visitors, and families, carers and dependents' rights to maintain connection may intersect with service requirements, for example, maintaining adequate staffing to support visits, staff limitations overnight.

<table>
<tr><th></th><th>● Consumer journey example
Decision about Alex’s treatment pathway</th><th>● Systemic example
A service considering changing their visiting hours</th></tr>
<tr><td rowspan="4">Step 4: Balance and weigh (proportionality approach)</td><td colspan="2">How relevant is the principle proportionate to the action or decision?</td></tr>
<tr><td>● 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.</td><td>● For example, the families and carers principle is directly related as contact with families and carers will be supported or limited by the policy.</td></tr>
<tr><td colspan="2">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.</td></tr>
<tr><td>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.</td><td>How preferences shape the choice
● The service asks consumers, families and carers what the impact on them is and ensures their preferences have weight in decision making.</td></tr>
<tr><td rowspan="4">Step 5: Decide or act</td><td colspan="2">Have I shown and documented how proper consideration has been given and/or reasonable efforts made?</td></tr>
<tr><td>● 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.</td><td>● 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.</td></tr>
<tr><td colspan="2">Review point?</td></tr>
<tr><td>● Alex and the treating team agree to review how the chosen option (PARC) is working for him in a week.</td><td>● 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.</td></tr>
</table>

5. Service leadership actions to embed the principles

This section outlines actions for services to put the principles into practice at a leadership level. As with Part Two, actions relating to the Act are marked with a 📖 icon. All service types should be aware of these actions and must comply with them to the extent that they apply to their service type.

The Commission's approach to describing leadership obligations draws on various frameworks - including the Victorian Equal Opportunity and Human Rights Commission's (2008) *From Principles to Practice: Implementing the human rights-based approach in community organisations* guide and Safer Care Victoria's *Victorian Clinical Governance Framework* (2024a). High-level actions are grouped in five sections:

- Leadership and culture
- Partnering with consumers
- Workforce
- Risk management
- Clinical practice.

When taking these actions, services are expected to work with lived and living experience as deeply as possible for each activity. Participation models that can guide this work include:

- Arnstein's (1969) ladder of citizen participation
- Indigo Daya's consumer/survivor lens on the participation ladder, available at indigodaya.com
- Roper et al (2018)'s *Coproduction: putting principles into practice in mental health contexts*
- IAP2's spectrum of public participation (1999).

More detail about these actions is available in implementation tools on the Commission's website.

Most, if not all, of these actions are ones that service providers are already expected to take or can be achieved by adjusting approaches to existing work.

5.1 Leadership and culture

Governance

Give proper consideration to the Act, Charter and principles in decision making, and record how these frameworks inform decisions.

Strengthen human rights cultures. For example, by identifying portfolio holders, committees and/or champions for embedding human rights and safety - including cultural and gender safety, children's safety and wellbeing.

Embed a safety culture in services. For example, see Safer Care Victoria's *Victorian safety culture guide* (2024b).

Embed the mental health and wellbeing principles in all policies and procedures, using codesign approaches to the greatest extent possible. This could include identifying and including guidance about how to apply the principles in the context of a specific policy or procedure, and identifying and mitigating risks or anticipated barriers to applying the principles.

Quality improvement

Encourage innovation and new approaches to putting the principles into practice, using research evidence and adopting proven good practice. Use a plan-do-study-act cycle (for example, see Safer Care Victoria's Quality Improvement Toolkit (2024c)) to promote ongoing improvement.

Compare outcomes with sector benchmarks and learn from other services to promote a system improvement focus.

Explicitly link quality improvement and peer learning, including through reflective practice and critical incident reviews. For example, following a critical incident, consider how the principles were put in practice and incorporate lived and living experience feedback to strengthen future responses.

Have a clear approach to monitoring principle implementation, including for monitoring trends, making improvements and reporting on progress. Implementation could include:

- In annual quality or improvement plans, including lived and living experience-informed strategies to improve how the principles are considered, applied and reported on.
- Setting, monitoring and reporting on internal targets for improving how the principles are applied.
- Using incident data to understand opportunities to improve how the principles are applied.

📖 Mental health and wellbeing services that are required to prepare an annual report must report on implementation of one principle annually (s 30).

See implementation tools on the Commission's website for mapping of possible sources of relevant data or information against the principles.

5.2 Partnering with consumers

Embed lived and living experience in decision making

Develop or adapt a clear framework for ensuring lived and living experience drives all work. For example, ensure consumers and carers are embedded in decision making at all levels - including governance, service design, policy development and implementation, and quality improvement activities including monitoring and evaluation (for example, quality committees, review panels, co-design, etc). Codesign with people with lived and living experience that is relevant to the area of work, or who will be impacted by a decision.

Promote and protect rights

📖 Use codesign approaches and accessible materials to promote consumer, family, carer and supporter awareness of their healthcare rights, rights under the Act, and the specific rights of children and young people (for example, in line with the Child Safe Standards - see Commission for Children and Young People, 2023).

Complaints and feedback

Welcome complaints and feedback, and use them to identify and make improvements.

Ensure complaints processes are responsive, culturally safe and trauma informed.

📖 Ensure that no person experiences detrimental treatment or action for making a complaint, and communicate to consumers, carers, families, supporters and kin, and staff, that this must never occur.

With lived and living experience input, theme experience of care surveys, complaint data, and feedback with a principles lens to identify, make and report on improvements. For example, track trends in complaints and feedback from a range of sources including community meetings, community visitors, IMHA, consumer and carer surveys and debriefing processes to identify systemic issues, make improvements and measure whether these improvements are effective.

5.3 Workforce

Recruitment

Embed the mental health and wellbeing principles and the principles of the *Our workforce our future* capability framework (Department of Health, 2023a) into workforce recruitment, position descriptions, induction, professional development and performance management processes.

Have a clear strategy to ensure the workforce reflects the diversity and intersectionality of your local community, including First Nations, multicultural staff and staff with diverse gender and sexuality.

Set goals for employing Aboriginal workforce as well as clear strategies to ensure a culturally safe workplace that prioritises training, developmental pathways and career progression.

Lived and living experience workforce development and pathways

Working with the lived and living experience workforce and being informed by relevant frameworks, develop lived and living experience workforce leadership structures and career pathways to strengthen lived and living experience leadership and capacity to drive system change. Action areas include:

- Ensure access to discipline-specific supports such as reflective practice, training and education, including supporting applications for scholarships.
- Identify and address gaps in the current lived and living experience workforce at your service.
- Promote shared understandings of the value of the lived and living experience workforce by educating all staff about different lived and living experience roles, their scope of practice, and the differences between consumer and carer disciplines.

Workforce development

Embed the principles in co-developed staff training, development, reflective practice and supervision, incorporating realistic good practice examples as a basis for discussion and reflection. All disciplines should be expected and supported to undertake training and development activities.

Have clear plans for training staff about the principles (see implementation resources on Commission's website). Plans should:

- identify priority training and expected frequency
- monitor staff completion rates of core/critical trainings
- include plans for education to bank/agency staff (for example, short compulsory modules on Act rights and requirements) and the wider workforces including the security and emergency department/s.

Create ways for staff to seek advice and help to navigate complex and urgent situations. Review and explore the reasons behind uncertainties, gaps in knowledge and errors. For example, escalation pathways and reflective practice across different levels and workforce groups.

Support staff at all career stages to learn from lived and living experience.

5.4 Risk management

Risk framework

Have a clear framework for identifying and managing risk, that aligns with the dignity and autonomy, supported decision making, dignity of risk, and family and carers principles. Clearly and consistently communicate this framework to staff, consumers, carers, families, supporters and kin.

Develop consumer, carer and family-focused information aimed at creating shared understandings of risk and autonomy in a recovery-based framework, and how taking reasonable risks contributes to a consumer's personal growth, self-esteem and overall quality of life.

5.5 Clinical practice

Service delivery

Review and make changes to systems and/or existing resources to ensure they prompt staff to take action in key areas (see implementation resources on the Commission's website for details of areas this may cover).

Identify and respond to the specific needs of the diverse population groups that use your service and their families and carers, with specific attention to the health needs of Aboriginal consumers, families and carers. For example:

- Create a welcoming, safe environment for diverse communities. For example, build relationships with key cultural and religious organisations and tailor approaches to ensure they are culturally safe and responsive.
- Tailor communications to reflect the diversity of local communities.
- Understand the intersectional needs of the consumers, families and carers who use the service.

Strengthen relationships and referral pathways with relevant services, so as to learn from services with specialist expertise and improve access to services.

Support staff to use flexible, creative approaches to meeting a person's preferences, including those expressed in an advance statement of preferences.

Implement, evaluate and learn from improvement programs and resources (including Safer Care Victoria's Mental Health Improvement Program, Safewards initiatives).

Part Two: Putting each mental health and wellbeing principle into practice

How the guidance is structured for each principle

Part Two of the guidance outlines specific considerations for each mental health and wellbeing principle.

In most circumstances, services will need to consider more than one principle when making decisions. Some principles - for example, dignity and autonomy and supported decision making - must always be considered. For this reason, most principles include cross-references to other principles.

Figure 1 shows the structure of the individual principle guidance, outlining the eight sections and the type of content in each.

Figure 1: How each principle is structured

1. What do **the Act** and relevant guidance say?	• the principle as worded in the Act with detail from the Explanatory Memorandum and IMHA plain language statements, as well as relevant national standards or Chief Psychiatrist guidance
2. How do **human rights** relate to this principle?	• how various rights under the *Charter of Human Rights and Responsibilities Act 2006* are relevant to each principle • related mental health and wellbeing principles and decision making principles
3. How might a **consumer** experience this principle? 4. How might **carers, families and supporters** experience this principle?	• what consumers and carers could expect to experience for each principle - noting this will be different for different people
5. How do **treating teams** put this principle into practice?	• the requirements for services to comply with each principle • good practice examples, as advised by the service provider and sector partner networks • tips for talking with consumers and carers
6. How might **services reflect** on practice?	• reflective questions for individuals or teams in services to consider their practice and what they might do differently
7. **Scenario**	• simple scenarios written by Commission lived and living experience staff to demonstrate each principle in practice
8. Where can I find **more information?**	• other principle-specific resources and links

Note about scope and relationship with other principles

The scope of this guidance is limited to the mental health and wellbeing principles, in accordance with the Commission's functions. There are other principles of the Act that must be given proper consideration by services including the decision making principles, the information sharing principles, and the health led response principle.

Decision making principles

The decision making principles[2] are:

- **Care and transition to less restrictive support principle:** Compulsory assessment and treatment should promote the person's recovery and transitioning them to less restrictive treatment, care and support. To this end, a person who is subject to compulsory assessment or treatment is to receive comprehensive, compassionate, safe and high-quality mental health and wellbeing services (s 79).
- **Consequences of compulsory assessment and treatment and restrictive interventions principle:** Compulsory assessment and treatment or restrictive interventions significantly limit a person's human rights and may cause possible harm including:
  - seriously distressing the person
  - disrupting the person's relationships, living arrangements, work or study (s 80).
- **No therapeutic benefit to restrictive interventions principle:** Restrictive interventions offer no inherent therapeutic benefit to a person (s 81).
- **Balancing of harm principle:** Compulsory assessment and treatment or restrictive interventions are not to be used unless the serious harm or deterioration to be prevented is likely to be more significant than the harm to the person that may result from their use (s 82).
- **Autonomy principle:** The will and preferences of a person are to be given effect to the greatest extent possible in all decisions about assessment, treatment, recovery and support. This includes when those decisions relate to compulsory assessment and treatment (s 83).

The Chief Psychiatrist has a role under the Act to assist clinical mental health service providers in meeting their obligations under the decision making principles in line with the Act, and may make guidelines. The Chief Psychiatrist developed interim guidance in September 2023 (Department of Health 2023b) that mental health and wellbeing service providers can use to develop local policies and procedures.

The decision making principles (ss 79-83) must be considered as part of any decisions relating to treatment and interventions, including capacity, informed consent, electroconvulsive treatment, neurosurgery for mental illness, compulsory assessment and treatment or the use of restrictive interventions. When these decisions are made, the mental health and wellbeing principles must also be considered. Services must document how both sets of principles have informed decisions.

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[2] Slightly abridged for readability. See ss 79-83 of the Act for the full decision making principles.

Dignity and autonomy principle

1. What do **the Act** and relevant guidance say?

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 (s 16).

The dignity and autonomy principle places the person's rights, dignity and autonomy above therapeutic outcomes or the concept of the best interests of the person (Explanatory memorandum to the Mental Health and Wellbeing Bill 2022, p 19). This means people should expect their independence to be supported, for example, by being able to make their own decisions (IMHA 2024). Placing autonomy above therapeutic outcomes or best interests will, at times, mean respecting people's choices and decisions, even where this involves some risk, See dignity of risk principle.

The dignity and autonomy principle, along with the supported decision making principle, underpins all other principles. Services must always consider these principles when providing care and treatment.

2. How do **human rights** relate to this principle?

The Charter includes in its Preamble that 'all human beings are born free and equal in dignity and rights.' This is also emphasised in international documents, including the *Universal Declaration of Human Rights 1948*, and the *Convention on the Rights of Persons with Disabilities 2008*.

The dignity and autonomy principle aligns with the Charter by requiring that services respect, protect and promote the rights, dignity and autonomy of people accessing mental health and wellbeing services.

Rights referred to under this principle include:

- patient rights in the Act, for example, a service's duty to make all reasonable efforts to follow a person's advance statement of preferences
- the requirement for services to provide a statement of rights at points required by the Act
- human rights set out in the Charter which mental health and wellbeing service providers must give proper consideration to, and
- other Victorian laws that promote and protect human rights, such as the:
    - *Equal Opportunity Act 2010* (Vic)
    - *Racial and Religious Tolerance Act 2001* (Vic)
    - *Change or Suppression (Conversion) Practices Prohibition Act 2021* (Vic).

A core provision of the Charter that underpins this principle is the right to recognition and equality before the law (section 8 of the Charter). This includes the right to be treated equally under the law and protected from discrimination. The right of children to protection without discrimination (section 17), is also core to this principle.

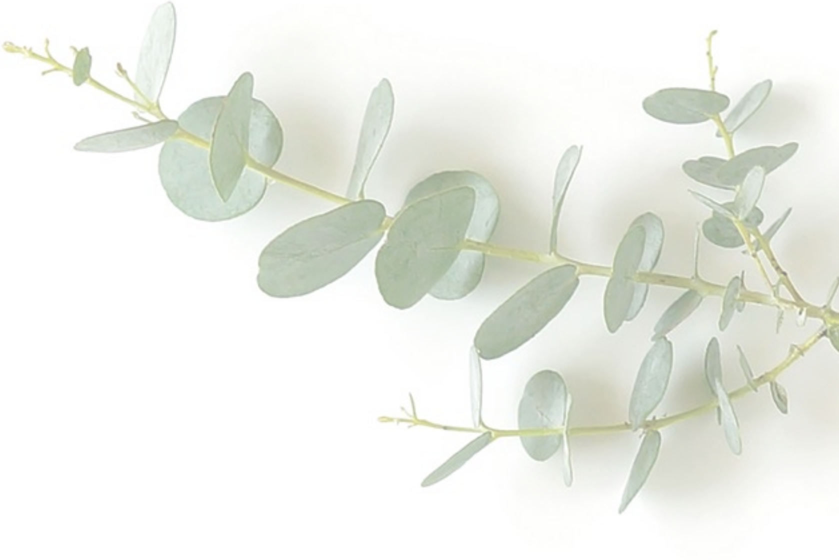
The concept of dignity underpins all the mental health and wellbeing principles in the Act, as well as human rights more broadly. A key right in the Charter that relates to dignity is the right to humane treatment when deprived of liberty (section 22). This means that if a person's liberty is limited - such as by compulsory treatment - they must be treated with humanity and with respect for their inherent dignity.

The concept of autonomy is supported by several rights in the Charter, particularly those concerning freedoms. These include the rights to:

- freedom of movement (section 12)
- freedom of thought, conscience, religion and belief (section 14)
- freedom of expression (section 15)
- liberty and security of the person (section 21).

The right to privacy (section 13) is also important as it protects bodily integrity.[3] The right to the protection from torture and cruel, inhuman or degrading treatment (section 10) is also relevant as it protects people from being subjected to medical treatment without their full, free and informed consent.

Related mental health and wellbeing principles include:	Related decision making principles include:
Supported decision making Least restrictive Dignity of risk Gender safety Cultural safety	Care and transition to less restrictive support Consequences of compulsory assessment and treatment and restrictive interventions Autonomy



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[3] See *Kracke v Mental Health Review Board* (General) (2009) 29 VAR 1; [2009] VCAT 646.

3. How might a **consumer** experience this principle?

When my rights, dignity and autonomy are respected and promoted:

- I understand my rights and feel supported to exercise them in all situations. I know the service will support me if I need any help to do this (for example, an interpreter or communication aids).
- I feel safe, heard and respected. If I do not feel safe, I can speak up and will be listened to.
- My carer, family and supporters are as involved in my assessment, treatment, recovery and support as I want them to be.
- My preferences are respected as much as possible and are prioritised over what other people think is best for me. This includes when I am receiving compulsory treatment.
- My rights will only be limited when it is lawful, necessary and reasonable. If this happens, the reasons will be explained to me and I know what needs to change for the limits to be lifted.
- I understand the legal basis of my treatment, including whether I am being treated voluntarily or compulsorily.
- I know that I can apply to have my treatment order changed or stopped, and I can get help to do this.
- I can communicate with (for example, call, email, text or have visits with) the people I want to communicate with. My right to communicate is only restricted in limited circumstances permitted by the Act, when absolutely necessary and clearly explained to me.
- My communication with a lawyer, the Chief Psychiatrist, the Commission, the Tribunal, a community visitor or an IMHA advocate is never restricted.
- I can raise concerns or complaints without fear, and I see that my feedback helps improve services.

4. How might **carers, families and supporters** experience this principle?

When the rights, dignity and autonomy of the person I care for or support are respected and promoted:

- I am confident that their rights are upheld at all times, including when I am not present to advocate for them.
- I am notified and consulted at key points of assessment and treatment as required by the Act (including discharge), if I am a carer, parent of a patient aged under 16, a guardian, or a nominated support person.
- I receive the information I need to support them effectively.
- I am involved in their assessment, treatment and recovery in a way that meaningfully supports and respects me in my role.
- I am confident that the person is supported to make their own decisions, including with the use of communication aids, supported decision making tools, and the time and space they need.
- My experience and knowledge of what helps them feel safe, respected and empowered are valued and welcomed by services.

5. How do **treating teams** put this principle into practice?

This section provides an overview of actions services must take to put the dignity and autonomy principle into practice, as well as good practice suggestions.

Upholding people's views and preferences (for example, by presuming capacity to give and refuse informed consent to treatment, promoting and following advance statements of preferences, promoting nominated support persons) and providing least restrictive treatment, also respects and upholds their dignity and autonomy. See supported decision making and least restrictive principles.

Explore the key topics covered in this section:

- Take reasonable steps to identify and provide appropriate supports
- Give and explain accessible rights information, statements of rights and compulsory orders
- Protect the right to communicate
- Promote responsive feedback practices
- Support people to apply for their order to be revoked, and to participate in Mental Health Tribunal hearings
- Support access to second psychiatric opinions
- Support access to community visitors
- Support the right to request amendments to records and make a Health Information Statement
- Promote and protect dignity
- Minimise searches of persons and belongings

Take reasonable steps to identify and provide appropriate supports

Requirements include:

📖 When required by the Act to communicate with a person (for example, a consumer, carer, family, guardian, nominated support person or support person), services must take reasonable steps to identify and provide appropriate supports to help that person to make and participate in decisions, understand information and their rights, and communicate their views, preferences, questions or decisions (ss 6-7).

Reasonable steps may include:

- asking a person what they need
- giving information about what supports are available
- revisiting needs regularly, as people's needs can change.

Appropriate supports include:

- Access to interpreters and written information in languages other than English.
- Accessible communication, including using technology. For example, Easy English resources, communication apps, communication boards, decision support tools, simple communication tools like listing options clearly and simply on a piece of paper with the person, or providing flip cards with information about treatments, other visual aids.
- Responding to literacy, developmental or cultural needs. For example, involving Aboriginal Mental Health Liaison Officers or providing other cultural support for Aboriginal consumers and families.
- Communicating in appropriate physical or sensory environments. For example, finding quiet spaces for discussions, adjusting lighting to suit the person's needs.
- Involving families, carers, supporters and IMHA advocates in rights discussions and providing appropriate spaces for consumers to communicate with them. For example, providing family rooms, facilitating phone calls (particularly where that can support treatment discussions), facilitating visits within reasonable hours.
- Helping people access legal assistance. For example, from Victorian Legal Aid (VLA) Mental Health Legal Rights Service Helpline, the Mental Health Legal Centre or the Victorian Aboriginal Legal Service.

Good practices may include:

- Involve lived and living experience workforce in decision making and rights processes, to support people to understand their rights and build capacity for decision making.
- Make reasonable efforts to find endorsed translated versions of official documents, being aware of the risk of using interpreters to translate key documents.

Give and explain accessible rights information, statements of rights and compulsory orders

Requirements include:

- Explain general healthcare rights to consumers, carers, families, supporters and kin, and provide information about how the service works and who to contact with questions or concerns.
- 📖 Take all reasonable steps to provide and explain copies of compulsory orders and relevant statements of rights (including statements of rights for voluntary inpatients) to consumers and their nominated support person, guardian, carer or parent of a consumer aged under 16 as soon as practicable. For example:
    - 📖 Give a person copies of their orders and statement of rights, explain what they mean in ways the person understands, and answer any questions as clearly and fully as possible.
    - Share accessible resources about principles and rights - for example, IMHA, Tandem and VMIAC resources (see 'Where can I find more information?' in section 8 of this principle), other materials in easy-read formats, translations, videos, posters and visual aids.
    - Identify and provide appropriate supports to help the person understand their rights (as above). Make additional efforts to explain rights if they are not initially understood, and continue to talk about rights during a person's treatment.
    - Make multiple attempts to identify and contact relevant people (nominated support person, guardian, parent of a person aged under 16, or carer) who should be provided with copies of compulsory orders and relevant statements of rights. For example, check the clinical record, ask the consumer, explore whether a consumer has support people at more than one point in treatment.
    - Document all attempts to give information or explain rights.

Good practice may include:

- Provide copies of relevant paperwork in more than one format (for example, a hardcopy for immediate reference, copies by email for future reference) to consumers and their supporters.

Protect the right to communicate

Requirements include:

- 📖 Support the person to exercise the right to communicate, for example, by taking reasonable steps to support patients to send and receive private letters, phone calls, messages, emails and to receive visitors at reasonable times.
- 📖 If restrictions are reasonably necessary to protect the health, safety and wellbeing of the inpatient or of another person, ensure those restrictions are the least restrictive possible to protect health, safety and wellbeing and are regularly reviewed. This review may include considering whether, even if restrictions are still reasonably necessary, restrictions could be lessened. Protecting the health, safety and wellbeing of another person includes protecting the privacy of staff or of other consumers.
- 📖 Ensure that communication with a lawyer, IMHA advocate, the Chief Psychiatrist, Mental Health Tribunal, the Commission or a community visitor is never restricted. Ensure consumers can make and receive contact from these bodies promptly - for example, ensure there are enough ward telephones available if a person's mobile has been removed, and prioritise the person's right to communicate with any of the above agencies.
- 📖 Take reasonable steps to notify the patient, any nominated support person, guardian, carer (if the restriction will affect the caring relationship), parent if the patient is under 16, DFFH Secretary if relevant[4] and IMHA, of any restriction and the reasons for it. For example:
    - give information in multiple ways (for example, verbally or in writing)
    - use appropriate supports (see above)
    - make more than one attempt to notify the relevant person.

Good practices may include:

- Work with consumers to find common ground about safe use of communications before considering restrictions.
- Promote timely and easy access to charging communication devices - for example, if charging devices are lost or access to them is limited for safety reasons.

Practices to avoid:

- Avoid removing mobile phones as a universal or standard practice - this may be a breach of human rights. Access to a mobile phone must only be restricted on an individual basis after other ways to support safety have been exhausted.
- Avoid unreasonably restricting the use of electronic communication devices. Examples of unreasonable restriction include restrictions on making complaints, seeking legal advice or advocacy, expressing anger at the service, writing about experiences on social media or researching issues related to an admission - for example, treatment, diagnosis, the service.

Promote responsive feedback practices

Requirements include:

- 📖 Share and promote information about how to give feedback and make a complaint.
- 📖 Offer support to help someone make a complaint either directly to the service or to the Commission. For example, help to fill out a form or survey, or speak with a relevant staff member.
- Ensure consumers, carers and families are aware that services must take reasonable steps to ensure that no person suffers any detriment for making a complaint (s 514).
- Involve lived and living experience in theming complaints. Share themes and improvements with consumers, carers, families, supporters and kin, and the workforce.
- Use complaints as opportunities to improve safety, quality and responsiveness to people's needs.

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[4] If the Secretary has parental responsibility for a child under a relevant child protection order.

Good practices may include:

- Be curious about the underlying issues, concerns or harms at the heart of a person's complaint.
- Consider the 4 As framework (see the Commission's website) as a way to understand what people may be seeking as an outcome of their complaint (Acknowledgment, Answers, Action and Apology).
- Be willing to apologise for a person's experience wherever possible.

Support people to apply for their order to be revoked, and to participate in Mental Health Tribunal hearings

Requirements include:

- 📖 Explain the right to apply to the Mental Health Tribunal for a hearing about their compulsory treatment order.
- Support the person to access legal assistance and information in a timely way including from VLA's Mental Health Legal Rights Service Helpline, the Mental Health Legal Centre or the Victorian Aboriginal Legal Service.
- Provide and support the person to complete relevant paperwork to apply for compulsory treatment to stop.
- 📖 Enable and support the person to receive IMHA advocacy or other help to apply for their compulsory treatment order to stop.
- 📖 Ensure the person is given their report for the Mental Health Tribunal hearing, and any other information that will be used by the service in the hearing, at least 2 business days before the hearing (s 373(1)(a)).
- Ask the person sensitively about what would help them to participate in the hearing. For example, involving family, carers or supporters (including cultural, spiritual or community supports), offering to help the person access a lawyer, facilitating appropriate supports (see above) that will help the person to participate in their hearing. Be mindful of barriers including language, trauma, and life experiences including family violence.

Good practice may include:

- Provide access to the Mental Health Tribunal website, including the application form to stop a compulsory order, and videos explaining the Mental Health Tribunal's processes.

Support access to second psychiatric opinions

Requirements include:

- 📖 Explain to compulsory, security and forensic patients that they have a right to seek a second psychiatric opinion about their status under the Act, or treatment, and take reasonable steps to help them to do so. For example, helping people to locate and complete documentation.
- 📖 Give a psychiatrist providing a second psychiatric opinion any reasonable assistance they need to perform their role. For example, share relevant clinical information in a timely way.
- 📖 If a second psychiatric opinion expresses the view the treatment criteria do not apply or recommends changes to treatment, the authorised psychiatrist must review the patient and determine whether they believe the criteria apply, or review their treatment, then decide whether to adopt the recommendations as soon as practicable after receiving the report.
- 📖 If the authorised psychiatrist believes the criteria do not apply or decides to adopt only some or no recommendations about treatment, they must tell the patient why and explain their rights. All staff have an obligation to help patients exercise those rights. For example, to help people to appeal their Order to the Mental Health Tribunal, access legal assistance including from VLA's Mental Health Legal Rights Service Helpline, the Mental Health Legal Centre or the Victorian Aboriginal Legal Service, or to ask the Chief Psychiatrist for a further review of treatment.
- 📖 If any recommendation (either in relation to treatment criteria or treatment) is not adopted, give verbal explanations as soon as possible and written explanations within 10 business days to the patient, any person who requested the opinion for them, any nominated support person, guardian, carer, or a parent of a person aged under 16[5].

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[5] DFFH Secretary if the Secretary has parental responsibility under a relevant child protection order.

Support access to community visitors

Requirements include:

- 📖 Explain the role of community visitors, enable consumers to speak with a community visitor and advise the Community Visitors program of any request from a consumer to speak with a community visitor.
- 📖 Give a community visitor any reasonable assistance they need to perform their role.

Support the right to request amendments to records and make a Health Information Statement

Requirements include:

- 📖 Explain to consumers, families, carers and supporters that they have a right to ask for changes to their health information record. For example, to ask for information to be clarified or corrected.
- 📖 If a request is refused, give written reasons to the person who made the request and inform them that they can make a Health Information Statement (HIS) (s 739).
- 📖 Place a HIS that relates to a refused request to amend or correct a record on the person's health information record (s 740(3)).

Good practices may include:

- Wherever possible, work with the person to agree on terms and descriptions used in clinical notes. For example, co-write notes, read back notes and invite feedback, or create opportunities to review notes (where possible) and ask for changes at the next contact. If there is no agreement, document the person's perspectives, including direct quotes if possible.
- Help a person to make a HIS. For example, by providing links to the Mental Health and Wellbeing Act 2022 Handbook, including the template for consumers to make a HIS (*Department of Health 2023c*).

Promote and protect dignity

Requirements include:

- 📖 Ensure people receiving inpatient treatment have adequate access to facilities and supplies - for example, bedding, clothing, food and water, including when subject to a restrictive intervention (s 136) or treatment in a more restrictive environment.

Good practices may include:

- Ensure that people do **not** have to repeatedly talk about their trauma to understand what is important to them. For example:
  - ask what a person needs to feel safe and dignified, document these, and reassure them that they do not need to explain why they need those things
  - check if the person has an advance statement of preferences or if a nominated support person can share information about the person's preferences
  - with consent, seek information from family, carers and supporters about what will help the person feel dignified and safe
  - review clinical notes to understand what information may have previously been shared
  - ensure relevant information is shared in handover/transfers of care
  - check medical records for information. When care is transferred or handed over to someone else, share all relevant details to ensure the person does not have to explain again.
- Uphold a person's right to privacy as far as possible. For example, in bed-based services:
  - ensure that people can lock their bedroom doors for privacy and safety
  - explain that night rounds will occur and ask people what they would like staff to do before entering a room to take observations. For example, knock, identify themselves and wait a reasonable time for a response before entering.
- Show and promote respect for a person's sexual and gender identity and cultural needs. For example, respect pronouns and names, tell people about and help them to access prayer rooms, be mindful of intersecting cultural and gender needs, such as in relation to access in a women's only area or preference for staff of a particular gender.

- Support consumers in bed-based services to access comforts from home such as clothing, books, personal blankets or cushions, art and craft materials.
- Give consumers in bed-based settings a clear orientation to the service and surroundings, to promote comfort and increase confidence.
- Give consumers clear information about the treatment and support options available to them including advice about the lived and living experience workforce.

Minimise searches of persons and belongings

Requirements include:

- Follow the Chief Psychiatrist's guidance *Criteria for searches to maintain safety on an inpatient unit - for patients, visitors and staff* (Department of Health, 2014). In making decisions about whether a search is required and how it is conducted, ensure human rights and the principles are given proper consideration at all points (for example, consider trauma, gender and cultural safety, and how people's intersecting identities, experiences and needs may impact their experience of a search).
- 📖 Provide appropriate supports (see above).

Good practices may include:

- Provide secure locked boxes for consumers, carers, families, supporters and kin to store their items, to minimise the need for searches of belongings.

Tips for talking about rights, dignity and autonomy

- **Be mindful that** the person may not have received, or may not remember, information about their rights
- Keep **checking in** about whether the person would like to talk about rights or get help to exercise them
- Consider the **environment** and what the person's verbal and non-verbal communication is showing when having these discussions - for example, is the environment private? Noisy/overstimulating? Restrictive? What do the person's words or body language say about whether they are feeling safe or unsafe?

6. How might **services reflect** on practice?

- What assumptions might we be making about the consumers, families and carers we work with?
- How might these be influencing our actions?

Rights

- How do we know if a consumer understands their rights?
- How do we make sure we give the correct statement of rights and explain it in ways that the consumer and their support people understand?
- How do we ask what appropriate supports would help the consumer to understand information and communicate decisions? For example, plain language rights statements, access to interpreters, engaging support people in discussions about rights, using visual aids and considering time of day.

Dignity

- Does <insert action to consider> uphold the person's dignity? If not, how could we approach things differently so that our actions do uphold the person's dignity?
- How do we talk to consumers about their individual needs and what will help them to feel safe and respected? For example, environment, supports, personal comforts, communication needs and preferences.
- How do we ask for feedback about how we can improve people's experiences?
- How can we make, or advocate for changes that consumers identify?

Autonomy

- How do we know, share and respond to what is important to the consumers we work with?
- How do we use decision making supports and, with consumer consent, engage family, carers, supporters and kin, to promote a consumer's right to make as many decisions as possible?

7. **Scenario:** providing appropriate supports[6]

What happened?

Ali, a young man of Iranian background, was admitted to an inpatient unit. Ali was a long-term consumer of the service and he knew the service, staff and other consumers. Ali's mum, Zahra, and dad both came with him when he was admitted.

Ali understood the admission process well. Staff knew Ali well and knew that he did not need an interpreter, but they had not met his parents before. However, his parents were less confident with English. Before staff could check whether an interpreter was needed, Zahra became distressed because she could not understand what was happening. Staff confirmed with Ali and his parents if Farsi was the primary language spoken in their family.

What actions did the service take?

Staff checked Ali's preferences about how his parents might be involved in his care and what information he was happy to share. Staff called the Telephone Interpreting Service (TIS) to arrange for a Farsi interpreter. They explained the interpreter would keep confidentiality and that the service could book an interpreter anytime Ali's parents wanted to speak with the treating team. The initial focus of the first call was to explain why Ali was coming to hospital, what the initial care and treatment plan was, and that family is always welcome to visit Ali and be included in care and treatment discussions, if Ali agreed. Having an interpreter helped Zahra and Ali's father be involved in his admission and contribute to his care and treatment. They also received the information that they needed to be able to support him.

Reflections from Commission lived and living experience staff

Having an interpreter for the family showed respect for Ali's needs - he should have the right to have his family involved if he chooses to, and shouldn't be asked to interpret for his parents, especially when he is unwell - and respect for his family's right to receive information in ways they understand.

Which other principles were engaged?

Mental health and wellbeing principles: family and carers, diversity

How would you approach this situation?

What might you do differently?

8. Where can I find **more information?**

Department of Health (2014) *Criteria for searches to maintain safety on an inpatient unit - for patients, visitors and staff* https://www.health.vic.gov.au/chief-psychiatrist-guidelines/criteria-for-searches-to-maintain-safety-in-an-inpatient-unit

IMHA website - what are my rights?
https://www.imha.vic.gov.au/what-are-my-rights

Mental Health Tribunal website
https://www.mht.vic.gov.au/

Mental Health Legal Centre website
https://mhlc.org.au/

Tandem - Your rights
https://tandemcarers.org.au

Victoria Legal Aid website
https://www.legalaid.vic.gov.au/

Victorian Aboriginal Legal Service website
https://www.vals.org.au/

Victorian Mental Illness Awareness Council website
https://www.vmiac.org.au/

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[6] Note: The scenarios in this guidance are adapted from real examples. These simple scenarios focus on the application of one principle and are intended to show that applying the principles is not always complicated. Scenarios that address the principles in more complex situations and ways are available in implementation resources on the Commission's website.

Diversity of care principle

1. What do **the Act** and relevant guidance say?

The diversity of care principle states that 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 (s 17).

This principle recognises the importance of people having access to different types of care and support, based on what they want and prefer (IMHA 2025, p 1). It relates strongly to the concept of recovery, as diverse supports can help people live a contributing life that is meaningful to them, and to live with hope and optimism.

Accordingly, the *Framework for recovery-oriented practice* (Department of Health, 2011a) offers a useful framework to consider in relation to this principle - for example, supporting access to spiritual or pastoral care as part of someone's treatment could promote autonomy and self-determination, support holistic, personalised care and help them to maintain links to their community. Standard 5 of the National Safety and Quality Health Service Standards (Australian Commission on Safety and Quality in Healthcare, 2021), particularly action 5.13 on shared decision making and developing a comprehensive care plan, is also relevant.

2. How do **human rights** relate to this principle?

The diversity of care principle recognises the importance of bringing an intersectional rights-based approach to mental health and wellbeing care, treatment and support. It recognises that a person's experience of mental illness or psychological distress is shaped by multiple factors of their identity and social context.

This principle can refer to multiple areas of a person's life. Assessing which Charter rights are most relevant, will depend on what areas of a person's life intersect with the care and support services being sought. For example, consideration of accessibility requirements will also prompt consideration of the equality and non-discrimination provisions in section 8 of the Charter.

Related mental health and wellbeing principles include:	Related decision making principles include:
Dignity and autonomy Wellbeing of dependents Supported decision making Cultural safety Gender safety Diversity	Care and transition to less restrictive support Consequences of compulsory assessment and treatment and restrictive interventions Autonomy

3. How might a **consumer** experience this principle?

When diversity of care is applied in practice:

- I am offered care and treatment that includes access to peer support, cultural and spiritual care, and social supports that reflect my values, goals and preferences.
- My care responds to my needs - it is trauma-informed, LGBTIQA+ inclusive, and culturally safe.
- If one type of care is not helping, I am supported to explore something else - without judgment or delay.
- I can access support in ways that work for me - online, in person, at a community hub, or with help from a peer worker.
- My care plan includes goals beyond treatment - like connecting with my community, learning new skills, or finding work.
- Services work together so I do not have to navigate complex systems like Centrelink, the NDIS, or housing on my own.
- When I am in hospital, I can still do meaningful activities, stay connected to outside supports and have a clear plan for continuing my recovery after I leave.

4. How might **carers, families and supporters** experience this principle?

When diversity of care is upheld in practice, I feel confident that:

- The person I care for or support can access a mix of clinical, cultural, community, and peer-led supports that reflect who they are and their preference at the time.
- The care provided is integrated with cross-sector collaboration, ensuring supports are based on the needs and preferences of the person I care for and go beyond treatment.
- Past trauma from accessing services and supports is acknowledged and considered. Care and assistance are provided to re-connect with appropriate services or alternate services.
- Our cultural background, values and preferences are respected and shape how care is offered.
- With the agreement of the person I support, or as required by the Act, I am included in conversations about care and treatment options and supported to understand what's available.
- Services adapt when our needs change - we are not left without support.
- Different forms of knowledge, including lived and living experience, are valued in decisions about care.

5. How do **treating teams** put this principle into practice?

This section gives an overview of requirements and good practice suggestions for putting the diversity of care principle into practice. As noted earlier in this guidance, the dignity and autonomy and supported decision making principles must always be considered. See these principles for detail.

Explore the key topics covered in this section:

- Share accessible information and offer a range of diverse, person-centred care options
- Connect people to a range of supports and promote community participation

Share accessible information and offer a range of diverse, person-centred care options

Requirements include:

- Give information about what treatment and care options are available in accessible ways. For example, verbally, in writing, use plain language, Easy English, translations, videos, posters, or QR codes linking to information. Continue to share and discuss this information during a person's treatment, as preferences and readiness to engage in different options may change over time.
- 📖 Provide appropriate supports to help people understand information and rights and make and communicate decisions. See dignity and autonomy principle.
- 📖 Check if a person has an advance statement of preferences or nominated support person that can help you to understand the diverse care options they would like to access. Make all reasonable efforts to give effect to the statement and/or to support the nominated support person in their role. See supported decision making principle.
- Use more than one approach to understand the person's preferences, if they are not able to discuss this. For example, check recovery or treatment plans, or ask the person's chosen carers, families, supporters and kin for information about the kinds of treatment and care the person has found helpful or unhelpful in the past.
- Offer access, or refer people to a range of treatment and support options to support their treatment and recovery goals. What is available may depend on the treatment setting. However, in all cases, services should ask about the person's preferences, help a person to access services available in that setting, and have clear plans for working towards the person's preferred treatment and support options. Options may include:
    - Different types of care and treatment. For example, psychology, group therapy, peer support, online help, dietician services, exercise physiologist, art or music therapy.
    - Access to lived and living experience and allied health workforces.
    - Access to cultural, spiritual and other kinds of support.
- Avoid defaulting to clinical or inpatient care, if community-based or non-clinical supports may better meet a person's needs. See least restrictive principle.

Good practices may include:

In clinical inpatient and residential settings, depending on what can be offered in a particular setting:

- Offer group activities based on people's interests and recovery needs, including cultural needs.
- Offer options like exercise, mindfulness, cooking, and creative arts.
- Consider group outings where possible (gardens, libraries, pools).
- Include recreational activities on weekends, to support healing and connection.

Connect people to a range of supports and promote community participation

Requirements include:

- Make reasonable efforts to support access to services that meet the person's expressed preferences and needs. For example:
    - make internal referrals or connect the person to external support services
    - ask the person if they prefer to access private, low cost or free options and offer relevant information and referrals
    - ensure people have adequate community supports in place for after they are discharged from an inpatient unit or from a service.

Relevant services may include:

- housing, trauma, relationships, training, education and employment including job-readiness programs, alcohol and drug supports, gambling supports, disability supports (including NDIS), Centrelink, legal services, or financial services
- Mental Health and Wellbeing Locals, who may offer many of the above services
- culturally appropriate services. For example, Aboriginal Community Controlled Health Organisations (ACCHOs), Aboriginal Community Controlled Organisations (ACCOs), multicultural support services
- gender and sexuality support services. For example, Minus18
- peer-run groups. Some services may offer their own peer-run groups and can refer internally. Others may refer to peer-run groups offered by other mental health and wellbeing services including Hearing Voices groups, GROW, Mind Australia, Wellways, or Neami
- community resources and groups that meet the person's interests and preferences, and support their recovery goals. For example, gardening groups, neighbourhood centres, walking groups, Landcare, or sporting groups such as RecLink.
- Mental Health and Wellbeing Connect Centres for carers, families, supporters and kin, and for consumers who also have a caring role.

Good practices may include:

- Offer system navigation and advocacy support either directly or in partnerships (such as with cohealth, Mind or Wellways) or state-wide services or connections with Mental Health and Wellbeing Locals.
- Promote and support access to digital tools like SANE forums, ReachOut and Black Dog Institute resources for those facing geographic or accessibility barriers, and offer support to explore and try digital supports.
- Share opportunities to join lived and living experience groups (for example, Blue Voices) including options for telehealth or digital group access where needed.

Tips for asking people about what care and treatment works best for them

- Approach discussions with curiosity and openness.
- Ask what matters to the person and what they have found helpful or not helpful in the past.
- Avoid making assumptions about what support looks like.
- Welcome discussions about all kinds of support - including cultural, community or spiritual supports.
- Revisit preferences over time.

Example questions:

- *What kinds of support have helped you, or haven't helped you, in the past? Is there a kind of support you'd like to try or are wondering about?*
- *Would you like to talk to a peer worker or someone with lived and living experience?*

6. How might **services reflect** on practice?

- Are we offering or referring to a broad range of supports, including peer-led, psychological, cultural, spiritual, and community-based options that meet people's needs and preferences?
- How do we consider the person's accessibility requirements, relationships, living situation, trauma history, education, financial circumstances and employment status when supporting them to access services?
- How do we respond when someone asks about a type of care or support we do not offer or are unfamiliar with?
- What barriers do we encounter in providing diverse care options? How can we address them together?

7. **Scenario:** Bringing community into hospital - the beauty salon[7]

What happened?

Ruth, who was receiving care in an acute inpatient unit, asked staff if she could have a facial treatment, to help her feel better about herself.

What actions did the service take?

Nursing staff firstly explained this service wasn't available at the hospital, and they did not think that Ruth was ready for leave. However, one nurse thought about this more, including thinking about the risks in Ruth's individual circumstances, and thought there could be a way to make this work. They found a local beautician, who happily agreed to come to the inpatient unit after hours. The staff confirmed that as children would not be present, the beautician did not need a working with children check, completed visitor sign-in, complied with infection control processes, and agreed to remain in communal areas.

The beautician sat with Ruth in the lounge during the facial treatment. Other consumers saw Ruth having a facial and asked if it could also be arranged for them. Over time, Ruth's idea became a regular self-care activity for some consumers.

Reflections from Commission lived and living experience staff

When Ruth's idea was taken seriously, she felt cared for and respected.

It is an ordinary thing to want to look after yourself despite being in hospital. Those small acts of self-care are powerful. The creative approach staff took allowed several people to develop a relationship with a warm and friendly beautician while they were in hospital. They now have this relationship out in the community as well.

It is lovely because it is growing connection to community and communities reaching in.

Which other principles were engaged?

Mental health and wellbeing principles: supported decision making, dignity of risk.

How would you approach this situation?

What might you do differently?

8. Where can I find **more information?**

Australian Commission on Safety and Quality in Healthcare (2021) *National Safety and Quality Health Service Standards* https://www.safetyandquality.gov.au/standards/nsqhs-standards#links-to-the-nsqhs-standards

Department of Health (2011) *Framework for recovery-oriented practice* https://healthsciences.unimelb.edu.au/__data/assets/pdf_file/0011/3391175/framework-recovery-oriented-practice.pdf

IMHA (2025) *Principles of the Mental Health and Wellbeing Act: plain language* https://www.imha.vic.gov.au/sites/default/files/2025-06/imha-principles-mental-health-wellbeing-act-may-2025.pdf

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[7] Note: The scenarios in this guidance are adapted from real examples. These simple scenarios focus on the application of one principle and are intended to show that applying the principles is not always complicated. Scenarios that address the principles in more complex situations and ways are available in implementation resources on the Commission's website.

Least restrictive principle

1. What do **the Act** and relevant guidance say?

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 (s 18).

There is no hierarchy of what is considered more or less restrictive. **Least restrictive means 'the option most consistent with the person's preferences, rather than the one with less time experiencing other restrictions'**[8]**.** For example, inpatient treatment is not inherently more restrictive than community-based treatment. Understanding what 'least restrictive' looks like in practice is explored further in section 5 of this principle.

The decision making principles will generally be relevant in thinking about what is least restrictive. For example, the decision making principles state that compulsory assessment and treatment and restrictive interventions are inherently restrictive, as they significantly limit people's human rights and may cause harm including serious distress to the person, and disruption to their relationships, living arrangements, education and employment (s 80). Accordingly, compulsory assessment and treatment, or restrictive interventions, are not to be used if they will cause more harm than they are supposed to prevent (IMHA 2025).

Relevant guidance or standards that support compliance with this principle include:

- Australian Commission on Safety and Quality in Healthcare (2021) *National Safety and Quality Health Service Standards*, particularly actions 5.35 and 5.36
- Department of Health (2013) *Providing a safe environment for all: framework for reducing restrictive interventions*
- Department of Health (2024a) *Restrictive interventions: Chief Psychiatrist's guideline*
- Department of Health and Human Services (2016) *Safewards handbook: training and implementation resource for Safewards in Victoria*, and associated resources
- Safer Care Victoria's work to implement Royal Commission recommendations relating to reducing compulsory treatment and eliminating restrictive practices (see website)

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[8] *UVX v Mental Health Tribunal (Human Rights)* [2024] VCAT 102, 63

2. How do **human rights** relate to this principle?

Key human rights in the Charter to consider when the least restrictive principle applies include the right to equality (section 8), the right to humane treatment when deprived of liberty (section 22), the right to privacy (section 13(a)) and, among others, the right to liberty (section 21).

Related mental health and wellbeing principles include:	Related decision making principles include:
Dignity and autonomy Dignity of risk Family and carers Supported decision making Cultural safety Gender safety Lived experience Wellbeing of young people	All decision making principles are relevant to considering what is least restrictive.

3. How might a **consumer** experience this principle?

When the least restrictive principle is applied in practice:

- My rights, dignity and autonomy are always respected, and restrictions are only used when absolutely necessary and as a last resort.
- My preferences about what is helpful and least restrictive for me - whether noted directly or in my advance statement of preferences, are taken seriously and given priority.
- If restrictions are used, I am told why in a way I can understand, and what steps I can take to remove or avoid them in the future.
- If I am in hospital, I have access to tools and supports that help me feel safe and calm, including sensory spaces, peer support, and support people.
- My goals for recovery and community participation are respected, and services support me to live as independently and fully as possible.
- I am supported to express my needs and participate in decisions, including through interpreters, communication aids, or IMHA advocates if needed.
- I can give feedback or make complaints about restrictions, and I see that my voice leads to change.
- I am not subject to restrictive practices unless all other reasonable options have been explored and tried. If they are used, they end as soon as they are no longer necessary.

4. How might **carers, families and supporters** experience this principle?

When the least restrictive principle is applied in practice, as a carer, I feel confident that:

- The rights, dignity and autonomy of the person I care for are upheld. Compulsory assessment or treatment or restrictive practices are only used as a last resort.
- The care team works alongside the person I support to explore options that reflect their preferences and support their recovery in the least restrictive way possible.
- Any restrictions used are carefully reviewed, short-term, and guided by what matters most to the person I support - not by what is easiest or most convenient for the system.

5. How do **treating teams** put this principle into practice?

This section gives an overview of requirements and good practice suggestions for putting the least restrictive principle into practice. As noted earlier in this guidance, the dignity and autonomy and supported decision making principles underpin all other principles and must always be considered.

Explore the key topics covered in this section:

- Promote autonomy, choice and supported decision making
- If compulsory treatment is considered, prioritise the patient's views and preferences to understand what is least restrictive
- Promote leave from an inpatient environment where preferred and appropriate
- Reduce and eliminate restrictive practices
- If a restrictive intervention is used, follow Act requirements

Promote autonomy, choice and supported decision making

Requirements include:

- 🕮 Provide appropriate supports to help people understand information and their rights, to exercise their rights and make and communicate decisions. See dignity and autonomy principle.
- 🕮 Presume capacity and seek informed consent to treatment, using supported decision making mechanisms including advance statements of preferences, nominated support persons, IMHA advocacy and, with consent, support from carers, families, supporters and kin. See supported decision making and family and carers principles.
- Use recovery-oriented, trauma-informed practice approaches. For example, promote choice over as many decisions as possible, be aware of the likelihood that people accessing mental health and wellbeing services have previous experiences of trauma including trauma within those services and ask what people need to be and feel safe.

Good practice may include:

- Ask consumers if they would like to involve lived and living experience staff in care and treatment discussions. For example, to help the consumer identify treatment approaches that work for them and work towards voluntary engagement as far as possible.
- Ask Aboriginal consumers if they would like to involve Aboriginal mental health workers and Social and Emotional Wellbeing (SEWB) workers in their treatment. For example, to help ensure that connection to Culture is considered as a core part of decisions about what is least restrictive, and to promote voluntary treatment. See cultural safety principle.

> “Least restrictive treatment means treatment that is most in line with what the consumer wants.”

If compulsory treatment is considered, prioritise the patient's views and preferences to understand what is least restrictive

Criteria for compulsory assessment and treatment (summarised from ss 142-143 of the Act)

Compulsory assessment and treatment must only be used where all the following criteria apply:

- a person has (or, for assessment orders, appears to have) mental illness
- because the person has (or, for assessment orders, appears to have) mental illness, they need immediate treatment to prevent serious deterioration in their mental or physical health or serious harm to themselves or to another person
- if they are made subject to an assessment, temporary treatment or treatment order, they can be assessed or immediately treated, respectively
- there are no less restrictive means available to enable the person to be assessed or immediately treated.

Requirements include:

Deciding whether a person has mental illness and needs immediate treatment are matters for clinical judgment. However, an assessment of whether there are no less restrictive means available to enable a person to be assessed or immediately treated requires decision-makers to give proper consideration to the person's views and preferences about assessment and treatment while exploring what 'least restrictive' may mean for the person. For example, by:

- speaking with the person
- checking any advance statement of preferences
- speaking with a nominated support person to understand the views of the person who may be assessed or treated
- speaking with families, carers and supporters, and
- checking for any information the service may already have from previous contacts, about what the person would prefer.

Services must be able to show how the person's views and preferences have been considered in decisions around compulsory assessment and treatment. For example, if making a decision about compulsory treatment, the authorised psychiatrist must:

- 📖 Give proper consideration to the decision making principles for treatment and interventions set out in Part 3.1 of the Act. For example, consider and explore with the person as far as possible, the impact of compulsory assessment or treatment or restrictive interventions on their relationships, living arrangements, work or study (see Alex scenario in Part One on pages 18-20).
- 📖 Consider as far as reasonable in the circumstances:
  - the patient's views and preferences about treatment (including those expressed in an advance statement of preferences, and/or as communicated by their nominated support person) and the reasons for them, including any recovery outcomes the patient would like to achieve.
  - any beneficial alternative treatment that is reasonably available
  - the views of the patient's guardian, parent (if the person is under 16), or carer if the decision will affect the carer and care relationship[9]
  - any other relevant information (see s 180(2)).
- 📖 If making a treatment decision for a patient, the authorised psychiatrist must consider the above matters and:
  - the likely consequences for the patient if the treatment is not administered
  - the likely consequences if the treatment is provided to the patient without the patient's consent
  - any second psychiatric opinion that has been given to the authorised psychiatrist (s 89(4)).

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[9] And the Secretary DFFH if they have parental responsibility for a child under a relevant child protection order.

- Work with the person and (with consent) their family, carer, supporters and kin to meet their preferences wherever possible. For example, preferences about treatment:
  - type - private or voluntary assessment or treatment if preferred/applicable
  - options - talking therapies, groups, preferences about medication type, administration method and dosage
  - environment - community, inpatient or PARC, general inpatient or intensive care area. See also diversity of care and dignity of risk principles.
- With the consumer and (with consent) their family, carer, supporters and kin, with a focus on the consumer's recovery goals and treatment preferences, regularly review any restrictions of the person's rights, dignity and autonomy with a plan to move towards less restrictive treatment (s 79, care and transition to less restrictive support principle).
- When making decisions, remember that the least restrictive principle must be considered in the light of other principles of the Act that emphasise consumer choice and autonomy. If a person and their carer or supporters have different views about what is least restrictive for the person, the person's views have more weight.

Good practice may include:

- Offer timely, prompt opportunities to repair, debrief and discuss compulsory treatment decisions with the consumer and their chosen supporters, with a trauma lens.

Avoid the following practices:

- Avoid using community-based compulsory treatment orders as a default pathway to discharging a person from inpatient care. Rather, discuss with the person and their chosen supporters, available options for voluntary treatment in the community.
- Avoid using compulsory or inpatient assessment or treatment as the default pathway to care without exploring other options. For example, do not require a person to attend an Emergency Department (ED) for assessment without considering community-based assessment.
- Do not ignore less restrictive options that are suggested by the person or their family/carers without considering those options - for example, private or voluntary treatment.
- Avoid varying community-based orders to inpatient orders solely for the purpose of administering medication, as much as possible. Less restrictive alternatives, including working with the person about treatment options they would agree to, must be thoroughly considered before taking this approach. Document any steps taken to try or consider these alternatives, and advise people of their rights to appeal their order to the Mental Health Tribunal, and to access legal assistance including from VLA's Mental Health Legal Rights Service Helpline, the Mental Health Legal Centre or the Victorian Aboriginal Legal Service.

Promote leave from an inpatient environment where preferred and appropriate

Requirements include:

- Promote leave from the inpatient unit where this is in line with the person's preferences and risk and safety assessments. In making decisions about leave for a compulsory patient, the authorised psychiatrist must consider: the purpose of the leave, the need to ensure the health and safety of the person and safety of any other person, the need to minimise the risk of serious harm, the patient's views and preferences about leave, including any views and preferences expressed in an advance statement of preferences or on the patient's behalf by their nominated support person, the role of leave in promoting the patient's recovery outcomes, and the views of any guardian, carer (if the decision will affect carer and care relationship), or parent of a patient aged under 16.[10]

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[10] Or Secretary DFFH if they have parental responsibility for the person under a relevant child protection order.

- In decisions about leave, consider the interaction with other mental health and wellbeing and decision making principles. The following are examples only of how this interaction may apply:
  - the autonomy principle of the decision making principles, dignity and autonomy, supported decision making and dignity of risk: what are the person's preferences? How is their right to decide to take reasonable risks to achieve personal growth, self-esteem and overall quality of life being supported?
  - consequences of compulsory assessment and treatment and restrictive interventions: what is the impact of the decision about leave on their relationships, living situation, work and study?
  - cultural safety: what is the impact of the leave on the person's ability to stay connected to their culture?
  - health needs: does the person need leave to attend medical appointments?
- Decisions about leave for voluntary patients can be complex. Voluntary patients are free to leave hospital when they choose as long as their absence is discussed with nursing staff before leaving the ward so their whereabouts is known. It may be reasonable to ask a voluntary patient not to leave an inpatient unit until a psychiatrist has assessed their mental state and level of risk. If the person chooses to leave regardless, it may be necessary to consider whether the compulsory assessment criteria apply. In those circumstances, services must transparently discuss all options with the consumer and their support people and facilitate access to IMHA advocacy to support the consumer to express their views and ensure their rights are upheld. Take care to ensure voluntary patients do not feel coerced to remain in the hospital.

Reduce and eliminate restrictive practices

Restrictive interventions - Act requirements

Mental health and wellbeing service providers must work to reduce and eliminate restrictive interventions, and must consider the decision making principles when making decisions about restrictive interventions.

Restrictive interventions must only be used if necessary to prevent imminent and serious harm to the person or another person, or, in the case of bodily restraint, to administer treatment or medical treatment. Restrictive interventions must not be used unless all reasonable less restrictive options have been tried or considered and found to be unsuitable.

If a restrictive intervention is no longer necessary to prevent imminent or serious harm or administer treatment or medical treatment, a person who can authorise a restrictive intervention must immediately take steps to end the restrictive intervention. See sections 125 - 139 of the Act for details.

Requirements include:

- Offer education and resources for consumers, carers, families, supporters and kin about restrictive practices and rights. For example:
  - consumer rights - including the need for restrictive practices to be reduced and minimised, and the rights outlined in the dignity and autonomy and supported decision making principles
  - carer rights - including the right to be involved in care and treatment (see family and carers principle), and to be informed of the use of any restrictive practices.

Good practices may include:

- Seek and respond to consumer, carer and family feedback (individually on admission and during treatment, as well as in group settings, such as consumer meetings) about what helps people to feel safe, and act on feedback. For example, have sensory rooms and resources available, enable access to comforts from home.
- Promote and uphold cultural and gender safety, and ensure the diversity of all consumers is respected and welcomed.
- Be aware that feeling safe is individual. People's individual attributes, including intersecting attributes, will mean that every environment will affect people in different ways.
- Create opportunities for consumers to participate in social, cultural and educational activities to help alleviate feelings of boredom and isolation.
- Be transparent about what may lead to a consumer being subject to restrictive practices. When sharing this information, emphasise that restrictive practices are to be avoided wherever possible, and invite collaboration about what approaches work best for the person.

If a restrictive intervention is used, follow Act requirements

Requirements include:

- 📖 If considering a restrictive intervention, delay if possible, to give the person time to self-regulate. If this does not occur, before authorising a restrictive intervention, consider to the greatest extent possible:
    - the likely impact on the person considering their views, preferences and trauma history. This could include previous experiences in mental health and wellbeing services including restrictive practices, as well as trauma from physical or sexual abuse, neglect, war, refugee and migrant experiences, or other traumatic experiences.
    - the person's views and preferences about restrictive practices including any expressed in an advance statement of preferences or as represented by their nominated support person.
    - the person's culture, beliefs, values and personal characteristics. For example, consider the impact of a woman with a history of sexual assault being restrained by multiple male staff.
- 📖 Give proper consideration to the decision making principles for treatment and interventions set out in Part 3.1 of the Act.
- 📖 Clearly document any interventions or techniques used to try to respond to the person's known preferences to avoid using restrictive practices and to use them only as a last resort. Explain what informed any use of a restrictive intervention.
- 📖 Ensure that a person is released from a restrictive intervention as soon as it is no longer necessary to achieve a permitted purpose (for example, to prevent imminent and serious harm to the person or another person, or, in the case of bodily restraint, to administer treatment or medical treatment - s 127).
- 📖 Debrief with consumers (with support from their IMHA advocate, nominated support person, family member, carer or other supporter if they prefer) after any restrictive intervention to offer support for any trauma experienced and to gather feedback to improve practices. Consider the environment where the debriefing occurs. Ask the consumer's preferences - for example, to be in a quiet place, away from the unit in which the restrictive intervention was used.
- 📖 Comply with the requirements of the Chief Psychiatrist's *Guideline for restrictive interventions* (Department of Health 2024a) and *Reporting directive for restrictive interventions* (Department of Health 2024b).

Avoid the following practices:

- Avoid administering treatment without consent to keep a person calm, especially without using multiple strategies to give the person an opportunity to give informed consent to treatment.
- Do not use restrictive practices for non-permitted purposes - for example, to remove a person's mobile telephone.
- Avoid using restrictive practices solely to prevent a person from leaving an inpatient unit. Restrictive practices can only be used to prevent a person leaving an inpatient unit if there is concern that leaving the unit may result in imminent and serious harm to that person or another person.

Tips for talking about least restrictive treatment with a consumer

Be curious about the person's preferences, needs, strengths and supports.

Ask if they have an advance statement of preferences, nominated support person or other supporter.

Questions may include:

- *What is important to you about your treatment and recovery (for example, type or location of treatment)? What works well for you or makes things hard?*
- *What helps you understand information and make decisions?*
- *Who would you like to be involved in supporting you? Who and what is important in your life - family, connection to culture and community, wellbeing of children or dependents, work?*
- *How can we help you feel safe?*
- *Are there things that you don't like that we can try to avoid? For example, lots of people talking to you at once, crowded space, noise, bright lights, not being able to go outside.*
- *What helps you when things aren't going well? For example, peer support, maintaining regular contact with support people, sensory tools and supports or comforts from home.*
- *How do different restrictions affect you?*

Consider the environment and what the person's verbal and non-verbal communication is showing when having these discussions - for example, is the environment private? Noisy/overstimulating? Restrictive? What do the person's words or body language say?

6. How might **services reflect** on practice?

- How do we prioritise voluntary and/or community-based treatment and engagement? What works well, that we can do more of?
- How do we understand what each consumer sees as least restrictive (according to their own views, values, needs and preferences)? Do we always ask?
- What gets in the way of us providing less restrictive treatment (for example, difficulties in service access meaning people are acutely unwell on admission and during an inpatient stay, bed pressures, short stays, lack of training, workforce availability overnight, poor unit design, lack of sensory rooms, and differing views about risk and restrictiveness)? What can we change?
- If compulsory treatment is used, how do we understand whether and how it is helping the person to work towards their treatment and recovery goals? How can compulsory treatment be minimised?
- What helps us to avoid using restrictive practices? For example, understanding the person's preferences via advance statements of preferences, seeking their direct advice, advice from carers, families and supporters, availability of comforts from home, access to sensory rooms, resources and tools. How can we build on these strengths?
- How do we make sure consumers, and their support people, understand their rights if restrictive practices are used?

7. **Scenario:** Supporting a person in distress[11]

What happened?

Mark, an older man, was an inpatient. On this day several staff were off with the flu, some were agency, and less people available on shift. After a phone call with a family member, Mark became visibly upset and started shouting and throwing things. Staff could see other consumers withdrawing from the communal area. Staff asked Mark to calm down, and suggested he return to his room, but this approach wasn't helpful for him. More staff gathered in the area asking Mark to stop yelling.

What actions did the service take?

One staff member could see that the approaches being used weren't helping and they spoke to the Associate Nurse Unit Manager (ANUM). The ANUM asked staff to give Mark some space, approached him calmly and invited him outside for a chat - 'what's happening? Let's talk.' Mark was still shouting and throwing things. The ANUM explored how Mark was feeling and then validated his experiences.

The ANUM asked Mark if he would like to step outside or sit here in a quieter space. Mark chose to go outside with the ANUM and chatted on the lawn. After a chat with the ANUM, Mark came back inside calmer and not agitated or distressed. Another staff member asked Mark if he wanted a supporter called. Mark and the ANUM talked about what Mark had found helpful while he was distressed, and noted this together in Mark's file.

The staff member who had asked the ANUM for advice reflected later they had been afraid Mark's behaviour would continue to escalate, leading to more restrictive approaches. By listening and validating his distress, and encouraging Mark to go outside for fresh air and a chat, he felt supported and was able to re-enter the ward in a much better frame of mind.

The ANUM also used this as an opportunity to arrange for refresher education for staff around working with distress, including reminding staff about Safewards interventions, and reminded all staff about quick tools that could be referred to on the service intranet.

Reflections from Commission lived and living experience staff

A lot of us can go from zero to 100 quickly, depending on our circumstances. It is a great gift when people can help hold us in our distress. Here, the ANUM connected gently and led with kindness. They were mindful of where Mark was at emotionally, which helped them to see him and his distress, rather than focusing only on his language and actions.

Which other principles were engaged?

Mental health and wellbeing principles: Dignity and autonomy, supported decision making

Decision making principles: Consequences of compulsory assessment and treatment and restrictive interventions principle

How would you approach this situation?

What might you do differently?

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[11] Note: The scenarios in this guidance are adapted from real examples. These simple scenarios focus on the application of one principle and are intended to show that applying the principles is not always complicated. Scenarios that address the principles in more complex situations and ways are available in implementation resources on the Commission's website

8. Where can I find **more information?**

Australian Commission on Safety and Quality in Healthcare (2021) *National Safety and Quality Health Service Standards* https://www.safetyandquality.gov.au/standards/nsqhs-standards

Department of Health (2013) *Providing a safe environment for all: framework for reducing restrictive interventions* https://www.health.vic.gov.au/practice-and-service-quality/framework-for-reducing-restrictive-interventions

Department of Health (2024a) *Restrictive interventions: Chief Psychiatrist's guideline* https://www.health.vic.gov.au/chief-psychiatrist/chief-psychiatrists-restrictive-interventions

Department of Health (2024b) *Chief psychiatrist's reporting directive for restrictive interventions* https://www.health.vic.gov.au/chief-psychiatrist/chief-psychiatrists-restrictive-interventions

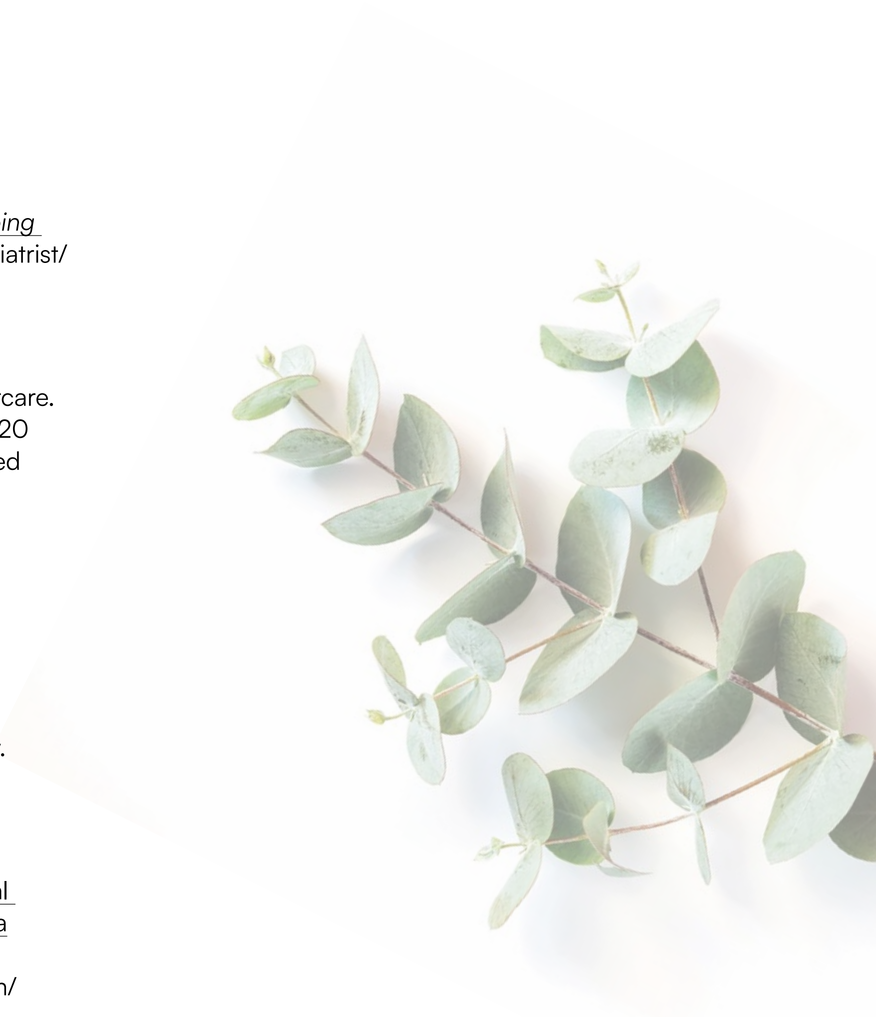
Department of Health (2025a) *Understanding and reporting chemical restraint: a factsheet for prescribing clinicians* https://www.health.vic.gov.au/chief-psychiatrist/understanding-reporting-chemical-restraint

Department of Health and Human Services (2016) *Safewards handbook: training and implementation resource for Safewards in Victoria* https://www.safercare.vic.gov.au/sites/default/files/2025-04/Safewards%20Victoria%20Handbook%202016.pdf and associated resources

Department of Health and Human Services (2019a) *Mental Health Intensive Care Framework* https://www.safercare.vic.gov.au/publications/mental-health-intensive-care-framework

Safer Care Victoria (2025) resources Working towards the elimination of restrictive practices in inpatient services | Safer Care Victoria https://www.safercare.vic.gov.au/best-practice-improvement/mental-health-improvement-program/initiatives/elimination-of-restrictive-practices

Reducing compulsory treatment in Victorian Mental Health and Wellbeing Services | Safer Care Victoria https://www.safercare.vic.gov.au/best-practice-improvement/mental-health-improvement-program/initiatives/reducing-compulsory-treatment



Supported decision making principle

1. What do **the Act** and relevant guidance say?

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 (s 19).

This principle is intended to reinforce the primacy and priority of a person's views and preferences when they are receiving mental health and wellbeing services and creates obligations on service providers with a view to achieving this (Explanatory memorandum to the Mental Health and Wellbeing Bill 2022, p 20).

Implementing this principle involves finding ways to maximise a person's choice and control including when they are receiving compulsory treatment. This requires services to presume and support capacity to make decisions about treatment (for example, by providing appropriate supports, revisiting capacity at different points, assessing capacity in ways that will result in an accurate assessment), seek informed consent to all treatment decisions and promote the supported decision making mechanisms of the Act. Maximising a person's choice and control will, at times, include supporting decisions that are not preferred by the service - see the dignity of risk principle for further exploration of what this may look like in practice.

The supported decision making principle, along with the dignity and autonomy principle, underpins all other principles. The actions outlined in this principle are always required.

2. How do **human rights** relate to this principle?

The principle of supported decision making is fundamental to upholding the human rights of people receiving mental health care, treatment and support. It is about ensuring that people who receive mental health care have their inherent dignity and autonomy respected and their right to participate on an equal basis is protected and upheld.

Highlighted by the Royal Commission into Victoria's Mental Health System, mental health laws have developed over time from being based on a 'best interests model' where the focus was on whether a person was 'mentally ill and requires care or treatment' to laws that include frameworks of supported decision making and recovery-oriented practice, in addition to human rights protections, while continuing to permit compulsory treatment' (State of Victoria, 2021, Vol 4, page 36).

The concept of supported decision making is also reflected in international human rights instruments, including Article 12 of the Convention on the Rights of Persons with Disabilities, which states that people with disability have a right to be supported to make their own decisions.

When the supported decision making principle applies, several rights and/or freedoms will be engaged under the Charter. These may include rights and/or freedoms such as: the right to recognition and equality before the law; the right to protection from torture and cruel, inhuman or degrading treatment (which includes the right to be free from medical treatment without full, free and informed consent), freedom of movement; privacy; freedom of thought, conscience, religion and belief; freedom of expression; and the right to take part in public life.

Related mental health and wellbeing principles include:	Related decision making principles include:
Dignity and autonomy Dignity of risk Family and carers Supported decision making Cultural safety Lived experience Wellbeing of young people	Autonomy

3. How might a **consumer** experience this principle?

When supported decision making is promoted in my care and treatment:

- I am supported to make as many decisions as I can about my care, treatment and recovery, including when I am receiving compulsory treatment.
- My preferences and views are heard and prioritised, even if others have different opinions.
- I can take my time to make decisions, ask questions, and change my mind if needed.
- I am offered options to support me to make and express decisions in a way that suits me, for example: written information, visual tools, extra time, or help from a peer, IMHA advocate, carer or interpreter.
- I am supported to make an advance statement of preferences, which is taken seriously and followed wherever possible. I know that if my preferences can't be followed, I will be given clear and respectful reasons why.
- I can choose someone I trust to help me to express my decisions.
- I am supported to build my confidence and skills to make decisions over time.
- Information about me will not be shared - even with my consent - if doing so would place anyone at risk of family violence.

4. How might **carers, families and supporters** experience this principle?

When supported decision making practices are promoted:

- I am involved in the person's assessment, treatment and recovery in ways that reflect their wishes, and the treating team works with us both to make that involvement meaningful and respectful.
- If the person I support chooses not to involve me in decision making, the service will still share the information I need to continue providing safe and effective care, in line with privacy and consent requirements.
- When I am a nominated person, carer, guardian or parent of a child under 16, I am notified and consulted at key points of care and treatment as required by the Act.
- I can see that the service actively supports the person I care for to understand their options and make their own decisions, including through supported decision making tools and communication aids.
- My knowledge of the person and what helps them feel safe and understood is respected, and I feel like a valued partner in their recovery journey - in line with their wishes.
- Information will not be shared - even if I agree it can be shared - if doing so would place anyone at risk of family violence.

5. How do **treating teams** put this principle into practice?

This section outlines actions treating teams can take to put the supported decision making principle into practice, as well as good practice suggestions. Upholding people's views and preferences goes hand in hand with upholding their dignity and autonomy. See the dignity and autonomy principle for actions about providing appropriate supports, sharing and explaining accessible rights information and upholding people's rights under the Act.

Explore the key topics covered in this section:

- Ask about preferences including in an advance statement of preferences
- Promote and involve nominated support persons
- Involve carers, families, supporters and kin
- Presume capacity
- Support people to give and refuse informed consent to treatment
- Promote advocacy and support advocates in their role

Ask about preferences including in an advance statement of preferences

Requirements include:

- Ask about people's preferences, views and priorities. For example, ask if they have a recovery or other treatment plan, what is important to them and what they need to feel and be safe.
- Give people information and options - for example, explore their preferences about different types of treatment and support (such as medication, peer support or peer-led community groups, psychological support) - and support their choices to the greatest extent possible.
- 📖 Take all reasonable steps to find out if a patient has an advance statement of preferences. **Reasonable steps** may include asking the person, checking the clinical file, asking any known family, carer, or supporter including any nominated support person and asking at multiple points in treatment, not just at the earliest point of contact with a service.
- 📖 Make all reasonable efforts to give effect to the statement. **Reasonable efforts** may include maximising what can be offered within the service including from other parts of the service, or researching services or supports that may be available from another service and making referrals. Consider every opportunity to meet the person's preferences, including preferences that involve reasonable risks.
- 📖 Follow a person's advance statement of preferences unless their preferences are not clinically appropriate or not able to be provided by the service, despite all reasonable efforts (as described above) having been made (s 90(1)). Mental health and wellbeing service providers should not assume that preferences expressed in an advance statement of preferences are not clinically appropriate or cannot reasonably be provided purely on the basis that they are different from treatment that is usually provided or is considered preferable.

  If preferred treatment cannot be provided, talk with the person, their nominated support person and (with consent) their family, carer or supporters to seek an outcome that is acceptable to the person.

  📖 If the advance statement of preferences can't be followed, explain the reasons why to the patient and their support people verbally (s 90(3)), and give written reasons (s 90(2)).
- With consent, involve the consumer's family, carer, supporters and kin to better understand the person's preferences.
- Document how the person's preferences have informed decisions including the steps taken to try to meet their preferences.

Good practices may include:

- Take a recovery-oriented, trauma-informed approach to discussions about treatment preferences. Support the person's own recovery goals and give as much information and choice as possible. A person's preferences and priorities may focus less on reducing symptoms and more on other factors that affect their life and wellbeing.
- Ask all consumers including voluntary consumers, and their family, carers and supporters, if the consumer has an advance statement of preferences.
- Explain the benefits of having an advance statement of preferences and offer support to prepare an advance statement of preferences.
- Make information about advance statements of preferences available in multiple ways. For example, hardcopies, QR codes, sharing IMHA resources, bookmark IMHA or Department of Health information on public access computers.
- Ensure advance statements of preferences are easily accessible to all relevant staff and are integrated into key documents like treatment and recovery plans, crisis/service response plans, and any other planning tools used to guide the person's treatment, care and support.
- Ask a person whether their advance statement of preferences remains accurate, at key points in care or if you are aware of changes to the person's life or experiences that may mean they may wish to make a new advance statement of preferences. For example, new information about treatments the person finds helpful or unhelpful, relationship changes.
- Use a simple, standardised form to capture people's views, preferences, and goals early in their engagement with the service. This 'living document' can help inform treatment and support and, if the person chooses, be used later to assist in developing a formal advance statement of preferences.

Promote and involve nominated support persons

Requirements include:

- 📖 Take all reasonable steps to find out if a patient has a nominated support person and if the nomination is current. **Reasonable steps** may include:
    - asking the patient
    - checking the clinical file
    - asking a carer/family member if they know whether the patient has a nominated support person
    - making more than one attempt to ask the consumer and their support people
    - exploring with the consumer if their views about who they would like to be their nominated support person has changed, or changes during their admission.
- If there is a nominated support person, take all reasonable steps to support them to perform their role under the Act (s 34). **Reasonable steps** include:
    - informing and consulting them as required by the Act (see the Mental Health and Wellbeing Act handbook for details)
    - allowing them to view treatment documents
    - giving information
    - giving reasonable opportunities to attend meetings with the patient and treating team.
- Services should document how the nominated support person's advice about the patient's views and preferences informs decisions.

Good practices may include:

- Ask all consumers including voluntary consumers, their family, carers and supporters, if the consumer has a nominated support person.
- Explain the benefits of having a nominated support person who can represent the person's views and preferences. Offer support to appoint a nominated support person.
- Share information about nominated support persons in multiple ways. For example, hardcopies, QR codes, share resources developed by organisations like IMHA and Tandem, bookmarking information on nominated support persons on public access computers.
- Ensure a nominated support person's details are clearly recorded and accessible in key documents such as treatment and recovery plans, crisis/service response plans, and any other planning tools used to guide decisions about the person's treatment, care and support.

Involve carers, families, supporters and kin

Requirements include:

- Involve carers, families, supporters and kin in line with the consumer's preferences.
- 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.
- Where there are differences in opinion between a consumer and a carer, uphold the consumer's preferences while respecting and supporting the carer's role (for example, by listening to their views and concerns, providing the information they need to provide care and connecting them with supports).
- See also families and carers principle.

Presume capacity

Capacity to give informed consent: key points summarised from ss 85 and 87

All people must be presumed to have capacity to give informed consent to treatment or medical treatment. Informed consent must be sought before giving treatment unless the person seeking consent reasonably considers that they do not have capacity.

A person has capacity if they can understand, remember, use or weigh relevant information and communicate their decision (including by speech, gestures or any other means).

Relevant information means the information needed to make a decision, not all the information that may be provided to a person.

Any assessment of capacity must be specific to the decision that needs to be made.

Capacity can change over time.

Making a decision that could be considered unwise (including declining treatment) does not mean that a person lacks capacity.

A person's age, appearance, disability, condition or behaviour does not determine whether they have capacity.

Capacity can be supported, including by providing appropriate supports. Capacity must be assessed at a time and in an environment that will support an accurate assessment.

Requirements include:

- 📖 Always presume capacity to give informed consent to treatment decisions including when a person is a compulsory patient and before making decisions about compulsory treatment.[12]
- 📖 Enable capacity by providing appropriate supports to help people understand relevant information, make and participate in decisions and communicate their decisions. See dignity and autonomy principle.
- 📖 Recognise that a person has the right to take reasonable risks to achieve personal growth, self-esteem and overall quality of life. See dignity of risk principle.
- 📖 Consider every decision individually and support people to make the decisions they can make, even if they do not currently have capacity to make some decisions.
- 📖 Reassess capacity regularly, recognising that it can change over time.
- 📖 Do not assume that a person lacks capacity to make decisions based only on their age, appearance, disability, condition or behaviour.
- 📖 Recognise that making a decision that could be considered unwise (including declining treatment) does not mean that a person does not have capacity.
- 📖 Conduct capacity assessments in an environment that is likely to result in an accurate assessment. For example, consider ways to make the environment calmer, move to a quieter environment, and offer the person food, drink or rest before their capacity needs to be considered.

Good practices may include:

- Show commitment to presuming and supporting capacity by using language that maximises choice, control and respect.
- While listening to information and concerns raised by family members and carers, share information and educate family members and carers about the presumption of capacity and steps a service must take to support a person's capacity.

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[12] Informed consent does not have to be sought if the person seeking consent reasonably considers that the person does not have capacity to give informed consent (s 85(3)). In order to reasonably consider this, the person seeking consent would need to consider the key points in the breakout box on this page.

Support people to give and refuse informed consent to treatment

Requirements include:

- 📖 Seek informed consent from the person before providing any treatment, including when a person is receiving compulsory treatment - unless you reasonably consider that the person does not have capacity to give informed consent - for example, after considering the factors in ss 85 and 87.
- 📖 Engage with the person about their preferences. Identify and explore real and meaningful choices about treatment. Give priority and weight to the person's preferences including any concerns about side effects or previous trauma or negative experiences of accessing services.
- 📖 Give the person adequate information to make an informed decision including:
    - an explanation of the proposed treatment (such as purpose, type, method and likely duration)
    - an explanation of the advantages and disadvantages of having the proposed treatment, including information about discomfort, risks and common or expected side effects
    - an explanation of any beneficial alternative treatments that are reasonably available, including their advantages and disadvantages
    - an explanation of the advantages and disadvantages of not having the proposed treatment
    - answers to any relevant questions
    - any other relevant information
    - any relevant statement of rights (and explaining it in a way the person understands).
- 📖 Give a reasonable opportunity to decide whether to consent by:
    - giving the person time and supporting the person to ask questions
    - providing appropriate supports to make the decision. See dignity and autonomy principle
    - giving a reasonable opportunity to get other advice or help to make the decision. For example, from any nominated support person, carer, family or supporters, peer/lived and living experience staff, IMHA advocates, other health professionals.
- 📖 Check the person can give consent freely without undue pressure or coercion.
- 📖 Check the person has not withdrawn consent or shown that they want to withdraw consent.
- 📖 Respect the person's right to make decisions that involve reasonable risks. See dignity of risk principle.
- 📖 Document the steps taken to support a person to give informed consent. For example, what options were discussed, how the person's preferences informed the choices, what information was shared, what opportunity a person had to decide whether to consent.

Good practices may include:

- Give information and explanations in more than one format. For example, verbal and written information, links to websites, fact sheets, videos where consumers share their experiences with specific treatments including positives and negatives.
- Give information about what to expect at your service, including choices within treatment and options for treatment by other services.
- Encourage and support consumers to participate in clinical reviews.

Promote advocacy and support advocates in their role

IMHA is the designated non-legal mental health advocacy service provider. IMHA advocates have a role under the Act to support people receiving or at risk of compulsory mental health treatment to understand and exercise their rights, express their views and preferences about treatment and make informed decisions about their assessment, treatment and recovery.

Requirements include:

- 📖 Give any reasonable assistance to IMHA advocates to support them to carry out their role. Reasonable assistance includes:
    - If an IMHA advocate is supporting a consumer aged at least 16, who gives their consent, enabling and supporting the IMHA advocate to:
        - access the consumer's personal or health information, including any advance statement of preferences
        - attend meetings with the treating team (for example, by letting the consumer and IMHA advocate know in advance when meetings will occur, or scheduling meetings on days the IMHA advocate attends the service if possible)
        - seek information from the service on the consumer's behalf
        - liaise with a consumer's nominated support person, family, carer or supporters and advocate for their rights if they relate to the consumer's treatment, care, support or recovery.
    - If an IMHA advocate is supporting a compulsory patient aged 16 years or older who cannot give instructions to an advocate, enabling and supporting the advocate to:
        - observe and meet the consumer
        - access the consumer's personal and health information including any advance statement of preferences and contact details of a nominated support person or other support person if the person doesn't have a nominated support person
        - liaise with a nominated support person or carer to understand the consumer's views and preferences
        - advocate for the consumer's views, preferences and rights.
    - if the consumer is a child (15 or younger), the advocate may promote the consumer's views and preferences and to work with the consumer's family, carers and supporters to protect their best interests.

Good practice may include:

- Promote the role of IMHA advocates to compulsory patients and those at risk of compulsory treatment. For example, in addition to explaining the right to advocacy, talk about the benefits of having an IMHA advocate (see IMHA - what we can do for you), tell First Nations consumers that they can request a First Nations advocate.

Tips for talking with consumers, families, carers and supporters about supported decision making

- Be curious, and focus on a person's experiences, rather than symptoms

  For example, *What has happened to you?* rather than *What is wrong with you?*

- Recognise that people know what works for them

  What has helped you in the past?

- Offer options, information and support to help people make decisions

  Is there anyone you would like me to contact who can support you?

  How do you prefer to receive information - talking, in writing, or something else?

- Give time and space for questions

  Do you have any questions about what we're talking about today? You can ask us at any time, even if something comes to mind later.

6. How might **services reflect** on practice?

- Do we consistently presume capacity at all points including for compulsory patients and before making decisions about compulsory treatment?
- How do we support and encourage people to lead decisions about their treatment? For example, by providing appropriate supports, access to supported decision making mechanisms, genuine options and alternatives, and with consumer consent, involving family, carers, supporters and kin?
- How could we improve how we identify and provide appropriate supports to help people understand their rights and information, and make and communicate decisions?
- How often do we make treatment decisions for a patient where the patient has capacity to give informed consent but does not give informed consent? Could we have made a different decision that was more consistent with the person's views and preferences?
- How do we respond if an advance statement of preferences includes a preference that we don't usually offer or aren't familiar with?
- With the consumer's agreement, how do we work with the person's supporters to help us understand the consumer's views, preferences and priorities? (for example, working with nominated support persons, IMHA advocates, carers, families and supporters).
- How do we involve the lived and living experience workforce in supporting a person to advocate for their preferences and make decisions?
- How do we work with external organisations to ensure we are complying with this principle, such as IMHA, the Commission, Victoria Legal Aid's Mental Health Legal Rights Service?

7. **Scenario:** Upholding an advance statement of preferences and autonomy[13]

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. She was able to start medication by her own choice. It was a good outcome for staff as well, who were able to uphold her dignity and autonomy.

Which other principles were engaged?

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

Decision making principles: autonomy principle

How would you approach this situation?

What might you do differently?

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[13] Note: The scenarios in this guidance are adapted from real examples. These simple scenarios focus on the application of one principle and are intended to show that applying the principles is not always complicated. Scenarios that address the principles in more complex situations and ways are available in implementation resources on the Commission's website.

8. Where can I find **more information?**

IMHA - I want to make an advance statement of preferences https://www.imha.vic.gov.au/i-want-make-advance-statement-preferences

IMHA - I want to nominate a person to support me https://www.imha.vic.gov.au/i-want-nominate-person-support-me

IMHA - What we can do for you | IMHA https://www.imha.vic.gov.au/what-we-can-do-for-you

Department of Health, *Mental Health and Wellbeing Handbook 2022* - Advance statements of preferences https://www.health.vic.gov.au/mental-health-and-wellbeing-act-handbook/advance-statements-of-preferences

Department of Health, *Mental Health and Wellbeing Handbook 2022* - Nominated support persons https://www.health.vic.gov.au/mental-health-and-wellbeing-act-handbook/supported-decision-making/nominated-support-persons

Tandem Information kit - Helping a person participate in decisions about their treatment and support https://www.tandemcarers.org.au/Common/Uploaded%20files/Your-Rights/250228%20Tandem%20info%20sheet%205.pdf

Family and carers principle

1. What do **the Act** and relevant guidance say?

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 (s 20).

This principle recognises the importance and centrality of the role of families, carers and supporters in a person's assessment, treatment and recovery (Explanatory Memorandum to the Mental Health and Wellbeing Bill 2022 (Vic), p 21).

Carers, families, supporters and kin (including children) play a vital role in supporting a person's recovery and decision making in mental health and wellbeing services. The Act recognises this by outlining specific provisions that require services to involve and consult with carers at various stages of assessment, treatment, and recovery.

The *Chief Psychiatrist's guideline: Working together with families and carers* (Department of Health and Human Services 2018c) emphasises the importance of acknowledging care relationships and ensuring carers have access to information, support, and skills to fulfill their role. Compliance and continuous improvement in line with the Chief Psychiatrist's guideline will support proper consideration of the family and carers principle.[14]

Balancing the involvement of carers, families, supporters and kin with a person's right to autonomy and privacy can be complex. The Act sets out principles and requirements for information sharing, ensuring that decisions about disclosure are made carefully, particularly where there is a risk of family violence or other serious harm, or where sharing information could pose a risk to the health or safety of any person or unreasonably impact on the privacy of other people.

Different terms are used throughout this section, including 'carers, families, supporters and kin', 'families, carers and supporters', and 'carers, guardians and parents of consumers aged under 16 years'. See our note on language for further discussion.

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[14] We acknowledge that at the time of publication, the *Working together with families and carers guideline* has not yet been updated to reflect the *Mental Health and Wellbeing Act 2022*. However, the practice guidance it contains remains relevant, and can be read together with relevant sections of the Mental Health and Wellbeing Act handbook (e.g. information sharing, and families, carers and supporters).

2. How do **human rights** relate to this principle?

Generally, when the family and carers principle is applied to a decision being made or function being exercised under the Act, the right of 'protection of families and children' in section 17 of the Charter will be relevant and will also need to be given proper consideration. Summarised, section 17 of the Charter recognises that families are entitled to be protected and that every child has the right to such protection as is in the child's best interests.

Other relevant rights under the Charter include the right not to have a person's privacy, family, home or correspondence arbitrarily interfered with (section 13(1)) and cultural rights particularly in relation to the maintenance of kinship ties (section 19(2)(c)).

In Victoria, being a parent or a carer is also considered a protected attribute under the *Equal Opportunity Act 2010* (Vic). Mental health and wellbeing services must not unlawfully discriminate against parents and carers when providing a service, because of their status.

Related mental health and wellbeing principles include:	**Related decision making principles include:**
Supported decision making	Care and transition to less restrictive support
Dignity and autonomy	Autonomy
Cultural safety	Consequences of compulsory assessment and treatment and restrictive interventions
Wellbeing of dependents	

3. How might a **consumer** experience this principle?

When my family, carers, supporters or kin are recognised and supported in their roles:

- I am asked who supports me and who I want involved in my care. My choices are respected, documented and reviewed regularly.
- I receive clear explanations about privacy, confidentiality, and what information can or cannot be shared.
- The people I choose to involve are welcomed, informed, and supported to assist me in my recovery.
- With my agreement, the service works in ways that help to maintain and strengthen relationships with the people who are important in my life.
- If I decide not to involve someone, my choice is respected (unless there is a legal or safety reason not to).
- I am supported to understand and make decisions about who receives information about me, and how to change those decisions over time.
- My role as a parent or carer is acknowledged and supported (see wellbeing of dependents principle).
- The people I rely on are supported in their caring role, including access to carer peer support, carer consultants, and local or state carer services to support their wellbeing.

4. What may this principle mean for **carers, families and supporters**?

When I am recognised and supported in my role:

- I am acknowledged as someone who plays an important role in the person's life, and my insights are respected and considered in decisions about their care - where appropriate and with their consent.
- I am supported in ways that help maintain, strengthen, or restore a respectful, supportive relationship with the person, in line with their wishes.
- I am provided with clear, timely information (with consent or to the extent allowed without consumer consent) that helps me understand the person's treatment and how I can support their recovery.
- I am supported to maintain my own wellbeing and mental health, including through access to carer peer support, carer consultants, and relevant local and statewide resources.
- I am helped to navigate the service system and understand my rights and responsibilities as a carer, including around privacy and information sharing.
- When safety concerns arise, I am treated with sensitivity and care, and the person's and my own safety are prioritised in how information is shared or withheld.

5. How do **treating teams** put this principle into practice?

This section gives an overview of requirements and good practice suggestions for putting the families and carers principle into practice. As noted earlier in this guidance, the dignity and autonomy and supported decision making principles underpin all other principles and must always be considered.

Explore the key topics covered in this section:

- Identify and welcome carers, families and supporters
- Identify and support consumer preferences about family and carer involvement
- Proactively involve carers, families, supporters and kin
- Share information
- Identify and respond to family violence and other risks
- Learn from the lived and living experiences of carers, families, supporters and kin
- Actively support family and carer wellbeing

Identify and welcome carers, families and supporters

Requirements include:

- Consistently and inclusively identify carers, families, supporters and kin (including young carers).
- 📖 Regularly review and update family, carer and supporter details and involvement preferences at key points in care (such as admission, discharge, transfers of care). Make sure any changes are clearly recorded and accessible. Note, the accuracy of information principle (s 726) requires reasonable steps to be taken to ensure information about a person receiving mental health and wellbeing services is accurate, relevant and up to date.
- Acknowledge and welcome diverse family structures including extended family, kin, community Elders, and family of choice. Use posters, signage, lanyards, etc. to welcome all families. Greet visitors warmly and ask who they are.
- Share accessible information, tailored to the diverse needs of the community you work with, about:
  - rights, responsibilities and supports (for example, sharing Tandem rights resources, general information about consumer healthcare rights)
  - service-specific resources about how your service works with carers, families, supporters and kin - such as videos, posters or brochures.
- 📖 Take all reasonable steps to find out whether a person has an advance statement of preferences that outlines who they would like involved in their care. See supported decision making principle.
- 📖 Take all reasonable steps to find out whether a person has a nominated support person. For example, ask the consumer and any known family, carer or support person, check the clinical file, explore if the nomination is still current. See supported decision making principle.

Good practices may include:

- Undertake projects to increase the proportion of consumers accessing the service with an identified carer or support person.
- Ensure consumers, carers and families receive information and support about how to appoint a nominated support person and the benefits of doing so.

Identify and support consumer preferences about family and carer involvement

Requirements include:

- 📖 Explore how the consumer would like their carer, family, supporter or kin involved in their care and treatment. Discuss the benefits of families, carers and supporters receiving information that will help them to support the consumer, and what kinds of information the consumer agrees to or prefers not to share. Revisit these discussions regularly.
- Explain information sharing, privacy and confidentiality policies in plain language to consumers, families, carers and supporters. For example, share Tandem's resources about information sharing with families, carers and supporters.

Good practice may include:

- Identify a clear plan with the consumer, carer, family and supporters about who the consumer would like to be involved as a primary contact. If possible, within health information systems, this may include more than one contact if that is in line with the consumer's preferences.

Proactively involve carers, families, supporters and kin

Requirements include:

After exploring consumer preferences and seeking their agreement as outlined above:

- Involve carers, families, supporters and kin in the consumer's care. This includes inviting family members and carers to be involved in discussions about treatment, care, and discharge planning, for example, case management meetings, family meetings, care planning meetings, family-based interventions - and welcoming ongoing dialogue.
- 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.
- 📖 Use appropriate supports (including interpreters) to communicate with carers, families and supporters. See dignity and autonomy principle.

Good practices may include:

- Create opportunities, early and often during a person's care and treatment, to capture and use carer, family and supporters' insights into the consumer's strengths, history, preferences, communication styles, early warning signs, how to support the consumer's autonomy and decision making, and protective factors. Record these insights in care and crisis support plans.
- Ensure care plans also reflect carer feedback about their ability to provide care, and any limits.
- Give clear orientation and welcome information to carers and families - for example, about the service environment and key contacts. For bed-based services, clearly share information about visiting hours and ways to maintain contact with the consumer.
- Reduce barriers to carer and family engagement - for example, offer flexible visiting or out of hours contact arrangements, make reasonable efforts to offer flexible meeting times or approaches to accommodate carer/family responsibilities such as work or caring for dependents, recognise diverse family structures and support connection to rural or remote carers and families.
- Maintain and support relationships between consumers and their carer, family, supporters or kin as part of quality treatment and care planning. For example, arrange access to family-friendly spaces for visits.

Share information

Requirements include:

- 📖 Give carers, guardians, parents of consumers aged under 16 and nominated support persons copies of compulsory orders and relevant statements of rights at points required by the Act (for example, when a temporary treatment order is made, varied, revoked or expires, when a psychiatrist makes a treatment decision, applies for a treatment order, gives a second psychiatric opinion, when a restrictive intervention is used). See the families, carers and supporters page of the Mental Health and Wellbeing Act 2022 Handbook for a full list of these points.
- 📖 Consult and inform carers, guardians, parents of consumers aged under 16 and nominated support persons of key decisions (see link in the above dot point).
- Share information and resources to help carers, families and supporters understand their rights - for example, Tandem's information kit for families, carers and supporters.
- Share general information - for example, about how the person is feeling or visiting hours - if doing so is not against the consumer's views and preferences (s 730(2)(f)).
- Share information that a family member, carer or supporter of a compulsory patient reasonably needs to help them provide care or prepare for their caring role. For example, information about the person's mental health condition, early warning signs, strategies for responding to concerns, safety planning, support options and practical assistance. The consumer's preferences about information sharing including any expressed in an advance statement of preferences must be considered before sharing such information (s 730(2)(g)).
- Explain to carers, families and supporters that, even if the consumer does not wish information to be disclosed to them, carers and families can still share their concerns and any information they would like the service to know (for example, strategies that have worked well in supporting the consumer and their family), and this will be considered. Explain to families and carers that information they share may be shared with the consumer unless there is a reason to protect that information - for example, where disclosures could negatively affect the care relationship or cause personal risk. If indicated, enable private opportunities for carers to share and discuss concerns. Be mindful of the possibility of family violence, child protection or child custody disputes in considering this information.
- 📖 Do not share information even if permitted or required by the Act and even with the consent of the person whose information it is: if you have a reasonable belief that doing so would pose a risk of family violence or other serious harm to a person (s 31).
- 📖 Do not share a person's health information (even with consent) if you have a reasonable belief that disclosing the information could: pose a risk to the life or health of any person, unreasonably impact on privacy, be unlawful or inconsistent with another legal requirement, prejudice law enforcement activity or damage national security (s 723).

Identify and respond to family violence and other risks

Requirements include:

- Separately, ask consumers, carers, families and supporters sensitively how they experience key relationships, including what works well and any concerns - for example, trauma, abuse, child custody or child protection issues, or family violence. Follow any steps required by the MARAM framework (Family Safety Victoria, 2018).

Learn from the lived and living experiences of carers, families, supporters and kin

See lived experience principle.

Actively support family and carer wellbeing

Requirements include:

- 📖 Give reasonable assistance to an IMHA mental health advocate (s 49), who, with the consumer's consent, is advocating for the rights of a family member, carer or supporter as they relate to the consumer's treatment, care, support or recovery.
- Support carers, families, supporters and kin in their caring role. For example:
  - Proactively check in with families, carers, supporters and kin about their wellbeing throughout their engagement with the service, not just at crisis points.
  - Ensure that family, carer, and supporter wellbeing and support needs are actively considered and addressed in care planning, including discharge planning.
  - Refer carers to confidential support so they can address their own wellbeing needs.
- Proactively identify young carers. Provide information about and connect young carers with age-appropriate supports, such as peer support groups, counselling and school-based supports. For example, Satellite Foundation or Little Dreamers. Ensure their wellbeing is actively considered in all care planning.

Good practices may include:

- Actively acknowledge the interconnectedness of carer and supporter wellbeing and consumer recovery. This includes taking steps to maintain and strengthen supportive and respectful relationships where safe and appropriate.
- Refer to practical supports such as respite, flexible visiting arrangements, transport assistance, help to navigate multiple services/service systems, and carer support services. For example, Mental Health and Wellbeing Connects, Tandem's Support and Referral Line phone 1800 314 325, peer support groups, Carer Gateway, Carer Support Fund, Psychiatric Illness and Disability Donations Trust Fund (PIIDDTF).
- Link carers, families and supporters into targeted support for complex or high-stress caring contexts, such as when there is relational conflict or a history of trauma in the family or support network.
- Offer practical guidance on self-care and managing stress while supporting a loved one. For example, sleeping enough, eating well, moving your body, connecting with people, meditating, journalling, listening to music, or doing enjoyable activities.
- Support carers, families, supporters and kin to connect with the family carer lived experience workforce at your service, including carer peer support.

Tips for talking about family and carer involvement

- Ask open ended questions. For example: *Who usually supports you/who are important people in your life/who takes an interest in your wellbeing?*
- Avoid making assumptions about a person's family structure
- Talk with consumers about the benefits of involving support people and the kinds of information a consumer is willing to share, even if there are things they do not wish to share
- Be alert to the possibility of family violence or safety risks to consumers, carers, families and children
- Recognise that carers, families, supporters and kin, including young carers, hold valuable knowledge about what works and doesn't work for the consumer as well as the family
- Check in regularly with carers, families, supporters and kin about their own wellbeing and support needs.

6. How might **services reflect** on practice?

- How and when do we ask whether a consumer has someone who supports them, and how they would like them to be involved?
- How do we recognise the diversity of people's support networks (for example, extended families, Elders, families of choice)?
- How do we make sure carers, families, supporters and kin have the information and supports they need, including for their own wellbeing?
- Where the consumer and their supporters have different views, how do we support the consumer's views and preferences while supporting the role and wellbeing of the carer, family or supporter?
- How do we support our family carer lived experience workforce and embed them into the service?

7. **Scenario:** identifying family and carers and clarifying information sharing[15]

What happened?

21-year-old Sarah came into the emergency department and had not yet been admitted. Sarah had been using drugs that are impacting her mental health and wellbeing. Sarah lives in a share house with friends and one of her flatmates brought her to hospital. Sarah's clinical file indicated she did not have an identified carer, advance statement of preferences or nominated support person. Sarah is already known to the service, and her last admission was 18 months ago. Drug use was indicated in Sarah's previous admission, and she was discharged after a short stay and then linked in with a SHARC peer support group.

The service needed to understand her preferences and choices. While respecting her privacy, some information was required for safe care. The flatmate had exams and was unable to stay. The service identified Sarah needed immediate admission and care.

What actions did the service take?

Nursing staff asked Sarah if there is someone who usually supports her, noting that Sarah can choose what information the service shares with them. This assurance from the staff gave Sarah confidence to share that her preferred carer/family member was her older brother, Adam, who has supported her through a similar experience in the past. Sarah's in-patient stay lasted a few weeks, and Adam visited every day.

Adam wanted to understand more about her diagnosis, treatment and discharge plan so he could be better prepared to support her following discharge. This raised questions about confidentiality, prompting staff to explore with Sarah what information she felt comfortable sharing. Sarah expressed that she was anxious about Adam knowing about her drug use or diagnosis. However, she agreed with the treating team providing Adam with a fact sheet about the medication she has been prescribed, discharge plan, general education about supporting someone after a hospital stay and agreeing he could be informed about when her follow-up appointments were scheduled.

One of the senior staff members met with Adam to explain privacy and confidentiality and how best to support Sarah in the current circumstances. Adam was also referred to the service's family/carer peer support worker. The staff member documented that information was shared in accordance with Sarah's preferences, and offered carer education sessions separate from the clinical information.

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[15] Note: The scenarios in this guidance are adapted from real examples. These simple scenarios focus on the application of one principle and are intended to show that applying the principles is not always complicated. Scenarios that address the principles in more complex situations and ways are available in implementation resources on the Commission's website.

Reflections from Commission lived and living experience staff

Respecting Sarah's autonomy about what to share built trust in the service and the therapeutic relationship with the treating team. Working with Sarah to identify her preferred carer, helped to support Sarah's recovery in community. The service has also respected and navigated Adam's request for information in a way that respected Sarah's preferences, and can re-visit with Sarah over time whether she is willing to share more information.

The service respected Sarah's privacy and did not share any clinical information other than what Sarah agreed to. This shows families and carers can be supported without undermining a person's privacy and decisions about what can be shared. Staff validated Adam's concerns but kept Sarah's preferences central to decision making.

Which other principles were engaged?

Mental health and wellbeing principles: dignity and autonomy, supported decision making

How would you approach this situation?

What might you do differently?

8. Where can I find **more information?**

Guidance

Department of Families, Fairness and Housing (2018) *Recognising and supporting Victoria's carers: Victorian carer strategy 2018-2022* https://www.dffh.vic.gov.au/publications/recognising-and-supporting-victorias-carers-victorian-carer-strategy-2018-22

Department of Health and Human Services (2018c) *Working together with families and carers: Chief Psychiatrist's guideline* https://www.health.vic.gov.au/chief-psychiatrist/working-together-with-families-and-carers

Department of Health (2025b) Implementing the family violence MARAM framework in mental health and wellbeing services https://www.health.vic.gov.au/chief-psychiatrist/maram-framework-mental-health-wellbeing-services

Mind Australia (2016) - *A practical guide for working with carers of people with mental illness* https://www.mindaustralia.org.au/sites/default/files/2023-07/A_practical_guide_for_working_with_people_with_a_mental_illness.pdf

Resources

Department of Health *Mental Health and Wellbeing Act 2022 Handbook: Families, carers and supporters* https://www.health.vic.gov.au/mental-health-and-wellbeing-act-handbook/supported-decision-making/families-carers-supporters

Nexus *Three Step Carer Identification, Conversation and Options tool* https://www.svhm.org.au/ArticleDocuments/2140/ThreeStepCarerConversationSupport.pdf.aspx?embed=y

Nexus *Carers can ask* booklet https://www.svhm.org.au/our-services/departments-and-services/n/nexus/carers-can-ask

Tandem's Information and resources for family, carers and supporters including:

- *Information Sharing with families, carers and supporters* https://tandemcarers.org.au/Common/Uploaded%20files/Your-Rights/250228%20Tandem%20info%20sheet%202.pdf
- Tandem support and referral line 1800 314 325

Lived experience principle

1. What do **the Act** and relevant guidance say?

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 (s 21).

The lived experience principle reflects the Act's intention that people with lived experience play a crucial role in the design and implementation of improvement and innovation in the mental health and wellbeing system (Explanatory Memorandum, Mental Health and Wellbeing Bill 2022 (Vic), p 21).

People with mental illness or psychological distress, and their carers, families, supporters and kin are the experts in their own experiences and how they would like to be supported. This principle outlines how services can recognise and value lived and living experiences and ensure that it informs and drives system improvement and change. This includes those currently accessing, or supporting someone who is accessing, mental health and wellbeing services, as well as recognising and valuing the role of the lived and living experience workforce.

This principle also aligns strongly with Standard 2 of the National Safety and Quality Health Service (NSQHS) Standards (Australian Commission on Quality and Safety in Health Care, 2021) - Partnering with Consumers, which focuses on:

- consumers as partners in planning, design, delivery, measurement and evaluation of systems and services
- patients as partners in their own care, to the extent that they choose.

Just as the partnering with consumer standards underpins the rest of the NSQHS Standards, the lived experience principle underpins the rest of the mental health and wellbeing principles.

2. How do **human rights** relate to this principle?

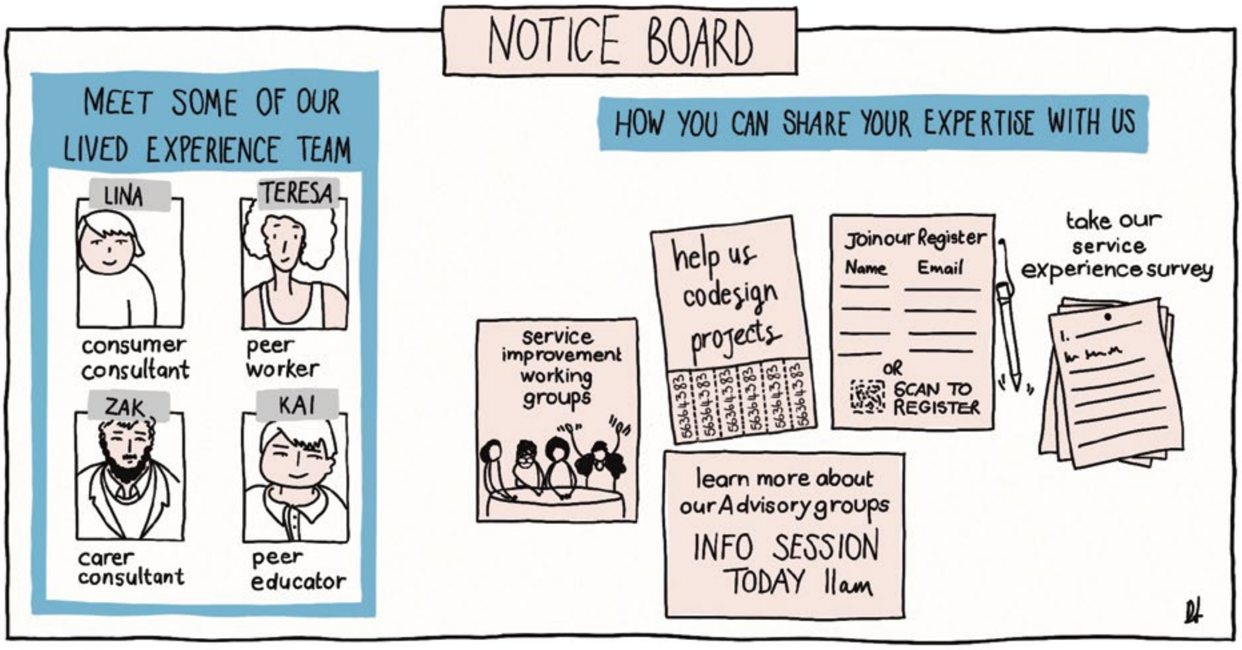
Central to the lived experience principle is the right to equality. Section 8 of the Charter states that 'all Victorians have the right to be recognised as a person, to enjoy their rights without discrimination, to be treated equally under the law and protected from discrimination'.

Due to its focus on recognising the leadership and active partnership role of consumers, carers, families and supporters, the lived experience principle underpins all other mental health and wellbeing principles and relates to all aspects of the decision making principles.

3. How might a **consumer** experience this principle?

When my lived and living experience is recognised and valued:

- I am seen as the expert in my own life, and my voice, views, and preferences are central to decisions about my treatment, care, and recovery.
- My lived experience is a strength. I am supported to express what matters to me, and it is taken seriously - even when it challenges standard clinical thinking.
- I have access to information and support, including peer support workers, consumer consultants, and carer consultants that help me make informed decisions.
- I can give feedback or make a complaint safely, and I trust that it will be respected and used to create meaningful change.
- I feel confident that my experience of the mental health system is welcomed and used to improve services for others.
- I am offered opportunities to contribute to service improvement in ways that are safe, inclusive, and empowering for me.
- I see people with lived experience in peer support and leadership roles within the service, and I feel represented and understood.
- I can identify and connect with lived experience workers who share similar cultural, community, or personal experiences to mine.



4. How might **carers, families and supporters** experience this principle?

When my lived and living experience is recognised and valued:

- My experience as a carer is listened to and valued. Services recognise that my insights can help shape better care and support.
- Services respect what I've learned from supporting someone with mental health needs and include me when planning care, in ways that align with the preferences of the person I care for.
- I see family members, carers and kin with lived experience represented in leadership and other visible roles within the service, and I know that family/carer perspectives help shape service policies and practices.
- I can give feedback about the service safely. I know it will be taken seriously and can help make things better for others.
- I can get support from people who've also been carers. This helps me look after my own wellbeing, feel less alone, and understand my rights as a carer.
- I am offered opportunities to contribute to service improvement in ways that are safe, inclusive, and empowering for me.

5. How can **services** put this principle into practice?

The lived experience principle has a particular focus on embedding lived and living experience leadership and partnership into services. Section 5 of Part One of this guidance and associated implementation resources include advice about leadership actions that will put this principle into practice. These actions must always be led by or codeveloped with lived and living experience. For example:

- Understanding the diversity of consumers, families and carers who use your service and ensure they are represented in lived experience engagement opportunities.
- Ensuring people with diverse lived and living experiences are involved in system change (for example, governance, design, training, measurement or evaluation) activities, and service delivery.
- Developing the lived and living experience workforce, including creating clear leadership structures, career pathways, and ensuring discipline-specific training, reflective practice and supervision.

This section outlines actions to put the lived experience principle into practice, as well as good practice suggestions.

Explore the key topics covered in this section:

- Recognise and value that people are the experts in their own lives
- Promote and learn from complaints and feedback
- Support the role of lived and living experience in systemic activities
- Support and value the lived and living experience workforce

Recognise and value that people are the experts in their own lives

Requirements include:

- Ask people what they need and want, support them to understand their rights including by providing appropriate supports (for example, interpreters, disability supports, involvement of supporters, IMHA advocacy) and to make decisions. See dignity and autonomy and supported decision making principles.
- Work in trauma-informed ways with consumers, carers, families, supporters and kin.
- Show cultural humility and respect for people's diverse identities and experiences. See cultural safety, gender safety and diversity principles.
- Involve carers, families, supporters and kin. See family and carers principle for detail.
- When speaking with consumers, carers, families, supporters and kin, and when considering the use of compulsory assessment or treatment or restrictive interventions, acknowledge that compulsory assessment and treatment and restrictive interventions significantly limit human rights and may cause harm including serious distress, and disruption to relationships, living arrangements, education and employment (s 80), and that restrictive interventions have no inherent therapeutic benefit (s 81).

Good practices include:

- Validate people's experiences by using and reflecting their language. For example, describe experiences as trauma, distress, crisis, or Madness - as preferred by the person rather than using solely clinical terms or jargon (University of Melbourne 2025, p 16).

Promote and learn from complaints and feedback

- Encourage consumers, carers, families, supporters and kin to give feedback and make complaints, and support them to do so, if needed.
- Ensure approaches to receiving and responding to complaints are culturally safe and trauma informed. For example, explain choices and protections, such as choice to make a complaint to either the service or the Commission, to involve support people, to ask for support from First Nations workforce within services or a First Nations IMHA advocate, to make anonymous complaints, that people must not be treated differently for making a complaint.
- Embed lived and living experience in analysing feedback and complaints to identify themes and improvements.
- Report in a timely way to governance, workforce and consumers, carers, families, supporters and kin about the outcomes and actions from complaints.
- Clearly and widely share de-identified examples of positive changes made because of feedback or complaints - for example, through discussions, posters, videos and brochures.

Tips for learning from consumer and carer feedback

Encourage all feedback including anonymous feedback - *Everything we hear from people who use our services is important, and we try to learn from it all.*

Ensure approaches are culturally safe and trauma informed.

Focus on the underlying needs behind feedback and complaints - *Could you tell me more about that? What would you like to happen now?*

Be clear about any immediate actions you can take, with the consumer's agreement.

Explain and encourage next steps if you're not the right person to act on the feedback or complaint directly.

Ensure complaint outcomes are shared with the person who made the complaint. In addition, share de-identified examples of improvements made because of feedback or complaints.

Explore opportunities for the person to share their experience and expertise more broadly, for example, by contributing to staff training or education.

Support the role of lived and living experience in systemic activities

- Actively encourage, support, and pay current and former service users for their input in service design, delivery, and improvement activities.
- Offer information, orientation and training to consumers, carers and families involved in system change activities. Where possible, offer opportunities to further develop leadership capabilities.
- Encourage formal opportunities (for example, Consumer and Carer Advisory Groups, governance committees) and informal opportunities to contribute to system change (such as community forums, or drop-in sessions). VMIAC is the peak body for consumers and have a consumer register in this link. Tandem is the peak body for families and carers and also has a participation register in this link.
- Work in Culturally safe ways with Aboriginal and Torres Strait Islander consumers, carers, families, supporters and kin contributing to system change activities (see also cultural safety principle). Good practices may include:
  - seeking advice from Aboriginal mental health workers, Social and Emotional Wellbeing (SEWB) workers or Aboriginal Liaison Officers about ensuring Culturally safe engagement
  - building relationships with Elders and community leaders and partnering with ACCHOs or other First Nations organisations
  - using informal approaches like yarning circles or sharing a meal, rather than formal advisory structures
  - preparing specific resources for Aboriginal and Torres Strait Islander consumers, carers and families that are Culturally safe and appropriate (for example, ensure language, design, and information is specific and relevant to First Nations consumers, carers and families).
- Include consumers, carers, families, supporters and kin on interview panels to ensure lived and living experience perspectives inform recruitment decisions.

Support and value the lived and living experience workforce

- Learn about relevant lived experience discipline frameworks, to self-educate about these workforces and reflect on how to recognise and value them at your service.
- Be curious about how you can collaborate with lived and living experience workforces in your role, and actively seek opportunities to learn from their perspectives.
- Recognise that lived and living experience work takes a different approach from clinical work. Give time and space for face-to-face discussions to support mutual understanding and collaboration.
- Be guided by lived and living experience workforces about where they see the most need for their involvement and where you can support and enable their work.
- Recognise that peer workers from First Nations or culturally diverse backgrounds may navigate cultural sensitivities as part of their role. Be mindful of cultural protocols such as the potential inappropriateness of discussing compulsory treatment for a community Elder.
- Identify and acknowledge power imbalances and take action to decrease differences in power. For example, include more than one lived and living experience staff member in a team/group/piece of work, speak up if lived and living experience is not involved and act on lived and living experience workforce advice about what would support their involvement.
- **Share power:**
  - Encourage lived and living experience workers as leaders or co-facilitators of programs, including wellbeing groups, psychoeducation groups, training.
  - Ensure lived and living experience workers are involved in systemic activities, such as working groups, committees, project teams, and reviewing complaints, feedback and care outcomes.
  - Analyse who isn't in the room/part of decision making. Is the diversity of your service well-represented? If no, implement strategies to improve diversity.
- **Give up power - 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.**

6. How might **services reflect** on practice?

- How do we recognise and value the lived and living experience of consumers and their carers, families and supporters, in treatment and care (for example, that they are experts in their own lives)?
- How do we learn from people with lived and living experience, so that their experiences drive change and improvement in mental health and wellbeing services?
- How can we strengthen and support the lived and living experience workforce's role in treatment and care, and in leading system change?

7. **Scenario:** building consumer leadership opportunities[16]

What happened?

A community-based mental health and wellbeing service had a consumer leadership day-to-day living program, led by a consumer consultant and a consumer peer worker with a fixed monthly budget of $500. The consumer consultant and peer worker identified that this program was a perfect opportunity for consumers to make more decisions - moving from previous approaches of *involving* consumers in decisions in how the program was run, to *empowering* consumers to drive the program within the available budget.

What actions did the service take?

The service invited all consumers who had attended any recent events to come to a monthly calendar planning meeting. The service shared the $500 budget and spending rules, then stepped back so consumers could decide - with the consumer consultant and peer worker on hand to provide any coaching or support that was requested or needed.

The consumers discussed options and decided to pursue free activities (for example, a movie day or coffee and chats in the meeting room) for a month so that the $500 could be spent for the group to attend a local cooking school and learn how to make a three-course meal.

Other activities identified by the consumers including op shopping, visits to national parks, going on walking tours or visiting public places like the Victoria Market, Arts Centre, National Gallery of Victoria and the State Library. Different consumers took the lead with different activities they were familiar with, helping others who had never been to these spaces to explore and develop new interests. Many consumers continued to visit these spaces outside of the group.

Some consumers were interested to know more about peer work and were supported to attend events to learn more. After the experience of leading their own activity group, some consumers joined the service's Consumer Advisory Committee (paid) and further developed their leadership, working on further projects like an orientation booklet for new consumers, and being paid at organisational rates to do so. One consumer later joined a sub-committee of the board.

Reflections from Commission lived and living experience staff

Working in co-design principles means giving people all the information and being open about any constraints. Paying people recognises their time and lived experience and expertise is valuable.

Which other principles were engaged?

Mental health and wellbeing principles: diversity of care, dignity and autonomy, supported decision making

How would you approach this situation?

What might you do differently?

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[16] Note: The scenarios in this guidance are adapted from real examples. These simple scenarios focus on the application of one principle and are intended to show that applying the principles is not always complicated. Scenarios that address the principles in more complex situations and ways are available in implementation resources on the Commission's website.

8. Where can I find **more information?**

Department of Health (2021) Mental Health Lived Experience Engagement Framework https://www.health.vic.gov.au/publications/mental-health-lived-experience-engagement-framework

Harm Reduction Victoria (2025) Harm Reduction Lived Experience Framework https://www.hrvic.org.au/_files/ugd/ebb8bf_f1d2347fd1c64956a7793998530767a1.pdf?index=true

Mental Health Coordinating Council (2022) Recovery Oriented Language Guide https://mhcc.org.au/wp-content/uploads/2022/07/Recovery-Oriented-Language-Guide-Mental-Health-Coordinating-Council-2022.pdf

Our consumer place (2012) - Psychobabble: the little red book of psychiatric jargon https://www.ourcommunity.com.au/files/OCP/PsychobabbleFeb2012.pdf

Self Help Addiction Resource Centre (2025) Alcohol and Other Drug (AOD) Family Lived Experience Workforce Discipline Framework https://www.sharc.org.au/wp-content/uploads/2025/03/AOD-Family-Lived-Experience-Workforce-Discipline-Framework.pdf

Self Help Addiction Resource Centre (2025) Alcohol and Other Drug (AOD) Lived Experience Workforce Discipline Framework https://www.sharc.org.au/wp-content/uploads/2025/03/AOD-Lived-Experience-Workforce-Discipline-Framework.pdf

Tandem and the Carer Lived Experience Workforce (2025) Mental Health Family Carer Lived Experience Workforce Discipline Framework https://tandemcarers.org.au/Common/Uploaded%20files/Publications/Mental%20Health%20Family%20Carer%20Lived%20Experience%20Discipline%20Framework.pdf

University of Melbourne (2025) Mental Health Consumer Lived Experience Workforce Discipline Framework https://healthsciences.unimelb.edu.au/__data/assets/pdf_file/0020/5242142/384076-DOH-MH-Consumer-framework-WEB-WCAG-5.0.pdf

Health needs principle

1. What do **the Act** and relevant guidance say?

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 (s 22).

The health needs principle specifically refers to medical or health needs related to the use of alcohol or other drugs, and requires consideration of how a person's physical and mental health needs may intersect. This principle reflects the importance of a holistic, integrated approach, and is intended to prevent people who live with substance use or addiction being precluded from accessing treatment, care or support (Explanatory memorandum to the Mental Health and Wellbeing Bill 2022, pp 21-22).

People living with mental illness experience worse health outcomes and lower life expectancy (excluding as a result of suicide) than the general population (National Mental Health Commission (NMHC), 2016, pp 10-11). Aboriginal and Torres Strait Islander people have a lower life expectancy than other Australians, which is further increased for those experiencing mental illness (NMHC 2016, p 10).

What are some factors that contribute to worse health outcomes and lower life expectancy for people living with mental illness?

- the serious side effects of many mental health treatments: particularly the side effects of many antipsychotic medications, high doses of medication, and polypharmacy
- compulsory treatment and lack of informed consent: many consumers experience that compulsory treatment takes away the opportunity to choose treatment options that have fewer health risks, for example, talking therapies, peer support and reduced doses
- impacts of mental health problems and emotional distress: living with reduced motivation, having more important priorities (like housing), or self-medicating because treatments are not helpful or available, can also impact physical health
- discrimination in health care: people experience physical health being ignored because symptoms are seen as mental illness
- impacts of socioeconomic disadvantage: many consumers live with poverty, homelessness or unstable housing, isolation, stigma and discrimination, creating further disadvantage. Those experiencing these disadvantages are also more likely to smoke.

(As outlined in VMIAC's foreword to *Equally well in Victoria: physical health framework for specialist mental health services* Department of Health and Human Services, 2019, p 2)

The health needs principle requires mental health and wellbeing service providers to work collaboratively with consumers and their carers, family, supporters and kin to identify and respond to the range of medical and physical health needs a person may have, being guided by what is important to the person. In doing so, services must recognise, respect and respond to people's diverse identities, needs and experiences (gender, family circumstances, culture, language, religion, sexual and gender identity, age and disability.

Services must be guided by the principles and priority areas of the Equally well in Victoria framework. The Commission understands that future priority areas will include support to quit smoking or vaping, improving metabolic health - nutrition and eating behaviour, physical activity, harm minimisation (alcohol and substance use), sexual and reproductive health and blood-borne viruses, medicine optimisation, dental and oral health, reducing falls, women's health, cancer screening, Aboriginal and Torres Strait Islander peoples' health, and young people.

The NSQHS Standards (Australian Commission on Safety and Quality in Health Care, 2021) are also relevant, particularly Standard 2: Partnering with consumers, Standard 5: Comprehensive care standard and Standard 8: Recognising and responding to acute deterioration standard.

2. How do **human rights** relate to this principle?

A human rights approach to this principle involves responding to the medical and other health needs of consumers in a person-centred and collaborative way.

Many consumers have experienced stigma and discrimination within health and mental health settings. Sometimes this can lead to diagnostic overshadowing, which is where a person's physical symptoms are incorrectly attributed to mental illness and not responded to. Acting compatibly with the right to equality in the Charter (section 8) and the positive duty to prevent discrimination in the Equal Opportunity Act 2010 are important part of taking a human rights approach to this principle and preventing discrimination.

The Charter also requires that people who are deprived of their liberty must be treated humanely (section 22). In the compulsory treatment context, complying with the health needs principle is important to upholding this right.

Related mental health and wellbeing principles include:	Related decision making principles include:
Dignity and autonomy Least restrictive Supported decision making Family and carers	Care and transition to less restrictive support Autonomy

3. How might a **consumer** experience this principle?

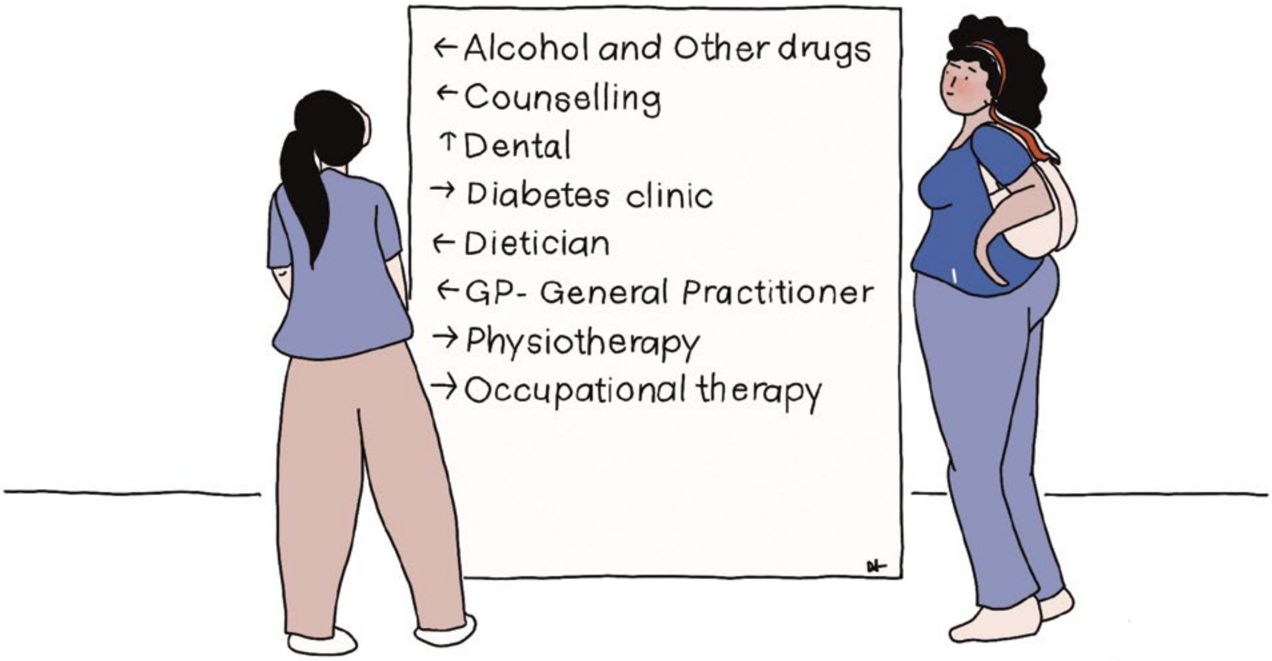
When my medical and health needs are identified and responded to:

- My physical and mental health are treated together, not separately.
- I can talk openly about drug use, smoking, or physical health habits without feeling judged.
- People check in with me about my sleep, nutrition, exercise, medication effects, and sexual/reproductive health.
- I am supported to access GPs, dentists, and other specialists when I need them.
- I feel hopeful that improving my physical health will support my recovery and quality of life.

4. How might **carers, families and supporters** experience this principle?

When the medical and health needs of the person I support are identified and responded to:

- I feel confident that the person I care for is receiving appropriate and timely medical and health support, including for co-occurring alcohol or drug use.
- I am informed and included in discussions about how the physical and mental health needs of the person I care for are being addressed.
- I feel supported and respected by health professionals when raising concerns about the physical or substance-related health needs of the person I care for.
- I understand how the person's mental illness and substance use may interact with their physical health, and I feel equipped to help them navigate these challenges.



5. How do **treating teams** put this principle into practice?

This section gives an overview of requirements and good practice suggestions for putting the health needs principle into practice. As noted earlier in this guidance, the dignity and autonomy and supported decision making principles underpin all other principles and must always be considered.

Explore the key topics covered in this section:

- Ask the person about their priorities, preferences and concerns
- Offer tailored support to address physical health disparities
- Give relevant information, education and support
- Work together to develop a holistic plan that reflects individual needs and preferences
- Review progress and revisit priorities

Ask the person about their priorities, preferences and concerns

Requirements include:

- Ask the person about their views, preferences and priorities for their physical health. Respect where the person is at. If there are aspects of their physical health that they do not wish or are not ready to address, revisit this another time. Prompts may include:
    - What is important to the person, their daily life and what they would like to do?
    - What would they like to maintain, change or improve?
    - Is there anything that worries them about their physical health?
- Take all reasonable steps to find out if a person has an advance statement of preferences and make all reasonable efforts to follow those preferences. See supported decision making principle.
- Take all reasonable steps to find out if a person has a nominated support person and if that nomination is current. If yes, take all reasonable steps to involve the nominated support person in treatment and care discussions.
- Ask the person if they would like to involve any carer, family or supporter in discussions about their physical health.
- Where it is in scope for your role and training, use relevant health and medical screening processes on presentation, during clinical examination and history taking and when required during care, in accordance with relevant guidance and any local protocols.
- Be non-judgmental about any alcohol or substance use. Explore the person's reasons for substance use, and how it impacts their mental health, wellbeing and recovery.
- Be alert to the person's safety and that of their family, including any dependents, which may be related to physical health issues. For example, personal safety issues or family violence risk that may relate to substance use. Use the tools of the MARAM framework to identify and respond to family violence risk, including consultation with specialist services if indicated.

Good practices may include:

- Enable the person to speak with a peer support worker to help them identify their physical health goals and priorities.

Offer tailored support to address physical health disparities

Requirements include:

- Ensure that services are safe and responsive for all. See cultural safety, diversity and gender safety principles.

Good practices may include:

- Be aware of the impact of diverse life experiences and identity on physical health. People who have faced discrimination in healthcare based on culture, ethnicity, diverse gender and sexuality, disability or substance use may face additional barriers to accessing care. Take steps to ensure people's needs and identities are respected and responded to. If people feel safer accessing specialist services, support their preferences wherever possible. For example, LGBTIQA+-friendly services, ACCHOs.
- Work with consumers, carers, families, supporters and kin from identified communities (for example, Aboriginal and Torres Strait Islander communities) to develop specific strategies for supporting physical health during engagement with mental health and wellbeing services.

Give relevant information, education and support

Requirements include:

- 📖 Give and explain copies of orders and statements of rights, in ways that the person understands, using appropriate supports. See dignity and autonomy principle.
- Identify and explain real and meaningful choices, and give the person all relevant information including about the risks and benefits of different choices and a chance to ask questions and get support to make decisions. This includes choices about treatment for mental illness, or choices that relate to the person's physical health priorities. Give priority and weight to a person's reasons for their preferences, including concerns about side effects or previous experiences, including trauma.

Good practices may include:

- Encourage and support consumers to participate in clinical reviews.
- Take all opportunities to improve health literacy, for example, share accessible resources including videos, in-language resources where possible, using the health promotion messages from *Equally well in Victoria* when talking about physical health.
- Run educational groups on aspects of physical health, guided as far as possible by the preferences and interests of consumers accessing the service at the time. This could be in partnership with the health promotion team at your service (if applicable).

Work together to develop a holistic plan that reflects individual needs and preferences

Requirements include:

- Work together with the person and, with their consent, their carer, family, supporters or kin, to develop a treatment plan that addresses their needs, preferences and priorities around medical and physical health.
- Be guided by the priority areas and advice of the *Equally well in Victoria* framework, when published. Demonstrate how these inform practice. Ensure that the impact of physical health needs, including alcohol and drug use or disability related needs, is considered core to mental health care and treatment planning.
- Make referrals to other parts of your service or external services as needed to help the person access the services they need. For example, dietitians, exercise physiologists, dentists, podiatrists, dual diagnosis services, harm reduction programs such as opioid replacement therapy or needle exchange programs, peer support for mental health and/or alcohol and drug use, specialist referrals as needed.
- Recognise the importance of cultural and spiritual activities as part of a person's overall wellbeing, which may have significant impact on their physical health, and include these as priorities in line with the consumer's preferences.
- Work with general practitioners (GPs) as part of a person's broader care team.
- Support the person to work through practical barriers that may be preventing them from improving their physical health. For example, explore the impact of medication side effects, financial barriers to taking steps to improve physical health, any other barriers to accessing services or activities that may help to address their goals for their physical health - for example, accessibility and inclusivity.
- If the person is a smoker, explore interest in reducing or quitting smoking and offer support. If the person is an inpatient, offer nicotine replacement therapies in accordance with relevant guidance.

Good practices may include:

- Consider collated consumer and carer feedback about their priorities for their physical health, whether they can currently be met either within your service or people can reasonably access them externally, and work on systemic solutions.
- As far as possible try to maintain awareness of local GPs who have a particular interest in mental health and/or who offer bulk billing, acknowledging that it can be extremely hard for consumers to find an affordable GP with an interest in mental health and complex care. Consider approaches such as a dedicated GP liaison clinician in community clinics.
- Work with local partners and other agencies to ensure service users have access to leisure centres, gyms and sports facilities.
- Support eligible people to access free dental care by providing letters of recommendation to access priority dental services through Dental Health Services Victoria.

Example: A service developed an internal multidisciplinary team to better support consumers living with mental ill health and substance use. The team included mental health professionals, medical doctors, substance use specialists, and lived and living experience workforce, including AOD peer workers to offer comprehensive care to support people's mental health, medical and physical health needs including those associated with alcohol and drug use.

Review progress and revisit priorities

Requirements include:

- Monitor physical health regularly, including comparing physical health against intake/admission, and update plans if things have changed. Ensure this monitoring prioritises the person's experiences and views about what is or isn't working well for them and where they would like more support.
- Follow relevant clinical guidance for monitoring specific health conditions and/or medication - for example, specific guidelines for monitoring Clozapine.

Good practices may include:

- Consider dedicated roles in community clinics or outreach services to support the physical health needs of consumers who are receiving long-term support, or who have identified physical health as a priority, or who are identified as having high physical health needs.
- Ensure physical health is routinely addressed in clinical reviews and make efforts to involve the consumer and, with consent, their carer or family, in these reviews, to ensure the things that are important to them are prioritised.

Tips for talking about health needs with consumers

- Be curious about the person's values, preferences and priorities for their physical health. Explore what is important to them and how their physical health interacts with their recovery goals.
- Listen deeply to the person's concerns. If medication side effects are impacting their physical health and wellbeing, explore different options including support to manage side effects, the benefits of different approaches including peer support and talking therapies and exploring medication options including alternative medications, doses, or timing.
- Explore with the person what support they may need to address their priorities. This may be information and education, referrals including within your service, to community-based services or to specialists, or coordination with their GP.
- Share and discuss clear information about any physical health risks of medication as part of seeking informed consent to treatment and as part of overall discussions about the risks and benefits of different treatment approaches.

6. How might **services reflect** on practice?

- How do we explore physical health with people in ways that are led by their priorities, preferences and values?
- Are we providing health promotion messages in accessible, inclusive ways that respond to the diversity of people's priorities and experiences (for example, education groups, video resources, etc.)? Do we tailor our education and health promotion activities to the interests of consumers using our services at any given time?
- How do we share information about the impacts of smoking and substance use, in non-judgmental ways?
- How can we improve how we share information about medication side effects and work through people's concerns and experiences with them?
- How do we promote physical health (including in inpatient or residential services)? For example, activity areas, supported access to gyms, walking groups, cooking groups, etc.

7. **Scenario:** addressing health needs holistically[17]

What happened?

Oli presented to the service with a very low mood. They hadn't slept for several days and hadn't been eating. Oli had engaged with the service over several years and had co-occurring alcohol and drug use. Oli had presented to the service in the past with similar issues, and their sleep and food issues had resolved after getting support with their drug use.

What actions did the service take?

The service admitted Oli with depression and eating issues, and started by adjusting their medication as this had helped Oli in the past. However, within a day or two of admission, Oli spoke of severe toothache.

The nurse asked if Oli had been to the dentist recently. They responded that they had never been to a dentist because of the cost.

The nurse referred Oli to the social worker arranged an immediate visit to the hospital's dental service. Oli had serious tooth decay which was able to be addressed by the dentist. Oli's psychiatrist immediately reviewed their medications because it was the toothache - rather than deteriorating mental health - that was impacting Oli's eating, sleep and mood.

The service used Oli's experience to reflect on how health needs must be considered as early as possible in a patient's stay. The service embedded an oral health screening at admission, including a process for referral to public dentistry if needed.

Once the tooth issue was resolved, Oli was asked what else might be impacting their sleep. Oli told their nurse that their mattress at home was so thin, they could feel the bed base. Oli's case manager then applied for funding for a new mattress, which was approved. This helped immensely with Oli's sleep, and Oli was happy with the treating team's support of their health needs.

Reflections from Commission lived and living experience staff

It is so important to address the person's health needs. When Oli was seen in their whole context, with understanding of how much physical health can affect mental health, and when people considered physical health as well as mental health and drug use, the things that were really impacting Oli could be identified and addressed. In this case, Oli's medications were reduced back to normal levels, their tooth pain was fixed, they knew where to get support if further dental work is needed, and they could go home to a comfortable bed.

Which other principles were engaged?

Mental health and wellbeing principles: dignity and autonomy, supported decision making, diversity of care

How would you approach this situation?

What might you do differently?

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[17] Note: The scenarios in this guidance are adapted from real examples. These simple scenarios focus on the application of one principle and are intended to show that applying the principles is not always complicated. Scenarios that address the principles in more complex situations and ways are available in implementation resources on the Commission's website.

8. Where can I find **more information?**

Department of Health (2025) *Equally well in Victoria*

National Mental Health Commission (2016) *Equally Well consensus statement: Improving the physical health and wellbeing of people living with mental illness in Australia* https://www.mentalhealthcommission.gov.au/sites/default/files/2024-03/equally-well-consensus-statement_1.pdf

Dignity of risk principle

1. What do **the Act** and relevant guidance say?

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[18] owed to all people experiencing mental illness or psychological distress with actions to afford each person the dignity of risk (s 23).

This principle is intended to alter the balance of power between medical authority and persons having mental illness in the direction of respecting their inherent dignity and human rights, and to weigh against a paternalistic or overprotective approach to the provision of services (Explanatory memorandum to the Mental Health and Wellbeing Bill 2022, p 22).

This principle strongly relates to the supported decision making, least restrictive and dignity and autonomy principles. Respecting and supporting people's right to make choices that involve reasonable risks, in pursuit of goals, autonomy and wellbeing, also respects their inherent dignity.

The dignity of risk principle also relates to the diversity, cultural safety and gender safety principles, given people's diverse identities, needs and priorities are likely to inform what personal growth, self-esteem and overall quality of life mean for them. Carers, families, supporters and kin also have an important role in decisions about a person's assessment, treatment and recovery including decisions that involve risk.

What is dignity of risk?

The concept of dignity of risk raises competing considerations for consumers, families, carers, supporters, and the workforce. On one hand, by including the criterion that a person needs 'immediate treatment to prevent serious deterioration in their mental or physical health or to prevent serious harm to the person or to another person' (s 142(b)) because of their mental illness, the Act enables compulsory treatment in order to prevent serious harm.

One the other hand, the Act and its decision making principles:

- require services to presume that people have capacity to give informed consent to treatment even if they are a compulsory patient (unless there is a reasonable belief that a person does not have capacity) (s 85).
- acknowledge the harms that can be associated with compulsory assessment and treatment or restrictive interventions, including limiting a person's human rights and causing serious distress or disruption to the person's relationships, living arrangements, work and study (s 80) and
- require people making decisions about compulsory assessment and treatment to avoid using them if they will cause more harm than they are supposed to prevent.

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[18] Duty of care has a specific legal meaning. For example, a doctor owes a duty to their patient. Clinicians should check their hospital's policies and procedures for advice about what their duty of care involves.

In addition, legislation, guidelines and frameworks guide the mental health workforce to use recovery-oriented, trauma-informed and human-rights focused practices, that:

- require 'respect for inherent dignity, individual autonomy including the freedom to make one's own choices' (United Nations Convention on the Rights of Persons with Disabilities, 2006) and the right to recognition and equality before the law (s 8, Charter).
- prioritise consumer choice and autonomy while acknowledging the need to balance these considerations with safety and responsibility to provide care and treatment (Department of Health 2011a).

These positive factors align with the idea of positive risk-taking - recognising that people have the right to choose to try new things and experience personal growth, including from any setbacks.

The dignity of risk principle, as with all the mental health and wellbeing principles, applies to all people receiving or attempting to receive a mental health and wellbeing service. Both voluntary and compulsory patients have a right to make decisions involving reasonable risks. What is a reasonable risk may depend in part on the person's current circumstances and supports.

2. How do **human rights** relate to this principle?

The dignity of risk principle acknowledges that individuals have the right to make their own choices. From a human rights perspective, this principle is about ensuring that people receiving mental health and wellbeing treatment can participate in the community without discrimination, exercise autonomy and make decisions that involve risk. When this principle applies, the following Charter rights and freedoms are likely engaged: recognition and equality before the law; the right to privacy and reputation; the right to liberty and security of person; freedom from medical treatment without consent and freedom of movement.

Related mental health and wellbeing principles include:	Related decision making principles include:
Dignity and autonomy Least restrictive Supported decision making Family and carers Cultural safety Gender safety Diversity Lived experience Wellbeing of young people Wellbeing of dependents	Care and transition to less restrictive support Consequences of compulsory assessment and treatment and restrictive interventions Balancing of harm Autonomy

3. How might a **consumer** experience this principle?

When dignity of risk is promoted in my care:

- I am supported to make my own choices, even when those choices involve taking reasonable risks or if others disagree with my choices or think my decisions are unwise.
- I feel heard and respected when I talk about the risks (choices) I want to take and the goals I hope to achieve.
- I am encouraged and supported to create or update an advance statement of preferences, and I know it will be taken seriously.
- If my preferences cannot be followed, I am told why in a clear, respectful, and timely way, both verbally and in writing.
- I am offered help to appoint a nominated support person and feel confident that they will be informed and involved when it matters.
- I know my nominated support person will be contacted and included at key times during my care, and their role will be respected by staff.
- I have access to safety planning that reflects my values, preferences, and hopes - not just what others think is safest or best for me.
- I am not judged for taking risks - my strengths, experiences, and reasons are respected, and my dignity is upheld.

4. How might **carers, families and supporters** experience this principle?

When the dignity of risk principle is applied in practice, I feel assured that:

- I understand how the service supports the person I care for to take reasonable risks in pursuit of their goals, independence, and wellbeing.
- I am actively involved in exploring with the person I support - and their treating team - what a reasonable risk looks like for them, and in developing practical ways to support safety.
- My perspectives on risk and safety, including my own boundaries and needs, are respected and meaningfully considered in decision making processes.
- The benefits the person I care for hopes to achieve - like greater independence, confidence, or quality of life are taken seriously and guide the way risks are approached.
- I work with the person I support and the treating team to manage risk and create safety together. I am supported by services to navigate uncertainty in a way that honours both the person's rights, dignity of risk and my role.

5. How do **treating teams** put this principle into practice?

This section gives an overview of requirements and good practice suggestions for putting the dignity of risk principle into practice. As noted earlier in this guidance, the dignity and autonomy and supported decision making principles underpin all other principles and must always be considered.

Explore the key topics covered in this section:

- Explore people's preferences, values and priorities
- Respect and support the right to make decisions
- Support decisions to take reasonable risks and work with people and (with consent) their supporters on safety planning
- Only make substitute decisions where it is necessary and lawful to do so
- Clearly document decisions and share safety plans

Explore people's preferences, values and priorities

Requirements include:

- Ask the person about their treatment preferences, including how they would like to receive support, anything that has worked well for them in the past, and things they would like to avoid - including holding space for people to talk about negative experiences.
- Seek to understand what is important to the person and what personal growth, self-esteem and quality of life mean for them. For example, a person's values and priorities could include autonomy/independence, wellbeing of children/dependents, family, social connection, connection to Country, work, education, or other priorities.

Respect and support the right to make decisions

Requirements include:

- 📖 Recognise that all people, including compulsory patients, must be presumed to have capacity to give, or refuse, informed consent to treatment (see supported decision making principle). This includes having capacity to make decisions that involve reasonable risks that the person believes will help them achieve personal growth, self-esteem and overall quality of life, as well as decisions that others disagree with, or consider unwise. See supported decision making principle.
- 📖 Give the person enough information, time and support to enable them to give informed consent. See supported decision making principle.
- 📖 Give and explain information about rights. See dignity and autonomy principle.
- 📖 Provide appropriate supports to enable decision making. See dignity and autonomy principle.
- 📖 Take all reasonable steps to find out if a patient has:
    - an advance statement of preferences, and if so, make all reasonable efforts to give effect to it including in relation to preferences that involve reasonable risks
    - a nominated support person, and if so, involve them in treatment. See supported decision making principle.
- 📖 With consumer consent, involve the person's carer, family, supporter or kin. See supported decision making and family and carers principles.
- 📖 With consumer consent, work with IMHA advocates who can help to represent the person's views, preferences and priorities. See dignity and autonomy principle.

Support decisions to take reasonable risks, and work with people and (with consent) their supporters on safety planning

Services that provide compulsory mental health treatment often need to weigh competing concerns of:

- supporting people's choices and autonomy, and
- working to prevent risks of serious deterioration to a person's health or mental health, or serious harm to the person or someone else.

The dignity of risk principle requires services to start from a position of seeking to support people's decisions and choices, including those that involve reasonable risks, and intervening only when necessary and lawful to do so.

Perkins and Repper (2016, p 102) note that 'open, honest and transparent relationships where each understands the others perspective and constraints and where the shared goal is one of promoting recovery and self-determination' are key to promoting safety rather than attempting to eliminate all risk. Carroll and McSherry (2020) note that risk management in mental health generally involves balancing short-term risk and long-term recovery. They propose an approach that requires clinicians to consider the:

- foreseeability, likely seriousness and probability of harm occurring for an individual including by considering evidence-based risk and protective factors and information about the person who would like to take the risk (for example, their history and their current circumstances such as current mental health, personal supports and challenges)
- burden of taking steps to prevent the risk (including the harms that may be caused by a course of treatment including, for example, loss of trust between the person and their treating team, loss of autonomy, serious distress, disruption to relationships, living arrangements, work and study)
- benefit to be gained by taking the risk
- practical resource constraints that may limit a service's ability to support positive risk taking.

What is a reasonable risk will depend on the person's individual circumstances. For example, protective factors and the benefit to be gained by taking the risk compared with the nature and seriousness of the risk.

It is not always possible to give detailed consideration to the matters described above. What is required to comply with this principle will vary according to the circumstances.

Requirements include:

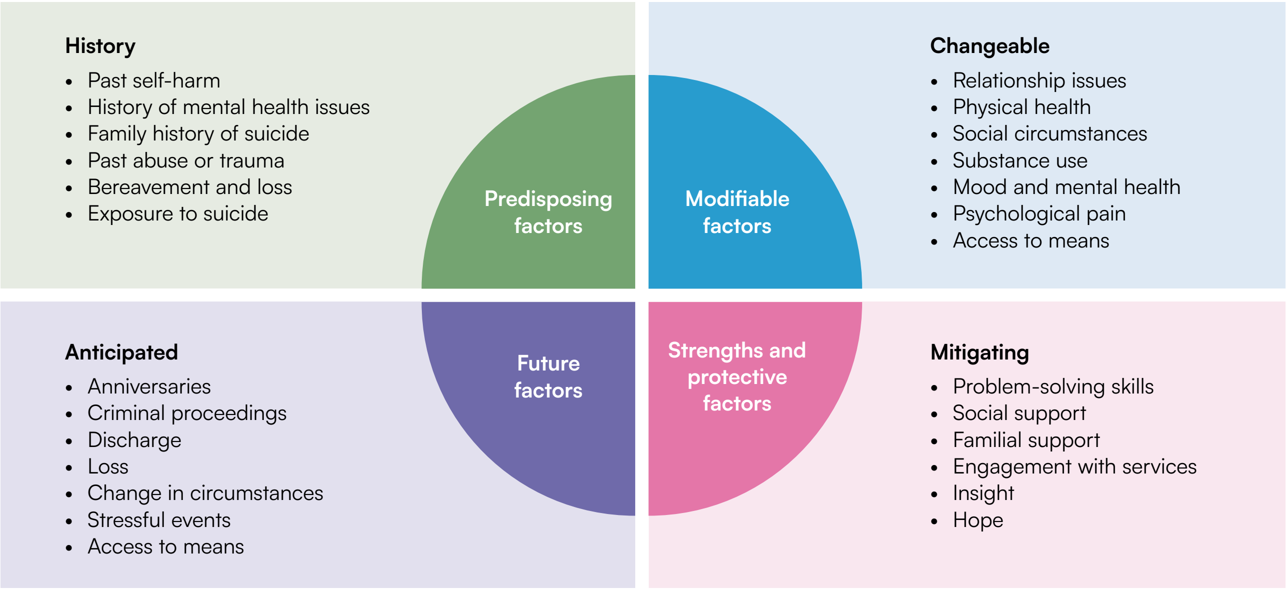
📖 Support the person's right to make decisions and support their choices wherever possible. Before considering making a substitute decision for a compulsory patient, take the following actions:

- Work together with the consumer, their carer, family and support people to find ways to support people's decisions to take reasonable risks, being informed by:
    - The consumer's views, preferences, values and priorities for their treatment, and what personal growth, self-esteem and quality of life mean to them.
    - The potential benefits and risks of the person's preferred decision. For example, does the decision promote personal growth, support the person's self-esteem or quality of life, or their recovery and participation in the community? What general and specific information do you have about the likelihood and seriousness of possible harm to the person or another person?
    - The potential benefits and risks of treatment proposed by the service, or other alternatives. For example, the benefits of symptom stability or relapse prevention, compared with risks of trauma from compulsory treatment or restrictive practices, loss of trust between the person and their treating team, medication side effects, loss of control and autonomy, loss of identity, disconnection, serious distress, disruption to relationships, living arrangements, work and study.
    - Evidence-based protective factors and information about the person. For example, their history and their current circumstances including current mental health, wellbeing, personal supports and challenges.
    - Steps that can be taken to mitigate identified risks. For example, supporting consumers to access other services such as alcohol and drug services, psychological support, housing, or strengthening community connections.
    - The range of treatment and care options that are available and whether there are less restrictive ways to respond to a person's clinical needs and meet their preferences. For example, is intensive support in the community possible instead of inpatient treatment? Could the person access leave with support from family, carers, supporters and kin? Are there ways to support medication change? Are other supports available that may help the consumer - for example, peer support?

  - Agreed indicators to review the approach to treatment, risk and safety. These should be informed by relevant guidelines and requirements such as guidelines for low-risk drinking, requirements of family violence and child safety frameworks.
  - Any practical resource constraints that may limit a service's ability to support positive risk taking. For example, staffing constraints may impact decisions around leave or treatment in the community - however, these should not be the sole reason for a decision.
  - If the person is subject to any restrictions on their decision making, what steps are agreed on to work towards the person's preferred treatment.
- Recognising the limitations of risk assessment, use established risk assessment and management approaches to support decisions - for example, the risk formulation grid outlined in the Chief Psychiatrist's *White paper: On the principles of mental health risk assessment* (Department of Health, 2024c). Discuss risks and safety together with consumers, carers, families, supporters and kin to develop a shared understanding of safety, risks and opportunities.
- Maintain and support relationships between consumers and their carer, family, supporters or kin as part of quality treatment and care planning. See family and carers principle.

Figure 2: A risk formulation grid to inform conversations and decision making with consumers, carers and families

Source: adapted from Hawton et al 2012 in Department of Health 2024c.



History

- Past self-harm
- History of mental health issues
- Family history of suicide
- Past abuse or trauma
- Bereavement and loss
- Exposure to suicide

Changeable

- Relationship issues
- Physical health
- Social circumstances
- Substance use
- Mood and mental health
- Psychological pain
- Access to means

Anticipated

- Anniversaries
- Criminal proceedings
- Discharge
- Loss
- Change in circumstances
- Stressful events
- Access to means

Mitigating

- Problem-solving skills
- Social support
- Familial support
- Engagement with services
- Insight
- Hope

Good practices may include

- Use collaborative, trauma-informed approaches to promoting consumer autonomy and supporting consumers to take reasonable risks. For example, support staff to access training and coaching in recovery and strengths-focused frameworks used by the service provider, and evaluate their effectiveness.
- When assessing risk and planning for safety, use tools that are co-designed with lived and living experience if possible.
- Provide information about risk, decision making and safety to build shared understandings of dignity of risk among consumers, families, carers and services. This may include examples of the benefits of taking risks, as well as factors that may suggest that a person's right to make decisions may need to be temporarily restricted - for example, risk of serious harm to self or others.
- Link carers, families and supporters to carer-specific supports including peer support or mutual support groups, referrals to psychology or other wellbeing supports. See family and carers principle.
- Use non-judgmental and non-punitive approaches and language. For example, if talking about substance use, state facts - consumer uses/seeks help for specific drugs/alcohol use, state frequency.

Only make substitute decisions where it is necessary and lawful to do so

Requirements include:

Only intervene to make decisions for the person if it is absolutely necessary, and there is a lawful reason to do so. Decisions can only be made for a person if all the following criteria are met:

- the person is a compulsory patient (and therefore has been assessed as needing immediate treatment to prevent serious deterioration to their physical or mental health or serious harm to themselves or another person)
- the person does not have capacity to give informed consent to treatment or has refused to do so
- the treatment is clinically appropriate
- there is no less restrictive way to treat the person.

The requirement that there must be no less restrictive way to treat the person requires careful consideration of the person's views and preferences and the reasons for them, as well as views of any parent, guardian, carer, nominated support person, consideration of beneficial alternative treatments, the likely consequences of not providing the treatment or of providing the treatment without consent, and any second psychiatric opinion. Any advance statement of preferences must also be considered, and the preferences must be followed unless they are not clinically appropriate or able to be provided, and reasons must be provided in writing. See least restrictive principle.

Clearly document decisions and share safety plans

Requirements include:

- Clearly document decisions about risk and safety planning including the matters described above, doing so together with consumers, carers, families and support people wherever possible.
- Give copies of relevant documents (such as treatment plans, safety plans) to consumers and (with consent or where required to provide care) carers, families and support people.

Good practice may include:

- When documenting decisions about risk and safety planning, consider language carefully to focus on what will support, rather than restrict, future decision making.

Tips for talking about dignity of risk with consumers, carers, families, supporters and kin

- Show curiosity about consumers' views, preferences and priorities and what sits behind them.
- Equally, be curious about the needs and priorities of carers, families, supporters and kin, recognising that they may not agree with all the decisions of the person they support. *Can you tell me what you think about…? Is there any support we could offer to help you?*
- Be open about any concerns you have about consumers' preferences, and explore supports that could help - for example, building skills, peer support, family involvement, or practical aids.
- Balance and normalise risk taking as fundamental to living a meaningful life and as a step towards a person's goals and autonomy - not just something to be managed.
- Acknowledge strengths and past successes - highlight times a person has managed risks well and explore what made that possible, or what they have learned from times that didn't go well.
- Make space for and validate emotion - recognise that conversations about safety and risk can bring up fear, frustration, or grief for consumers, families, carers, supporters, and kin.

6. How might **services reflect** on practice?

- How do we know what personal growth, self-esteem and overall quality of life mean to consumers? For example, are these a regular focus in discussions, part of treatment/recovery planning, do we encourage people to develop advance statements of preferences that include their values and priorities?
- How do we understand what is most important to individual consumers? For example, autonomy/independence, wellbeing of children/dependents, social connection, connection to Country, work or other priorities.
- How do we support consumers to make decisions that involve reasonable risks, even if we consider the decisions to be unwise?
- Do we clearly and consistently share any concerns we have about the person's preferred choice, with consumers and their support people? Are there any unspoken concerns or assumptions that we need to share?
- How do we prioritise consumers' values and preferences as we work with the consumer to co-create safety?
- If we made a decision to intervene in a person's choices, are we clear that we have a lawful basis for doing so, and that there was no way to support the person in their preferred choice?
- What are the barriers to supporting people to make decisions that involve reasonable risks? For example, time pressures, concern for safety of consumers, families, carers and staff, fear of professional consequences if adverse events occur, resource limitations that hamper efforts to co-create safety. Are there things that are in our control, that we can improve?

7. **Scenario:** supporting decisions that involve reasonable risk[19]

What happened?

An Afghan man, Mohammed, was admitted to the inpatient unit on a compulsory treatment order. He was also a practising Muslim, and he asked to visit the hospital's prayer room 5 times a day, to practise his faith. On previous admissions, Mohammed had been reluctant to stay at the unit - at times, he had left the unit without discussing this with staff, and had self-harmed while away from the unit. However, staff recognised that supporting Mohammed to practise faith is integral to his dignity and autonomy and cultural safety within the unit and sought solutions to support his practises within staffing availability. They recognised that respecting and supporting Mohammed's preferences may help him to feel more comfortable in the unit.

What actions did the service take?

The service worked with Mohammed to talk about how visiting the prayer room might work - for example, how often he would go, who would attend with him, and what might show Mohammed could visit the prayer room by himself. Staff started by going into the prayer room with Mohammed. After a few days as everything went well, waited for him outside, then walked with him part of the way until Mohammed attended by himself. Staff also talked to Mohammed about their concerns about him leaving the unit without discussing this with staff and the harm he had experienced because of this, and that they wanted to work with him to avoid this.

As a result of this discussion, for the first few days of his admission, Mohammed went to the prayer room 5 times a day, with a staff member. After the first few days and gradually trialling less restrictive approaches, staff re-assessed their concerns about Mohammed leaving the unit and talked to Mohammed about going to pray by himself. Feeling more supported and safer in the unit than he had in previous admissions, Mohammed agreed to inform staff when he was going to pray, and returned to the unit each time.

Staff also reflected on Mohammed's experiences and thought about how they could build connections with local religious leaders, exploring options for regular visits from leaders of different faiths.

Reflections from Commission lived and living experience staff

The service took the time to collaborate with Mohammed to support his choices. They recognised that safety includes being able to practise one's religion, as well as concerns about self-harm. They explored ways to support Mohammed to pray, including initially providing support to attend the prayer space, and transitioning to be able to do that on his own over time.

Which other principles were engaged?

Mental health and wellbeing principles: least restrictive, supported decision making, cultural safety and diversity

Decision making principles: care and transition to less restrictive support, autonomy

How would you approach this situation?

What might you do differently?

8. Where can I find **more information?**

Carroll A and McSherry B (2020) *'Risk management in the era of recovery and rights'* BJPych Advances Vol 27 Iss 6 November 2021 , pp. 394 - 40

Department of Health (2024c) *White paper: on the principles of risk assessment*, https://www.health.vic.gov.au/chief-psychiatrist/white-paper-on-the-principles-of-mental-health-risk-assessment

Perkins R and Repper J (2016),"*Recovery versus risk? From managing risk to the co-production of safety and opportunity*", Mental Health and Social Inclusion, Vol. 20 Iss 2 pp. 101 - 109

United Nations Convention on the Rights of Persons with Disabilities, December 13, 2006 https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-persons-disabilities

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[19] Note: The scenarios in this guidance are adapted from real examples. These simple scenarios focus on the application of one principle and are intended to show that applying the principles is not always complicated. Scenarios that address the principles in more complex situations and ways are available in implementation resources on the Commission's website.

Wellbeing of young people principle

1. What do **the Act** and relevant guidance say?

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 (s 24).

This principle emphasises the need to provide information to children and young people, to support their autonomy and right to participate in decisions affecting them (Explanatory memorandum to the Mental Health and Wellbeing Bill 2022 (Vic), p 22).

Under the Act, consumers aged 18 and under are considered as young people. This definition applies to treatment and interventions, including compulsory treatment. For youth mental health and wellbeing services, a young person means people aged 12 to 25.

Mental health and wellbeing services providing services to children aged under 18 must also comply with the Child Safe Standards. The Child Safe Standards require organisations that provide services to/or facilities specifically for the use of children, or that employ children, to implement policies to prevent, respond to and report allegations of child abuse and harm (Commission for Children and Young People 2023, p 1).

2. How do **human rights** relate to this principle?

Young people (aged 18 and under) hold the same rights as adults under the Charter. The Charter also recognises that young people have specific needs due to their age and development which must be protected. Age is a protected attribute under the *Equal Opportunity Act 2010* which means that mental health and wellbeing services must provide care, treatment and support without treating young people unfavourably because of their age alone.

These rights are broadly underpinned by international human rights treaties including the *International Covenant on Civil and Political Rights*, the *Convention on the Rights of the Child* and the *Convention on the Rights of Persons with Disabilities.*

Related mental health and wellbeing principles include:	Related decision making principles include:
Dignity and autonomy Family and carers principle Cultural safety Diversity Wellbeing of dependents Gender safety Supported decision making	Care and transition to less restrictive support Autonomy Consequences of compulsory assessment and treatment and restrictive interventions

3. How might a **consumer** experience this principle?

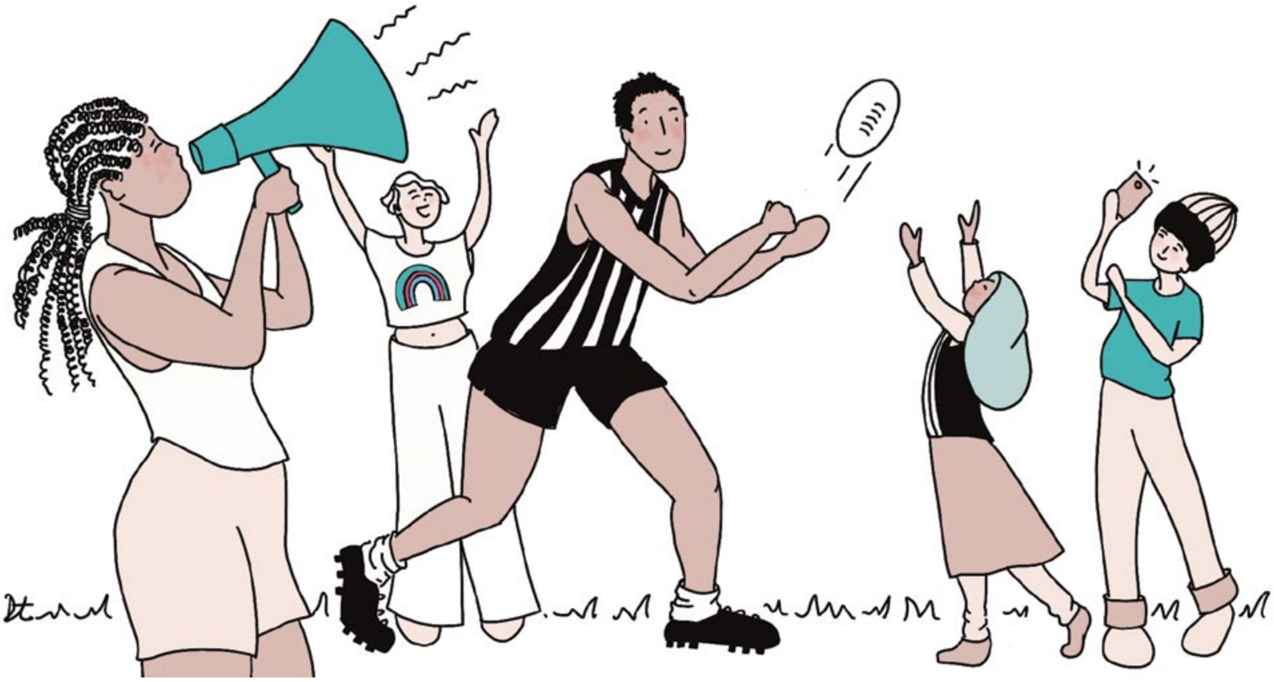
When my health, wellbeing and autonomy as a child or young person are supported:

- I feel welcomed, safe, and respected for who I am, including my culture, identity, gender, sexuality, disability, and lived and living experiences.
- I am supported in ways that suit my age, needs, and stage of development, with information and care that make sense to me.
- I am involved in decisions about my care, treatment, and recovery, and what matters to me is taken seriously. I am supported to make the decisions I can make, recognising that I may be able to make more decisions as I get older and more mature.
- I feel that adults in the service treat me as a partner in my recovery, not just as someone to be looked after.
- I am supported to stay connected with my friends, family and other support networks, community, education, and other things that are important in my life.
- I know who to talk to if something doesn't feel right, and I am encouraged to give feedback or make a complaint safely.
- My lived and living experience as a young person is valued, and I have opportunities to help improve services for others through youth advisory groups, interviews, projects, or feedback sessions.

4. How might **carers, families and supporters** experience this principle?

As a carer, when the health, wellbeing and autonomy of the child or young person I care for is supported and respected:

- I feel respected and included as someone who cares deeply about the young person in my life.
- I am given clear information that helps me support the young person in their health, wellbeing and autonomy in age and developmentally appropriate ways.
- I see the young person I care for being listened to, included, and supported in ways that are right for their age, development and identity.
- I feel confident that the service understands and values the strengths and needs of the young person in my life and of those with diverse backgrounds and experiences.
- I am supported to help my young person stay connected with their friends, school, community, and other parts of life that matter to them.
- If the young person and I see things differently, I trust the service to support respectful two-way communication, and supported decision making that prioritises the young person's needs.



5. How do **treating teams** put this principle into practice?

This section gives an overview of requirements and good practice suggestions for putting the wellbeing of young people principle into practice. As noted earlier in this guidance, the dignity and autonomy and supported decision making principles must always be considered.

Explore the key topics covered in this section:

- Create a safe, inclusive environment
- Promote and protect rights
- Promote autonomy and supported decision making
- Involve families and supporters
- Prevent and respond to risk
- Provide age and developmentally appropriate support
- Value young people's lived and living experience and include them in service design

Create a safe, inclusive environment

Requirements include:

- Respect and value the diverse and unique identities and experiences of Aboriginal children and young people (Commission for Children and Young People 2023, Child Safe Standard 1) including by:
  - acknowledging and appreciating the strengths of Aboriginal Culture and its role in wellbeing and safety
  - encouraging and supporting Aboriginal consumers to express their Culture and exercise their Cultural rights
  - identifying and taking action on racism (Commission for Children and Young people 2024). See also cultural safety principle.
- Respect and value the needs and identities of all children and young people using your service (Commission for Children and Young People 2023, Child Safe Standard 5) - including needs related to culture, religion, gender, sexuality, disability, neurodivergence, family violence, sexual safety, education, and housing.
- Connect young people with relevant services including:
  - education and employment supports
  - LGBTIQA+ supports (for example, Minus 18)
  - disability and neurodivergence advocacy
  - substance use services
  - housing and homelessness services
  - family violence services
  - sexual assault services or sexual abuse prevention programs.

Good practices may include:

- Use visual cues (posters, signs, lanyards and badges) to show that young people of all cultures, genders and sexualities are welcome and valued. See diversity principle.
- Talk in a way that feels natural and relatable to young people, using the words and style they normally use.
- Show interest in what matters to young people, what they need help with (such as sensory issues), and what they enjoy, and support them based on that.

Promote and protect rights

Requirements include:

- 📖 Give children and young people, and their carer, family, supporters or kin a written statement of rights and an accessible explanation, as soon as possible after entry to the service and at regular intervals (Commission for Children and Young People 2023, Child Safe Standard 2). Ensure rights information:
  - is accessible (use plain English, consider video or audio formats)
  - includes information about the right to safety, the right to participate in decision making and how to give feedback or make a complaint
  - explains how children and young people can expect adults at the service to behave, how they can raise concerns for themselves or others, and where they can access support (such as Kids Helpline).
- 📖 Give and explain statements of rights at key points as defined by the Act, and support children and young people, or their carer or parent on their behalf, to exercise their rights. See dignity and autonomy principle.

- 📖 Ask a young person what appropriate supports would help them to understand information and their rights, and make and communicate decisions. See dignity and autonomy principle.
- 📖 Promote the right of young people who are inpatients to communicate. If making a decision about restricting communication, consider and document the impact of the decision on a young person and their connection to supports. See dignity and autonomy principle.

Good practice may include:

- Explain the value of young people being actively involved in their treatment. Work with young people to identify their strengths as well as any supports.

Promote autonomy and supported decision making

See supported decision making principle for more information.

Requirements include:

- Ask young people what is most important to them in their treatment and recovery and what they need to feel and be safe while at the service.
- 📖 Take all reasonable steps to find out whether a young person has an advance statement of preferences and make all reasonable efforts to follow it.
- 📖 Take all reasonable steps to find out whether a young person has a nominated support person and take all reasonable steps to involve them.
- 📖 Remember the presumption of capacity applies to all people including children and young people, and they cannot be assumed to lack capacity to give informed consent to treatment based only on their age (s 87(2)(c)).
- 📖 Give young people accessible information about their options. Give time and arrange supports to help young people make decisions. For example, explain the information in ways that make sense to the young person, give the young person a chance to ask and receive answers to questions or to seek support from a family member, carer or nominated support person. Support young people's choices, to the greatest extent possible.
- 📖 Involve parents of children under 16, nominated support persons, and carers of children aged 16 to 17, where the decision may affect the care relationship, in decisions about compulsory treatment.
- 📖 Encourage the involvement of IMHA advocates, noting their role for consumers aged 15 and under is to promote the consumer's views and preferences, and to work with families, carers and supporters to protect the young person's best interests.
- Encourage and support the child or young person to access legal assistance including from VLA's Mental Health Legal Rights Service Helpline, the Mental Health Legal Centre or the Victorian Aboriginal Legal Service, particularly for any Mental Health Tribunal hearings. Lawyers can take instructions from a child or young person.

Good practices may include:

- Consider how young people's needs and strengths in supported decision making may differ from adults. For example, young people may:
    - Prefer accessing information and support online, rather than face-to-face.
    - Be exploring independence and their views about involving parents, families and carers may be nuanced. This may require frequent and sensitive conversations with young people and parents about balancing autonomy and support, and ensuring parents have the information they need to support their child.
    - Respond best to youth-specific resources, such as posters, easy-to-read fact sheets, videos, graphics or audio explanations.
    - Seek support from peers, who may also need age-appropriate resources and support. It may be necessary to explore additional supporters.

Involve families, carers and supporters

See family and carers principle for more information.

Requirements include:

- Involve carers, families, supporters and kin in line with the consumer's preferences.
- 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.
- Actively support and strengthen important relationships, including when there is disagreement, if safe to do so. Recognise that conflict between a young person's preferences and those of their parent, carer or family can quickly damage trust and negatively impact the care relationship. Services have an important role to support open, respectful dialogue and relationship repair or strengthening.
- For services supporting children under 18, share information with families and the community about your organisation's approach to child safety and wellbeing, for example, a statement of commitment to child safety (Commission for Children and Young People 2023, Child Safe Standard 2).
- If the young person is a compulsory patient, involve and notify parents of children under 16 as required by the Act (see Mental Health and Wellbeing Act 2022 Handbook for details). Clearly explain to the child how their parents will be involved and informed about their care.
- For compulsory patients aged 16 to 17, involve and notify parents about decisions as required by the Act with the young person's consent. Involve and notify carers as required by the Act if a decision affects a care relationship (see Mental Health and Wellbeing Act 2022 Handbook for details). Revisit how the young person and their parent, carer or family view this relationship.

Practices to avoid include:

- Do not share information if there are concerns that sharing information may lead to family violence or serious harm to any person, even if sharing the information is otherwise permitted by the Act or agreed to by the person to whom the information belongs (s 31).

Prevent and mitigate risks

Requirements include:

- Identify where children are at risk of harm outside of your service and report to Child Protection and/or Victoria Police as necessary. See wellbeing of dependents principle.
- Prevent, identify and mitigate risks of child abuse and harm in both physical and online environments within your service. This includes balancing risks with young people and children's rights to privacy, access to information, social connection and learning (Commission for Children and Young People 2023, Child Safe Standard 9).
- Ensure admission processes screen for child protection orders.

Good practices may include:

- As relevant to your service, work with and learn from specialists to identify and manage risks, for example:
  - FaPMI (Families Where a Parent has a Mental Illness) workers - to identify children at risk, refer appropriately and support follow-up actions.
  - Specialist Family Violence Advisors to support implementation of the MARAM Framework (see gender safety principle).
  - sexual safety leads - to identify and manage sexual safety risks. For example, educating young people on healthy boundaries, consent, what constitutes sexual assault and harassment, and the consequences of sexual activity in an inpatient setting. Recognise that young people may be especially vulnerable in an adult setting. Involve them in safety planning and support them to create realistic, individualised safety plans. For more considerations with regard to children, young people and sexual safety, see the Chief Psychiatrist's guideline (2023d, pp 35-36) on *Improving sexual safety in mental health and wellbeing services*.

Provide age and developmentally appropriate support

Requirements include:

- When supporting young people to make and participate in decisions about their treatment, encourage them to consider the type and setting of treatment that would best support them. For example, community mental health team, Youth Prevention and Recovery Care (YPARC), inpatient, child and youth services, adult services.
- 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, cultural, religious or spiritual needs, and access to outdoor space and meaningful, age-appropriate activities.

Good practices may include:

- Actively seek young people's ideas about activities and involve them in planning events.
- Support access to technology for connection to education, entertainment, friends, and seeking online support or information about rights and mental health.
- Work with young people on safe and respectful technology use, including education about the risks of grooming and the importance of respecting others' privacy, such as not taking photos without consent.
- Recognise the value of friendships and peer support by developing peer support initiatives and assisting young people in maintaining contact with friends and social networks during inpatient care.
- Acknowledge the importance of friendships and peer support.
- Connect young people with a Children and Young People (CYP) worker.

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

Section 5 of Part One of this guidance sets out a range of actions to be taken at a leadership level including around feedback, complaints, and lived and living experience involvement in service governance, design and evaluation. For children and young people, this might include:

- Work with young people to create age-appropriate materials like posters and flyers to help them know how to share feedback or complaints to the service or the Commission.
- Give young people different options to share their opinions or suggest changes, such as online forms, suggestion boxes, surveys, or group conversations.
- Recognise that young people might experience services differently from adults and ensure their needs and perspectives are understood and valued.

Example: An adolescent unit creates a colourful poster with simple illustrations and clear steps on how young people can share their feedback or complaints. They also set up an online feedback form, a suggestion box in the lounge, and hold regular group chats where young people can openly talk about what they like or want improved. The staff listen carefully and make changes based on what the young people share.

Tips for talking about the wellbeing of young people principle with consumers, carers, families, supporters and kin

Talking with young people

Show curiosity about and genuine interest in what matters most to the young person.

Give space to acknowledge any uncertainty or worry about being in a service, including whether it is a first admission, how it may affect their routines and supports such as school, family and friends.

Questions may include:

- *What's important to you or what do you enjoy (for example, friends, school, hobbies)?*
- *Is there someone who usually supports you (like a parent, carer or relative)? Would it help to involve them?*
- *How do you feel about the options we've talked about?*
- *Have you been to a service before? What worked well or didn't?*
- *How can we help you feel safe and supported?*

Talking with families and carers

- *What works well for [child/young person], and what should we avoid?*
- *What's important in their life, and how can we support that?*
- *How do you feel about the treatment options? What do you think matters most for them?*
- *How can we support you in your role?*
- [If in an adult service] *What do you think would help them feel safe here?*

6. How might **services reflect** on practice?

- How do we involve young people in decisions about their care and service improvement?
- How do we provide age-appropriate support and meet young people where they're at, emotionally and developmentally?
- How do we create a safe, welcoming space that values young people's identities (for example, culture, gender, neurodivergence)?
- How do we learn what young people want from mental health services, and respond to those needs?

7. **Scenario:** supporting age and developmentally appropriate activities[20]

What happened?

Cooper, an 18-year-old young man, is admitted to an inpatient unit under a compulsory treatment order, with a history of leaving the unit against staff wishes. Cooper plays basketball in a local team every week. Cooper is very fit and usually practices in his local park with his mates during the week. Cooper expressed being indoors all day was not good for his mental health.

Cooper wants to keep fit, keep his basketball drill practice going and have friends and family visit. He wanted to continue these activities to help his mental health. Cooper noticed the front courtyard had more room for practicing basketball drills and asked if he could use that.

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[20] Note: The scenarios in this guidance are adapted from real examples. These simple scenarios focus on the application of one principle and are intended to show that applying the principles is not always complicated. Scenarios that address the principles in more complex situations and ways are available in implementation resources on the Commission's website.

What actions did the service take?

The staff were initially concerned that Cooper might leave the service without permission again. Staff talked to Cooper about what was important to him. Cooper and the nurse talked about his request. The nurse and Cooper agreed to trial short periods (30 minutes) of unescorted leave to the front courtyard. Taking into account there was a basketball hoop in the interior courtyard, Cooper agreed to use that area only when people were not sleeping. Cooper and the treating team agreed that for layout drills he could use the front courtyard. Cooper's nurse suggested that his friends or family can bring a basketball from home, and Cooper agreed not to use the ball indoors. When Cooper wanted to practice drills in the front courtyard, staff and Cooper agreed that he would set a timer on his phone to come in after 30 minutes.

Cooper used both courtyards regularly, family and friends gave positive feedback to staff about being able to practice when they were visiting Cooper. Over time, some staff joined Cooper in his drills, with his agreement, which also helped to build trusting relationships, starting informal discussions about recovery planning. Cooper used the courtyard for the rest of his admission as agreed, with improved mood and engagement.

Reflections from Commission lived and living experience staff

This scenario shows how services can support the wellbeing of young people by recognising the importance of movement, sport, and outdoor activity as part of recovery. For Cooper, playing basketball and staying active are essential to his sense of identity, connection, and mental health. Staff listened to what was important to Cooper and worked with him to make sure he could continue some of these routines while in hospital. Staff responded with flexibility and respect, rather than focusing only on risk because of Cooper's past experiences of leaving without permission. It shows how young people's recovery is not only about clinical treatment, but also about holding onto meaningful activities, routines, and passions. Supporting these aspects of identity and daily life can make compulsory treatment feel less restrictive and more aligned with a person's goals and wellbeing. Fresh air and access to the outdoors can be therapeutic for so many people. Having a change of environment, looking at the sky, and feeling the fresh air is particularly important for people who are used to being active and spending time outdoors. Allowing Cooper to continue his basketball drills and have friends or family around him gave him both purpose and connection, which are central to wellbeing.

Which other principles were engaged?

Mental health and wellbeing principles: dignity and autonomy, dignity of risk, supported decision making, least restrictive.

Decision making principles: Autonomy principle, consequences of compulsory assessment and treatment and restrictive interventions principle

How would you approach this situation?

What might you do differently?

8. Where can I find **more information?**

Commission for Children and Young People (2023) *A guide for creating a child safe organisation* https://ccyp.vic.gov.au/assets/resources/New-CSS/A-guide-for-creating-a-Child-Safe-Organisation-27.04.23.pdf

Commission for Children and Young People (2024) *Understanding cultural safety for Aboriginal children and young people: a guide for implementing Child Safe Standard 1* https://ccyp.vic.gov.au/assets/resources/New-CSS/Understanding-cultural-safety-CSS1-guide.pdf

Department of Health (2023), *Improving sexual safety in mental health and wellbeing services: Chief Psychiatrist's guideline* https://www.health.vic.gov.au/chief-psychiatrist/improving-sexual-safety

Mental Health Coordinating Council (2022) *Recovery Oriented Language Guide* https://mhcc.org.au/wp-content/uploads/2022/07/Recovery-Oriented-Language-Guide-Mental-Health-Coordinating-Council-2022.pdf

Diversity principle

1. What do **the Act** and relevant guidance say?

The diversity principle requires that 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 (s 25).

IMHA's plain language explanation of this principle notes that in addition, this principle means that people can tell services what they need to feel safe (IMHA 2025).

Frameworks and standards that support compliance with this principle include the:

- *Framework for recovery-oriented practice* (Department of Health 2011a), particularly the responsiveness to diversity domain
- NSQHS Standards (Australian Commission on Safety and Quality in Healthcare 2021), particularly the:
  - Clinical governance standard (such as action 1.15 - identifying the diversity of consumers who use the service and incorporating that information into planning and delivery of care)
  - Partnering with consumers standard (such as actions 2.08 - using communication mechanisms that are tailored to the diversity of the consumers who use services and the local community and 2.10 - providing information in a way that meets the needs of patients, carers, families and consumers).

Note on terminology: The Commission notes that this principle uses the term 'race', and acknowledges that this is not preferred by many people. Where possible, we use alternative language.

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2. How do **human rights** relate to this principle?

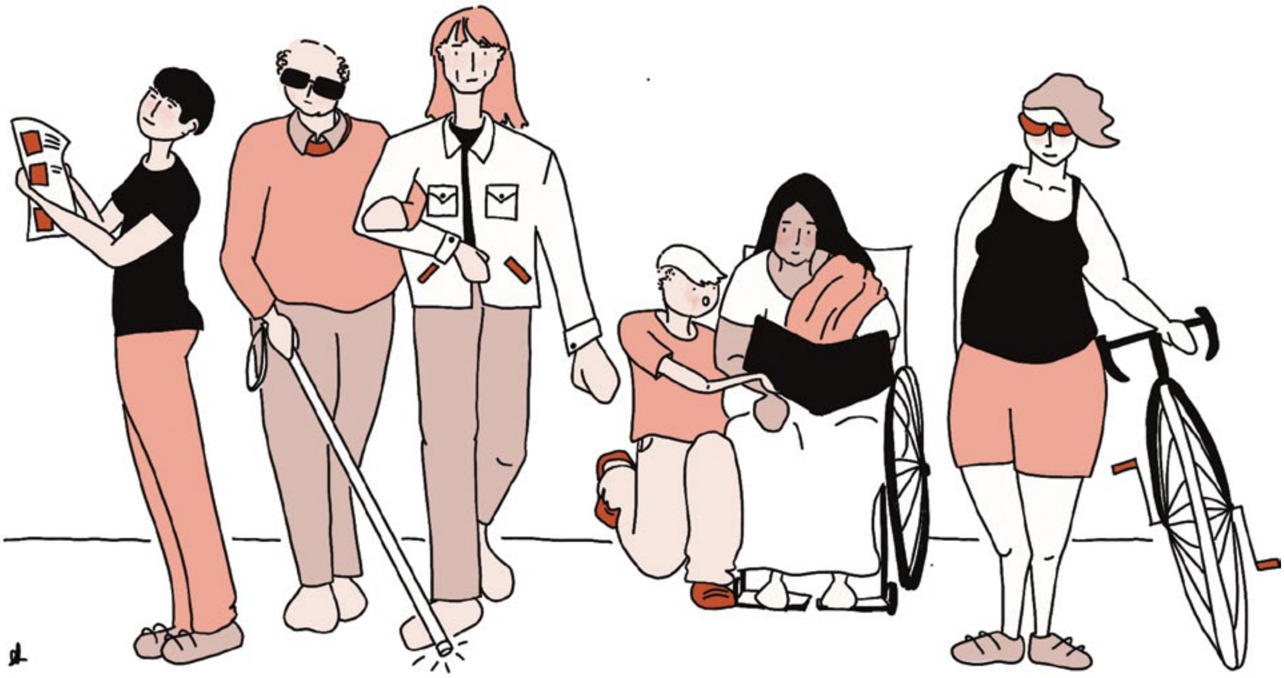
The diversity principle recognises the importance of bringing an intersectional rights-based approach to mental health and wellbeing care, treatment and support. A person's experience with mental illness or psychological distress intersects with other social identities and factors including those that are outlined in the principle. As this principle can refer to multiple areas of a person's life, the most relevant Charter rights will depend on what areas of a person's life intersect with the care and support services being sought. For example, consideration of accessibility requirements will also prompt consideration of the equality and non-discrimination provisions in section 8 of the Charter.

Related mental health and wellbeing principles include:	Related decision making principles include:
Dignity and autonomy Wellbeing of dependents Diversity of care Supported decision making Cultural safety Gender safety Family and carers	Consequences of compulsory assessment and treatment and restrictive interventions Autonomy

3. How might a **consumer** experience this principle?

When my diverse needs and experiences are actively considered:

- I am asked early in my care about my identity, including culture, gender, disability, and other aspects, and this information is respected and used to shape how I'm supported.
- I see that my identity and lived experiences are not just noted but actively valued in how my treatment, communication, and support plans are delivered.
- I can access services in ways that work for me, like through interpreters, translated materials, or support from peer workers who share my background or lived experience.
- I feel safe and welcome in the service environment from the way staff speak to me, to the signage, facilities, and symbols that reflect diverse communities.
- When I need support making decisions, I am given time, information, and tools like Easy English or visual aids to understand my options and make choices that are right for me.
- If I face discrimination or harm related to who I am, I know how to report it and trust that it will be taken seriously and handled respectfully.
- I have access to a range of services including culturally safe, trauma-informed, and peer-led options regardless of my background, disability, identity, or where I live.



4. What may this principle mean for **carers, families and supporters**?

When the diverse needs and experiences of the person I support are actively considered:

- I see that the unique needs, identity, and circumstances of the person I care for and of our family and relationships are actively considered in their treatment and support - including their culture, language, gender, neurodiversity, disability, or trauma experiences.
- I feel confident that care is not 'one-size-fits-all' - it is shaped by what matters to the person I care for, including their preferences, values, accessibility needs, and living situation.
- I am included in care planning where appropriate, and I can see that our family, culture, and community connections are respected as part of recovery.
- The person I care for has access to a diverse mix of services and supports - including culturally safe, peer-led trauma informed and holistic options, no matter their background or where they live.
- I feel assured that services uphold the rights of the person I care for to be treated with dignity, free from discrimination, and supported in ways that affirm their identity and support their full participation in community life.

5. How do **treating teams** put this principle into practice?

This section gives an overview of requirements and good practice suggestions for putting the diversity principle into practice. As noted earlier in this guidance, the dignity and autonomy and supported decision making principles must always be considered.

Explore the key topics covered in this section:

- Actively consider, and safely and sensitively respond to people's diverse abilities, needs and experiences
- Respond to trauma
- Consider and respond to the intersectionality of a person's mental health, needs and experiences

Please also see systemic and leadership actions outlined in detail in implementation resources on the Commission's website, that can be taken to ensure services are accessible and welcoming for diverse consumers, carers, families, supporters and kin.
For example:

- understanding the diversity of consumers and communities who access the service
- creating a visually welcoming and accessible environment that is reflective of diverse cultures, genders, and sexualities
- employing staff who reflect the diversity of the community including lived and living experience workers, Aboriginal staff, people with diverse gender and sexuality, and people from culturally diverse and underrepresented groups
- supporting staff to access relevant training
- encouraging reflective practice, supervision and staff conversations, including conversations about equity, privilege and bias in practice
- involving diverse community voices in service planning, feedback, codesign and co-evaluation.

Actively consider, and safely and sensitively respond to people's diverse abilities, needs and experiences

Requirements include:

- Communicate in ways that respond to the diversity of consumers, families, carers, supporters and kin and share information in ways that meet their needs.
- Routinely ask about the person's cultural, religious, communication, accessibility, or identity-based needs and then act on what they share. For example:
    - Provide appropriate supports to help a person understand information and rights and to make and communicate decisions. For example, a person preparing for a Mental Health Tribunal hearing should be proactively offered access to information, an interpreter or any other supports to help them understand the report and any other documents that will be considered in the hearing. See dignity and autonomy principle.
    - 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 or significant members of the person's community (for example, extended family, community leaders, faith leaders). See family and carers principle.
    - Recognise that cultural practices can be important for recovery (Department of Health and Human Services 2011a, p 21). For example, ask what is important to the consumer and their carer, family, supporters and kin and how you can support them to follow their cultural and spiritual beliefs and practices while receiving treatment. This may include access to prayer rooms, respecting dietary requirements, making space for ceremony such as healing ceremonies or breaking a fast.
    - Ask about and ensure continued access to any disability related supports including when a person is receiving inpatient treatment (for example, mobility aids).
- Take all reasonable steps to find out if a person has an advance statement of preferences and make all reasonable efforts to follow preferences related to diverse abilities, needs and experiences.
- Respect and follow the person's advice about their identity, and never question this or make assumptions.
- Check that the clinical record correctly reflects all aspects of a person's identity (where known). For example, ask a person's pronouns and preferred name at your first meeting, and update it if needed (s 726 - accuracy of information principle).

Good practices may include:

- Understand that diversity is broad and intersectional. This includes (but is not limited to) gender identity, sexual orientation, sex, race, ethnicity, language, culture, faith, spirituality, age, disability, neurodivergence, class, socioeconomic status, residency status, and geographic disadvantage.
- Recognise how overlapping aspects of identity can affect a person's experiences, including access to care, experiences of stigma, or trauma (see next section).
- Respect that each person defines their own identity and experience and avoid assumptions.
- Proactively support people who may face exclusion because of reasons such as visa status, rural location, poverty, disability or past trauma. For example, where possible offer travel vouchers, free transport, telehealth consultation options, assurances that accessing mental health and wellbeing support will not impact visa or immigration status.
- Complete relevant training such as training on cultural competency, responsiveness or humility and LGBTIQA+ inclusion. For example, explore cultural competency training to understand and work with cultural norms - such as differing cultural norms around eye contact, barriers to speaking up to people seen as authority figures, head covering, handshaking, and other practices such as avoiding direct questioning, waiting quietly before responding, respecting Sorry Business, valuing connection to Country, and the importance of extended family and Elders.
- Share culturally appropriate resources and acknowledge the significance of culture to wellbeing.
- Welcome diverse gender identities, for example, show you are gender affirming by introducing yourself with your pronouns or wearing a pronoun badge, and by using inclusive language.

Respond to trauma

Requirements include:

- Provide trauma-informed and responsive care to all consumers, recognising the high prevalence of previous trauma among people accessing mental health and wellbeing services. For example:
    - always ask people what they need to feel and be safe and welcomed in the service, give people as much choice as possible, support their capacity to make decisions about their treatment and care, and take least restrictive approaches. See dignity and autonomy, supported decision making, and least restrictive principles.
    - be mindful that people with diverse identities may be more likely to have experienced a range of compounded traumas - including racism, discrimination, targeted violence, trauma associated with refugee or migrant experiences, etc. - with impacts to their mental and physical health. See also health needs principle.

Consider and respond to the intersectionality of a person's mental health, needs and experiences

Requirements include:

- Tailor treatment, care and support to the person's values, identity and needs by exploring meaningful options together such as cultural, psychosocial, spiritual, community, peer-led or creative supports and making reasonable efforts to help them to access these where possible. For example, access within the service if possible, make referrals, identify options including private treatment, or free or low cost options according to the person's preferences.
- Make referrals to services that meet the person's needs. For example, to Aboriginal Community Health Organisations (ACCHOs), LGBTIQA+ services, refugee and asylum-seeker services, disability advocacy, or multicultural organisations.
- Work collaboratively with services across housing, education, employment, disability, alcohol and drug, youth, ACCHOs, multicultural, LGBTIQA+, and justice systems to support people holistically.

Good practices may include:

- Be aware of how diverse experiences and needs can intersect, impacting mental and physical health and creating barriers to accessing services - and create ways to make it easier for people to access and interact with services. For example:
    - some women, girls or gender diverse people from some multicultural backgrounds may not be comfortable accessing mixed-gender services. Facilitating access to single-gender services or sessions, or community outreach, may promote equitable access to services.
    - people with disability often face higher costs of daily living, may have limited or fluctuating ability to work and/or face discrimination or lack of accessible employment - and consequently may experience socioeconomic disadvantage that creates a further barrier to accessing services. By developing holistic care plans that also include, for example, support accessing the NDIS or material aid, service providers can increase people's ability to access the supports they prefer.
    - LGBTIQA+ people from multicultural, migrant or refugee backgrounds may have previous and recent experiences of discrimination and racism, including when accessing services. Gender diverse consumers may have experienced repeated questioning of their identity and misgendering - including in health care settings - as well as other experiences of discrimination and violence. Take action to show that everyone is welcome (such as visual cues in the service and as part of uniform including badges, lanyards, etc.), and actively seek to understand and respect a person's preferences and identity, to help reduce barriers to access.
- Be guided by resources that are codeveloped wherever possible. See 'Where can I find more information?'
- Use digital health and telehealth creatively to support people with limited mobility, geographic access or sensory needs.
- Build ongoing relationships with local community groups to better understand and respond to emerging needs.

Tips for respecting and responding to diversity

Ask open, curious questions:

- *Can you tell me about the things that matter to you?*
- *Is there anything you'd like me to know about you or your family, that will help you feel safe and welcome and help us to meet your needs?*
- Show your support of diverse gender identities - for example, by introducing yourself using your pronouns, wearing a pronoun badge
- Ask about safety needs - *What can we do or not do that will we help you be and feel safe?*

6. How might **services reflect** on practice?

- How do we ensure we ask respectfully about people's cultural background, gender identity, disability, faith, sexuality, and other aspects of identity that may shape their care needs?
- How do we adapt our service delivery to meet people's preferences, accessibility needs and communication styles?
- Does our physical environment, signage, and communication materials signal safety and welcome to people from diverse backgrounds?
- How do we support people who speak little or no English, are neurodivergent, or require cultural or spiritual accommodations?
- Do we offer equitable support to people from rural and regional areas, those with temporary visa status, or who have experienced systemic racism or trauma?
- Does our workforce reflect the diversity of the communities we serve?
- Are staff supported and trained to deliver inclusive and culturally safe care?
- Do we partner with local ACCHOs, multicultural, LGBTIQA+, disability, and community organisations to improve access and engagement?
- How do we support diverse community members and lived and living experience voices to be involved in service design, delivery and governance?
- Who is not in the room when decisions are made and how can we change that?

7. **Scenario**: breaking fast during Ramadan with family[21]

What happened?

Khadija was an inpatient in an acute inpatient unit during Ramadan. Khadija had a good relationship with her nurse, and told her that she intended to fast.

Khadija also asked that the service provide a private space for her family to break their fast with her in the evening each day.

What actions did the service take?

The treating team talked to Khadija about fasting. They started this conversation by recognising the religious and cultural significance of fasting during Ramadan. Staff checked in with Khadija for a physical health assessment, to ensure there were no underlying health issues that would impact fasting. They also asked what they could do to support Khadija while she fasted - for example, making sure no meals or snacks were offered to her during the day, and timing her morning (Suhoor) and evening (Iftar) meals to align with fasting requirements, and also adjust medication timing.

Khadija agreed she would let the treating team know if she was experiencing any difficulties or concerns, so staff could explore options with her.

Staff supported Khadija's request to eat with her family, recognising that breaking fast together is an important part of Ramadan, and a way for Khadija to maintain connection to her faith and family. Khadija's family brought home cooked meals in every day to eat together in the family and carer room. This helped Khadija to stay connected with her faith, family and culture during her admission.

Reflections from Commission lived and living experience staff

Staying strongly connected to family and faith is respect in action. How much relief Khadija would have had by maintaining those connections even though she had to be in hospital during Ramadan. If she did not already have a trusting relationship with her treating team, Khadija could have fasted without them knowing, and may not have told them if she felt unwell. The treating team showing Khadija that they respected her faith and culture helped to build even more trust.

Which other principles were engaged?

Mental health and wellbeing principles: dignity and autonomy, supported decision making, cultural safety.

How would you approach this situation?

What might you do differently?

8. Where can I find **more information?**

Australian Commission on Safety and Quality in Healthcare (2021) *National Safety and Quality Health Service Standards* https://www.safetyandquality.gov.au/standards/nsqhs-standards

Department of Families, Fairness and Housing (2025) *LGBTIQA+ inclusive language guide* https://www.vic.gov.au/inclusive-language-guide

Department of Health (2011a) *Framework for recovery-oriented practice* https://healthsciences.unimelb.edu.au/__data/assets/pdf_file/0011/3391175/framework-recovery-oriented-practice.pdf

Embrace Multicultural Mental Health *Framework for Mental Health in multicultural Australia* https://framework.embracementalhealth.org.au/

Zoe Belle Collective and Royal Melbourne Hospital (2021) *Transgender and gender-diverse inclusive-care guide for hospital-based healthcare professionals* https://www.thermh.org.au/files/documents/Corporate/transgender-gender-diverse-inclusive-care-guide-health-care-professionals.pdf

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[21] Note: The scenarios in this guidance are adapted from real examples. These simple scenarios focus on the application of one principle and are intended to show that applying the principles is not always complicated. Scenarios that address the principles in more complex situations and ways are available in implementation resources on the Commission's website.

Gender safety principle

1. What do **the Act** and relevant guidance say?

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 (s 26).

This clause is intended to promote safe and responsive service delivery, having regard to the specific needs of people of all genders, including trans and non-binary people (Explanatory memorandum to the Mental Health and Wellbeing Bill 2022, p 25). This principle, alongside the diversity principle, requires gender safety to be considered through an intersectional lens.

Relevant guidelines and documents that will support compliance with this principle include:

- Department of Health (2023c), *Improving sexual safety in mental health and wellbeing services: Chief Psychiatrist's guideline*
- Safer Care Victoria's Mental Health Improvement Program *Improving sexual safety within Victorian mental health inpatient units* initiative and associated resources
- Family Safety Victoria's (2018) *Family Violence Multi-Agency Risk Assessment and Management* (MARAM) Framework and associated resources
- Department of Health (2025b) *Implementing the MARAM framework in mental health and wellbeing services* - Chief Psychiatrist's guideline
- Department of Families, Fairness and Housing (2023) *Our equal state: Victoria's gender equality strategy and action plan 2023-2027*

2. How do **human rights** relate to this principle?

The gender safety principle enshrines the right to equality and non discrimination in section 8 of the Charter. Gender is also a protected attribute in the *Equal Opportunity Act 2010*. This principle embeds a human rights-based approach by requiring services to apply an intersectional lens to a person's experiences of discrimination and disadvantage.

Related mental health and wellbeing principles include:	Related decision making principles include:
Dignity and autonomy Least restrictive Supported decision making Family and carers Diversity Cultural safety Wellbeing of dependents	Consequences of compulsory assessment and treatment and restrictive interventions Autonomy

3. How might a **consumer** experience this principle?

When gender safety needs are recognised and responded to:

- I am asked what is important to me and what will help me feel and be safe. My needs are heard, respected and prioritised. I am supported to make decisions about my own treatment and care.
- I am seen as a whole person. My experiences, perspectives and concerns, and how these impact me in the context of my life - are taken seriously and responded to.
- I feel physically and emotionally safe in the service, including in shared environments. I can speak up if something does not feel right, and I know I will be heard and supported.
- My gender identity, name and pronouns are respected and correctly recorded, and I do not have to keep correcting people to be seen as myself.
- If I have experienced trauma or family violence, staff acknowledge without judgment, and offer care that is sensitive, trauma informed, supportive, and empowering.
- I am supported with knowledge and skills about what makes a healthy, safe, equal and respected relationship. I feel safe, hopeful, and empowered to address my needs.

- I am supported to access services and supports that reflect my needs including family violence services, gender-specific care, and gender-diverse peer workers.
- I can choose who is involved in my care - whether family, partners, or chosen supporters and I decide what information is shared and with whom.
- How staff speak to me, support me, and respond to safety concerns shows they are skilled in trauma-informed and gender sensitive care.
- My safety needs - including who provides my care, where I'm placed, and how staff interact with me - are taken seriously and respected at all times.

4. How might **carers, families and supporters** experience this principle?

When gender safety needs are recognised and responded to:

- I am confident that the care and treatment of my family member/person I care for is free from gender expectations, stereotypes, unconscious bias and assumptions.
- I feel confident that the service recognises and responds to the gender-based safety needs of the person I care for.
- I am confident that the service is aware, acknowledges and is respectful of the gender identity of the person I care for.
- The service recognises that people may have experienced discrimination, trauma, or violence, and takes an intersectional, gender-responsive, trauma-informed approach.
- I am supported to understand how gender, trauma, and discrimination may affect the mental health, treatment, and recovery of the person I care for.
- I am treated with respect and not excluded or overlooked based on my gender, cultural background, or caring role.
- I am encouraged and supported to contribute to service planning and decision making in ways that reflect the specific gendered and cultural needs of my family member and family.
- I trust that the service understands how gender and caregiving responsibilities can affect my wellbeing and offers support when I need it.

5. How can **services** put this principle into practice?

This section gives an overview of requirements and good practice suggestions for putting the gender safety principle into practice. As noted earlier in this guidance, the dignity and autonomy and supported decision making principles underpin all other principles and must always be considered.

Explore the key topics covered in this section:

- Create safety with and for people with diverse gender identities
- Respond to the impact of gender dynamics and of the intersection of gender and other types of discrimination and disadvantage
- Identify and respond to current or past family violence and trauma
- Uphold sexual safety

Create safety with and for people with diverse gender identities

Requirements include:

- Seek training to ensure practice is free from gender expectations, stereotypes, unconscious bias and assumptions.
- Seek and follow guidance developed with lived and living experience wherever possible.
- Check that the clinical record correctly reflects a person's pronouns and preferred name at your first meeting, and update it if needed (s 726 - accuracy of information principle). Follow what the person tells you about their name and gender.
- Be aware that some consumers may not wish to disclose their sex, gender identity or sexuality in certain settings or circumstances. Respect these choices (Department of Health 2023d, p 41).
- Accommodate inpatients in a part of the unit that is most appropriate for them, based on their identity, preferences and risk assessment (Department of Health 2023d, p 41).
- Link consumers, families, carers and supporters to services and groups that meet their needs. For example, gender-specific groups, LGBTIQA+-specific groups, ACCHOs, women's and gender-diverse health care services. See diversity of care principle.

- Be sensitive to consumers whose gender identity or body does not match society's expectations. This includes being particularly conscious of privacy, and considerate when undertaking procedures such as a medical review (Department of Health 2023d, p 41).
- Consider the needs of consumers undergoing gender transition, and the impacts of treatments such as hormone therapies (Department of Health 2023d, p 41).
- Take an inclusive approach to family, and be mindful that for some LGBTIQA+ consumers, their identity may be a source of conflict with their family of origin. Acknowledge and include the consumers' family of choice (Department of Health 2023d, p 41).

Good practices may include:

- Actively show that you respect diverse gender identities. For example, show that you are gender-affirming by introducing yourself using pronouns or wearing a pronoun badge, using inclusive language.
- Ask what a person needs to feel safe and supported. Assure them that staff will take any feedback or concerns about actions of staff or other consumers seriously (including options to give anonymous feedback), and will work to provide safe, gender-affirming care.
- Ask if a person prefers to be treated by staff of a particular gender, and meet their preference where possible. If not possible, explore other options for supporting the person to feel safe. For example, support from a different staff member of the preferred gender, or a family member, carer, or supporter present during treatment.

Respond to the impact of gender dynamics and of the intersection of gender and other types of discrimination and disadvantage

Good practices may include:

- Recognise barriers that may prevent people from accessing mental health and wellbeing services - or expressing and having their needs met once in the system - particularly culturally and linguistically diverse people, Aboriginal people, people with disability, LGBTIQA+ people, people from migrant or refugee backgrounds, women and gender diverse people.
- Be aware and responsive to the fact that women with disability are twice as likely as other women to experience sexual violence (Royal Commission into violence, abuse, neglect and exploitation of people with disability, 2023, p 109).
- Recognise how different life stages (for example, adolescence, parenthood) may impact mental health. Specifically, recognise how gendered medical conditions or experiences (for example, endometriosis or menopause) may impact the mental health of girls, women and gender-diverse people. Ensure that physical symptoms are fully explored and taken seriously.
- Recognise that women's health needs have been systemically overlooked and women are disproportionately impacted by chronic pain, yet 'face dismissal, misdiagnosis, unaffordable care, and long wait times when seeking help' (Department of Health 2025d, p 3). Respond proactively to women reporting pain.

Identify and respond to current or past family violence and trauma

Requirements include:

- Provide trauma-informed and responsive care to all consumers, recognising the high prevalence of previous trauma among people accessing mental health and wellbeing services. For example, promote autonomy, choice and supported decision making, and least restrictive approaches. See dignity and autonomy, supported decision making and least restrictive principles.
- Complete relevant training on the MARAM framework and comply with the framework's requirements (Family Safety Victoria 2018), 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.
- Comply with information sharing requirements including the requirement to not share information, even if permitted by the Act or even if the person whose information it is has agreed for the information to be shared, if you reasonably believe sharing it would place someone at risk of family violence (s 31).

Good practices may include:

- Ensure that people do not have to repeatedly talk about previous trauma to explain what is important to them. For example, ask what a person needs to feel safe and dignified and reassure them that they do not need to explain why they need those things (see also dignity and autonomy principle). Areas to explore or suggest may include:
    - telling a person about gender-sensitive areas of the unit that they could access
    - incorporating a person's responses about what helps them to be and feel safe into their care plan and also noting things to avoid
    - reassuring the person that staff want to hear, and help, if the person does not feel safe
    - if the only accommodation option is mixed-gender and this is something that feels unsafe for the person, explore community-based options, or ways to help the person feel safer in that environment.
- Understand that certain incidents, environments or practices - such as inpatient settings, compulsory treatment, and experiencing or witnessing restrictive practices - may have a different or additional impact on people based on their prior life experiences, including trauma.

Uphold sexual safety

Requirements include:

The Chief Psychiatrist's *Guideline on Improving sexual safety in mental health and wellbeing services* (Department of Health 2023d) outlines detailed actions that clinical mental health and wellbeing services must take. Other service types should use and adapt this guideline as appropriate to their setting. Some key actions from this guideline include:

- From the start of and throughout an admission, engage with consumers and, with consent, their family, carers or supporters about what will help them be and feel safe. For example, access to gender-specific services or areas, bedroom placement closer to staff, ability to lock bedroom doors, safe bathroom access, reassure that staff will respond to concerns.
- For bed-based services, ensure orientation and admission processes clearly state that sexual activity is prohibited. Services with a home-like setting such as Community Care Units (CCUs), may set their own policies but must still prohibit sexual activity if they cannot ensure it can be engaged in safely.
- If an incident is reported, observed, alleged or suspected, ensure the consumers involved are supported to be and feel safe in accordance with their needs as expressed directly, in an advance statement of preferences, or by a nominated support person or another support person.
- Support the person to exercise their rights. For example, to access sexual assault support services, make a complaint to the service or the Commission, or to make a report to Victoria Police. The consumer's consent to making a police report must always be sought. Consumers must also be advised that in some circumstances reporting may occur even without their consent (see the Chief Psychiatrist's guideline pp 27-29).
- Ensure all people receive the support, referrals and reporting responses required by the Chief Psychiatrist's guideline, regardless of views about whether the events they describe are plausible.
- Avoid minimising someone's experience based on another consumer's perceived intent or mental state (for example, when a person enters a consumer's room by mistake, or when a co-consumer gets too close to the person, or is disinhibited).
- Avoid relocating someone who reports being subjected to or witnessing sexual harassment or sexual assault to a more restrictive environment, unless they prefer this.
- Continue to support a person after an incident including revisiting external and internal supports. Clearly communicate how they can access additional supports as their needs change.
- Recognise that people with a history of trauma - including family violence, sexual violence, or other traumatic experiences - are more vulnerable to being subject to sexual harassment or assault. Some people, including women with disabilities and young people in adult units, are particularly vulnerable - see Chief Psychiatrist's guideline for more detail.

Good practice may include:

- Make improvements based on the lessons learned and resources available from Safer Care Victoria's Mental Health Improvement Program.

Tips for talking about gender safety

- Ask open, curious questions - *Is there anything you'd like us to know about you that will help us provide safe care, that meets your needs?*
- Show your support of diverse identities by consistently using pronouns, for example, by wearing badges or lanyards introducing yourself using your pronouns and asking a person what pronouns they are using, recognising that for some people identity and pronouns are fluid.
- Prioritise feeling as well as being safe - *How can we help you feel safe while you are here/during treatment?* Share strategies and options that may help, for example, lockable doors, peer support, gender-safe areas or units etc.
- Assure people that they have a right to feel and be safe, and that any concerns about safety will be heard and responded to, and let them know how to escalate any concerns.
- Consider the environment and what the person's verbal and non-verbal communication is showing when having these discussions - for example, is the environment private? Noisy/overstimulating? Restrictive? What do the person's words or body language say about whether they are feeling safe or unsafe?

6. How might **services reflect** on practice?

- How do we ask, and know, whether consumers feel safe in our service?
- How do we seek informed consent from the start of and throughout an admission, and ensure each interaction with a consumer is safe and respectful?
- How, when, and how often do we consider whether consumers have specific gender-based needs or preferences?
- How do we ask about and respond to consumers' experiences of discrimination, disadvantage, family violence and trauma?
- How do we recognise and respond to the ways gender intersects with other forms of discrimination and disadvantage?
- How do we clearly communicate information to consumers, carers, loved ones and supporters?
- How do we apply this principle to ensure equally safe and respectful interactions with family, carers and supporters?

7. **Scenario:** respecting diverse gender identity[22]

What happened?

19-year-old Jax was admitted for help with their mental health. Noticing that Jax seemed disengaged, their nurse chatted to them, checking if the service could do anything to help Jax feel comfortable and safe. Responding to their nurse's genuine care, Jax shared that they are non-binary and they had been misgendered in past experiences with other services. Jax asked the nurse to let all staff know to please use their pronouns (they/them).

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[22] Note: The scenarios in this guidance are adapted from real examples. These simple scenarios focus on the application of one principle and are intended to show that applying the principles is not always complicated. Scenarios that address the principles in more complex situations and ways are available in implementation resources on the Commission's website.

What actions did the service take?

With Jax's agreement, the nurse told the Associate Nurse Unit Manager (ANUM) about Jax's request. At that day's staff meeting, the ANUM reminded staff of the need to respect consumers' pronouns, distributing the hospital's relevant policies as a reminder. Coincidentally it was Pride Week, and plans were already in place to print posters for more visibility and to show support, and to remind staff of expected practice to check in with consumers about their pronouns.

The ANUM also suggested the peer support worker could raise a) Pride Week and b) use of pronouns in the mutual support meeting. Staff discussed that it was important to do this without drawing on Jax as an example - if Jax wished to share their identity with the group that is up to them. The aim of all the activities was to provide a supportive environment with clear expectations around respecting gender.

Jax's nurse also talked to them about strategies to make sure people respect Jax's pronouns and they agreed that a note would be put on Jax's file (nursing notes folder), stating their pronouns. Within a few days the whole floor was consistently using Jax's pronouns.

The service adapted to Jax's pronouns by following Jax's lead and offered Jax pronoun badges that they had for staff as part of Pride Week.

Reflections from Commission lived and living experience staff

Respecting Jax's identity, and showing their commitment to safety and inclusion through systemic actions, helped Jax to feel safe and be heard. Consumer engagement and therapeutic relationships are built on respecting and seeing the whole person.

The example also gave an opportunity for staff to refresh their learning about inclusive language and the gender safety principle.

Which other principles were engaged?

Mental health and wellbeing principle: dignity and autonomy

How would you approach this situation?

What might you do differently?

8. Where can I find **more information?**

Department of Families, Fairness and Housing (2023) *Our equal state: Victoria's gender equality strategy and action plan 2023-2027*

Department of Health (2023) *Improving sexual safety in mental health and wellbeing services: Chief Psychiatrist's guideline*

Department of Health (2025) *Implementing the MARAM framework in mental health and wellbeing services* - Chief Psychiatrist's guideline

Family Safety Victoria (2018) *Family Violence Multi-Agency Risk Assessment and Management Framework*

RANZCP position statement (2023) Sexual safety in mental health services in Australia and New Zealand

Royal Commission into violence, abuse, neglect and exploitation of people with disability (2023)

Resources

Safer Care Victoria - Mental Health Improvement Program Improving Sexual Safety resources https://www.safercare.vic.gov.au/best-practice-improvement/mental-health-improvement-program/initiatives/improving-sexual-safety

Zoe Belle Collective and Royal Melbourne Hospital (2021) *Transgender and gender-diverse inclusive-care guide for hospital-based healthcare professionals*

Cultural safety principle

1. What do **the Act** and relevant guidance say?

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 (s 27).

In summary, this principle requires that:

- people of all racial, ethnic, faith-based and cultural backgrounds receive culturally safe and responsive care
- treatment and care for Aboriginal and Torres Strait Islander people has regard to their unique Culture and identity (Explanatory Memorandum, Mental Health and Wellbeing Bill 2022 (Vic), p 19).

Note on this principle: The wording of this principle in the Act refers to cultural safety for people of all racial, ethnic, faith-based and cultural backgrounds, as well as specific obligations that relate to providing treatment and care to Aboriginal and Torres Strait Islander peoples. This means that there are two aspects to cultural safety for services to consider - a clear focus on what cultural safety means for First Nations peoples, as well as a universal approach that promotes cultural safety for all.

Cultural safety for First Nations peoples must never be conflated with or treated as 'part of' universal approaches. 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.

In addition to the cultural safety principle, the Act includes a statement of recognition and acknowledgment of Treaty process. The acknowledgment of Treaty process acknowledges the aspiration of Aboriginal people to achieve increased autonomy, Aboriginal decision making and control of planning, funding and administration of services for Aboriginal people, including through self-determined Aboriginal representative bodies established through treaty (s 14). Treaty negotiations opened in November 2024 and the *Statewide Treaty Bill 2025* (Vic) was passed in November 2025.

What is cultural safety?

A culturally safe environment has been defined as:

'an environment that is spiritually, socially and emotionally safe, as well as physically safe for people; where there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience of learning together' (Williams, R 1999).

Ahpra defines Cultural safety in healthcare as:

...determined by Aboriginal and Torres Strait Islander individuals, families and communities. Culturally safe practise is the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism (Australian Health Practitioner Regulation Agency 2020, p 9).

The NSQHS Standards (Australian Commission on Safety and Quality in Healthcare, 2021) also have specific requirements for services about making services responsive to diversity and specifically, safe for Aboriginal and Torres Strait Islander consumers.

Despite these requirements and efforts, many Aboriginal and Torres Strait Islander people do not experience mainstream services as culturally safe. Aboriginal and Torres Strait Islander people experience disproportionately high rates of compulsory treatment, seclusion and restraint. Putting these definitions and standards into practice requires mental health and wellbeing services and practitioners to show cultural humility in practice and systems.

2. How do **human rights** relate to this principle?

Cultural safety in mental health and wellbeing services should also include consideration of cultural rights in section 19 of the Charter. The Charter requires that:

- All persons with a particular cultural, religious, racial or linguistic background must not be denied the right, in community with other persons of that background, to enjoy their culture, to declare and practise their religion and to use their language.
- Aboriginal persons hold distinct Cultural rights and must not be denied the right, with other members of their community -
    - to enjoy their identity and Culture
    - to maintain and use their language
    - to maintain their kinship ties
    - to maintain their distinctive spiritual, material and economic relationship with the land and waters and other resources with which they have a connection under traditional laws and customs.

Other key rights in the Charter that may also require consideration include: equality (section 8); privacy (section 13(a)) which includes a right for a person not to have their family or home unlawfully or arbitrarily interfered with; the protection of families (section 17).

Other rights are also relevant to Aboriginal and Torres Strait Islander people. These include the United Nations Declaration on the Rights of Indigenous Peoples and the International Covenant on Economic, Social and Cultural Rights. Under international human rights law, everyone has the right to life, the right to enjoy the highest attainable standard of physical and mental health without discrimination, and is protected from torture, cruel, inhuman or degrading treatment or punishment.

Related mental health and wellbeing principles include:	Related decision making principles include:
Wellbeing of dependents Wellbeing of young people Least restrictive Supported decision making Family and carers Diversity	Consequences of compulsory assessment and treatment and restrictive interventions Autonomy

3. How might a **consumer** experience this principle?

When the cultural safety principle is applied in practice:

- I am asked about what social and emotional wellbeing means to me - including physical and mental health, spirituality and connection to community and Country - early in my care, and this shapes my treatment and support.
- I have access to culturally safe spaces and practices during my care - such as prayer rooms, space for ceremony (for example, healing ceremonies or for breaking a fast), or time for cultural obligations like Sorry Business - without needing to constantly explain or justify.
- I am offered support from workers who understand my culture or background, and can choose to involve them in my care.
- I feel confident that racism or cultural discrimination will not be tolerated at this service, and I know where and how I can report it safely if it occurs.
- The people I identify as important including family, kin, community members, or spiritual leaders are welcomed and respected as part of my care if I want them involved.
- When I raise concerns about cultural safety, they are taken seriously, and I see that actions are followed up to address those concerns.
- I see visible signs that my culture is welcomed in this service like inclusive posters, flags, staff with cultural knowledge, and cultural events being recognised and celebrated.
- As an Aboriginal or Torres Strait Islander person, I can access care that reflects my holistic view of wellbeing, and involves Elders, traditional healers, and community workers as part of my healing, if I choose.

4. How might **carers, families and supporters** experience this principle?

When the cultural safety principle is applied in practice:

- I can see how holistic and culturally appropriate treatment options and care are offered to the person I care for, and to myself and kin.
- I feel confident that the cultural identity, values and beliefs of the person I care for are respected and embedded in their treatment and care.
- I am confident that staff work in a culturally safe and trauma informed manner when supporting the person I care for.
- I am supported to express and advocate for the cultural, spiritual or community-based needs of the person I care for, and I am heard without judgment.
- I experience services as inclusive and free from racism, and I can access culturally safe support for myself as a carer, including from workers who understand my cultural background.
- I have increased understanding of cultural safety and how it affects the mental health and wellbeing of the person I support, and I feel safe to work with services to uphold these standards.
- I can see that services are actively working to avoid culturally unsafe interventions such as police contact, institutionalisation, or restrictive practices.

5. How do **treating teams** put this principle into practice?

This section gives an overview of requirements and good practice suggestions for putting the cultural safety principle into practice. As noted earlier in this guidance, the dignity and autonomy and supported decision making principles must always be considered.

To ensure that the unique rights of Aboriginal and Torres Strait Islander peoples are not conflated with other rights, this guidance is separated into two parts.

Part A of this section is specifically about Cultural safety for Aboriginal and Torres Strait Islander peoples. Services must have specific strategies for driving Culturally safe approaches for Aboriginal people, developed by or in codesign with Aboriginal and Torres Strait Islander peoples. Action areas include:

- Social and emotional wellbeing
- Learn from and work together with Aboriginal workforce and organisations
- Acknowledge and actively address the impacts of racism and discrimination
- Ensure treatment and care for Aboriginal and Torres Strait Islander people is responsive to their unique Culture and identity

Part B includes general guidance about how to:

- Create a welcoming environment, and actively ask about and respond to identity
- Actively ask about culture, and respect cultural and spiritual beliefs and practices
- Involve family and significant members of a person's community

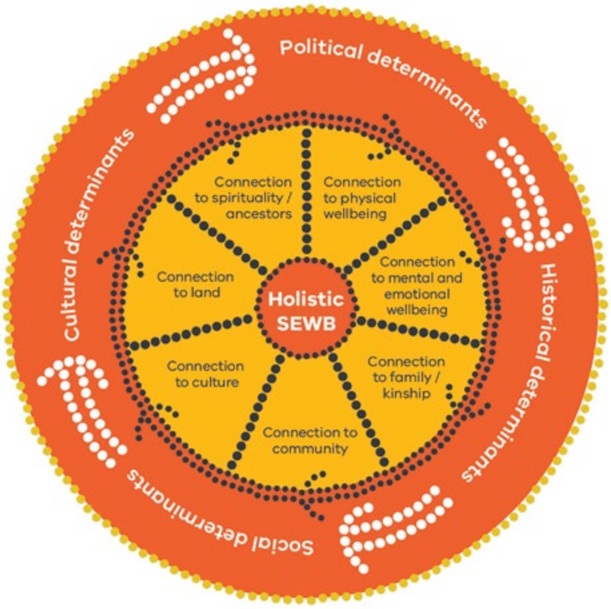
Part A: Cultural safety for Aboriginal and Torres Strait Islander people

Social and emotional wellbeing

The Aboriginal concept of ‘healing’ is an inclusive term that enables mental health to be recognised as part of a holistic and interconnected Aboriginal view of health. The concept of healing embraces social, emotional, physical, cultural, and spiritual dimensions of health and wellbeing (VACCHO website, Centre of Excellence for Aboriginal Social and Emotional Wellbeing - VACCHO, accessed 3 September 2025). The social and emotional wellbeing model represents holistic healing and includes protective factors that support good mental health for Aboriginal Communities.

Figure 3: Social and emotional wellbeing model.

Source: Department of Health and Human Services 2017 *Balit Murrup.*



Good practice requires services to understand and incorporate this framework into practice, working in partnership with Aboriginal consumers, carers and families, workforce, ACCHOs and Aboriginal Community Controlled Organisations (ACCOs).

Learn from and work together with Aboriginal workforce and organisations

Requirements include:

- Engage with Aboriginal and Torres Strait Islander mental health workers and Aboriginal Health Liaison Officers within your service to support culturally safe treatment and care, and give meaningful regard to their views. Note that there may be a range of titles in different services - also including Koorie Mental Health Officers, SEWB workers - as well as Aboriginal self-identified clinicians - staff who are not in designated roles but have identified as willing to contribute to specific responses for Aboriginal consumers, carers and families.
- Be aware of and engage with ACCHOs to ensure First Nations consumers have clear pathways to community-controlled health services (see also diversity of care principle), if they prefer. For example, strengthen relationships with ACCHOs to ensure their staff are welcome and supported to attend services to support consumers, carers and families.
- Take practical steps to recognise and welcome Aboriginal communities, for example, with formal Acknowledgement of Traditional Owners (such as a plaque or sign), posters, artwork and culturally appropriate pamphlets and health information for Aboriginal consumers.

Acknowledge and actively address the impacts of racism and discrimination

Requirements include:

- Be aware of the impact of colonisation, including ongoing practices, that are real barriers to Aboriginal consumers, carers and families being and feeling culturally safe within mainstream services. For example, within the mental health and wellbeing system, the higher rates of compulsory treatment and restrictive practices experienced by Aboriginal people (VMIAC 2022), and outside of the mental health and wellbeing system, the impact of Aboriginal deaths in custody, incarceration rates, and high rates of removal of Aboriginal children from their families, means there are real risks for Aboriginal people when interacting with mainstream services.
- Recognise and advocate against systemic barriers, including colonisation, racism and discrimination which impact individual and community health (Ahpra 2020, p 9).

- Acknowledge and address one's own biases, assumptions, stereotypes and prejudices and provide care that is holistic, free of bias and racism (Ahpra 2020, p 9). For example, be mindful of differing cultural norms such as norms about eye contact or handshaking.

Ensure treatment and care for Aboriginal and Torres Strait Islander people is responsive to their unique Culture and identity

Requirements include:

- Involve the people that the consumer and (with consent) their family, carers and supporters identify as important in their lives or in their treatment, including Elders, and Aboriginal workforce.
- Promote self-determined decision making. For example, ask what is important to the consumer and their carer, family, supporters and kin and how you can support them to follow their cultural and spiritual beliefs and practices, and support their social and emotional wellbeing while they are receiving treatment. This includes:
    - prioritising treatment options that the person identifies would best support their social and emotional wellbeing
    - offering options like engagement with Traditional Healers (see also diversity of care)
    - explaining the role of IMHA advocates and letting the person know they can ask for a First Nations IMHA advocate
    - ensuring 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, leave from inpatient units, make space for ceremony (such as, healing ceremonies).
    - asking about a consumer's preferences for engaging with ACCHOs - including health or legal services including the Victorian Aboriginal Legal Service.

Good practices may include:

- Recognise the strength and resilience of First Nations consumers and their carers, families, supporters and kin
- If doing outreach activities, use informal engagement like yarning circles, or sharing a meal
- Be aware of and support access to the Closing the Gap (CTG) Pharmaceutical Benefits Scheme (PBS) co-payment program where applicable, which provides reduced or free medications to eligible First Nations people in some circumstances.
- Encourage Aboriginal consumers to access culturally appropriate services including the Yarning safe and strong helpline.

Part B: Providing culturally safe services for all

Create a welcoming environment, and actively ask about and respond to identity

Requirements include:

See section 5 of Part One of this guidance, and the associated leadership self-assessment checklist, for leadership actions that help to ensure cultural safety for everyone. For example, actions about:

- staff training on cultural safety, responsiveness and/or humility
- understanding the diversity of your local community and tailoring approaches to ensure they are culturally safe and responsive - for example, by building relationships with key cultural and religious organisations
- seeking to employ staff that reflect that diversity, including in designated positions
- using signage, flags, translated materials, artwork, and inclusive symbols
- recognising significant days, weeks and events.

In addition, consider actions in the diversity principle that relate to creating a safe and welcoming environment. Be aware of the impact of people's individual circumstances and identity on their feelings of safety in any environment - for example, people holding temporary visas may be fearful that a diagnosis or treatment for mental illness may impact on their visa status and ability to stay in Australia.

Actively ask about culture, and respect cultural and spiritual beliefs and practices

Requirements include:

- Recognise and respect diverse understandings of mental health and illness, and work with consumers, carers, families, supporters and kin in ways that align with their understandings. For example, be aware that:
  - hearing voices can have spiritual meaning, and may not be seen as a symptom that needs to be 'managed'. The person and their family may wish to involve spiritual or faith leaders in their treatment and care.
  - many cultures have stigmatising beliefs about mental illness, that can impact help-seeking and engagement (Ahad et al 2023).
  - In some cultures, mental illness is not only stigmatised but may also be experienced as a source of shame within family circles, making privacy and confidentiality particularly important. Careful communication and consent processes can help families gradually adjust, understand, and move toward acceptance, while still respecting the consumer's wishes.
- Sensitively and respectfully ask about ethnicity, faith and culture at intake, during assessment and throughout an episode of care. Seek to understand how an individual's identity shapes their health beliefs, values and preferences (adapted from So et al 2024). For example, ask:
  - what is important to the consumer and their carer, family, supporters and kin - for example, spirituality, faith, religious requirements
  - how you can support a consumer to follow their cultural and spiritual beliefs and practices while receiving treatment - for example, access to prayer rooms, dietary requirements, making space for ceremony such as breaking a fast
  - what a consumer needs to feel and be safe - for example, being able to request to be seen by staff of a particular gender for personal care or review.
- Promote self-determined decision making, by working collaboratively with consumers, carers, families, supporters, and kin. Be guided by the consumer about who they would like involved in their care. See supported decision making principle.
- 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 officers to navigate conversations, and involve carers, families and community leaders to help to find solutions that preserve dignity, respect culture, and promote safety.

Involve family and significant members of a person's community

- Be guided by the person about who they would like to involve in their treatment and care. As well as carers, family, and nominated support persons, this may include kin or significant members of the person's community such as extended family, community leaders, or faith leaders.

Tips for talking about cultural safety

- Always ask about a person's identity and culture - *Is there anything you'd like me to know about you or your family, that would help you feel safe and welcome or that we should know so that we can meet your needs?*
- Encourage people to share what they think is important you know about them - *Can you tell me about the things that matter to you?*
- Always affirm what a person tells you about their identity
- Consider the environment and what the person's verbal and non-verbal communication is showing when having these discussions - for example, is the environment private? Noisy/overstimulating? Restrictive? What do the person's words or body language say about whether they are feeling safe or unsafe?

6. How might **services reflect** on practice?

- How do we consistently ask about a person's culture, faith and ethnicity, in ways that help them feel safe and supported to respond?
- How do we show respect for people's cultural and spiritual beliefs and practices, and adapt our treatment approaches to reflect them? How do we involve bi-cultural workforce or support consumers to involve important people from their community?
- How do we show responsiveness to First Nations consumers' connections to family, kinship, community, Country and waters?
- How do we involve families, kin, and community - including Elders, Traditional Healers and Aboriginal and Torres Strait Islander mental health workers, in care and treatment?
- How do we strengthen and build on relationships with SEWB workers and ACCHOs?

7. Scenario: connection to Mob[23]

What happened?

Hayden, a young Aboriginal man, was very withdrawn and isolated himself in his room. Staff had struggled to build rapport with him despite trying to engage him in discussions about what he needed. Staff had asked Hayden at admission whether he was Aboriginal or Torres Strait Islander, but Hayden had not felt safe to answer.

What actions did the service take?

The peer support worker spoke with Hayden, who shared that he felt ashamed, and far away from his mob and country. The peer support worker told Hayden that the service had a dedicated Aboriginal Mental Health Liaison Officer, who is a woman, as well as a general Aboriginal Health Liaison Officer, who is a man. Hayden said he would prefer to speak with the male Aboriginal Liaison Officer, who then visited him daily. Speaking with people who deeply understood his cultural needs helped Hayden to feel safe, supported and able to leave his room and talk with staff and other consumers. This also helped Hayden and staff to start discussing what he needed so that his care could better reflect his preferences. For example, they explored whether Hayden would like to start connecting with the local ACCHO while in hospital, to work in partnership and ensure a smooth transition to post-discharge support.

Reflections from Commission lived and living experience staff

The peer worker was alert to Hayden's need to feel connected to Culture, and responded quickly. The Aboriginal Liaison Officer was able to support Hayden to feel safe, respected and connected. When he felt safe, he was able to share what was happening with his mental health, which helped staff to start meeting his needs.

Which other principles were engaged?

Mental health and wellbeing principles: dignity and autonomy, supported decision making

How would you approach this situation?

What might you do differently?

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[23] Note: The scenarios in this guidance are adapted from real examples. These simple scenarios focus on the application of one principle and are intended to show that applying the principles is not always complicated. Scenarios that address the principles in more complex situations and ways are available in implementation resources on the Commission's website.

8. Where can I find **more information?**

There are several frameworks that can guide mental health and wellbeing services in giving proper consideration to and making reasonable efforts to comply with this principle.

Department of Health and Human Services (2017a) *Balit Murrup: Aboriginal social emotional wellbeing framework 2017-2027* https://www.health.vic.gov.au/publications/balit-murrup-aboriginal-social-emotional-wellbeing-framework-2017-2027

Department of Health and Human Services (2017b) *Korin Korin Balit-Djak: Aboriginal health, wellbeing and safety strategic plan 2017-2027* https://www.dffh.vic.gov.au/sites/default/files/documents/202302/korin-korin-balit-djak.pdf

Department of Health and Human Services (2020) *Aboriginal and Torres Strait Islander Cultural safety framework* https://www.health.vic.gov.au/publications/aboriginal-and-torres-strait-islander-cultural-safety-framework-part-1

Further reading includes:

Australian Health Practitioner Regulation Agency (2020) *The National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025* https://nacchocommunique.com/wp-content/uploads/2020/02/aboriginal-and-torres-strait-islander-cultural-health-and-safety-strategy-2020-2025-1.pdf

Lee, T.; Mckenna, R.; Morseau, G.; Bacon, A.; Baguley, K.; Cowdrey-Fong, S.; Bertakis, A.; Shorey, T.; Mckenna, V.; Kitchener, E.; Meteoro N. (2024) *Aboriginal and Torres Strait Islander Lived Experience-led Peer Workforce Guide: A Learning Tool for All Peer Workers and Organisations*

Commission for Children and Young People (2024) *Understanding cultural safety for Aboriginal children and young people: a guide for implementing Child Safe Standard 1* https://ccyp.vic.gov.au/assets/resources/New-CSS/Understanding-cultural-safety-CSS1-guide.pdf

Edwige, V and Gray, P (2021) *Significance of Culture to Wellbeing, Healing and Rehabilitation* https://indigenouspsyched.org.au/resource/significance-of-culture-to-wellbeing-healing-and-rehabilitation/

Lowitja Institute (2025) *Co-design Versus Faux-design of Aboriginal and Torres Strait Islander Health Policy: A Critical Review* https://www.lowitja.org.au/wp-content/uploads/2025/06/Lowitija-Institute-Co-design-Review.pdf

So, N, et al (2024) *The importance of cultural humility and cultural safety in health care* Med J Aust 2024; 220 (1): 12-13. https://www.mja.com.au/journal/2024/220/1/importance-cultural-humility-and-cultural-safety-health-care

Victorian Aboriginal Community Controlled Health Organisation (2020), *Balit Durn Durn: Strong brain, mind, intellect and sense of self, Report to the Royal Commission into Victoria's Mental Health System*

Victorian Aboriginal Legal Service (2021), *Submission on Current Proposals for the new Mental Health and Wellbeing Act* https://www.vals.org.au/wp-content/uploads/2022/02/Mental-Health-and-Wellbeing-Act-Consultation-VALS-Submission-August-2021.pdf

Victorian Aboriginal Legal Service (2024) *Nuther-mooyoop to the Yoorrook Justice Commission: Health, Social and Emotional Wellbeing (SEWB) and the Healthcare System*

Williams, R. (1999), *Cultural safety - what does it mean for our work practice?*. Australian and New Zealand Journal of Public Health, 23: 213-214. https://www.sciencedirect.com/science/article/pii/S1326020023025840?via%3Dihub

Yoorook Justice Commission (2025) *Yoorrook for Transformation Third Interim Report Volume 4* https://www.yoorrook.org.au/reports-and-recommendations/reports/yoorrook-for-transformation-third-interim-report-volume-4

Resources include:

Department of Health, Disability and Ageing *Pharmaceutical Benefits Scheme Closing the Gap PBS Co-payment program* https://www.pbs.gov.au/info/publication/factsheets/closing-the-gap-pbs-co-payment-measure

Lowitja Institute Library - https://www.lowitja.org.au/resources/

Victorian Aboriginal Health Service *Yarning safe n strong helpline* https://www.vahs.org.au/yarning-safe-n-strong-media/

Wellbeing of dependents principle

1. What do **the Act** and relevant guidance say?

The needs, wellbeing and safety of children, young people and other dependents of people receiving mental health and wellbeing services are to be protected (s 28).

This principle recognises that the unique needs of children, young people and other dependants of people receiving mental health and wellbeing services, and require[s] that their wellbeing and safety be protected. The wellbeing of dependents may sometimes be in tension with the views or preferences off a person receiving mental health and wellbeing services (Explanatory Memorandum, Mental Health and Wellbeing Bill 2022 (Vic), p 26).

Parental mental health can impact dependent children in a range of ways. However, when parents are well supported, and children have broader family and social supports in place, the impact of parental mental illness can be minimised (Wade, C (2020) via Emerging minds).

Promoting and protecting the wellbeing of dependents is an important part of recovery oriented, person-centred care. All staff involved in providing care have a role to play in identifying dependents, and their relationship with the consumer, recording relevant information, and taking appropriate steps to ensure their needs, wellbeing and safety are protected.

The Chief Psychiatrist's *Working together with families and carers guideline* (Department of Health and Human Services, 2018c) offers detailed advice to services about the actions needed at both a practice and service level. Following relevant Chief Psychiatrist guidance, and demonstrating compliance and continuous improvement, is one way services can show proper consideration of the wellbeing of dependents principle.

2. How do **human rights** relate to this principle?

The Charter recognises the right Victorians have to the 'protection of families and children' (section 17). As is the case with the families and carers principle, when the wellbeing of dependents principle applies, this right to the protection of families and children will also be relevant.

Other relevant rights under the Charter include the right not to have a person's privacy, family, home or correspondence arbitrarily interfered with (section 13(1)) and cultural rights particularly in relation to the maintaining of kinship ties (section 19(2)(c)).

Related mental health and wellbeing principles include:	Related decision making principles include:
Supported decision making Families and carers Cultural safety	Consequences of compulsory assessment and treatment and restrictive interventions Autonomy

3. How might a **consumer** experience this principle?

As a parent or carer receiving mental health and wellbeing services, when the needs, wellbeing and safety of my children, young people or other dependents are protected:

- I am given access to parenting supports to be the best parent or carer I can be while receiving the mental health care I need.
- My role as a parent or carer is recognised, respected and considered in all aspects of my care planning. I am supported to preserve and strengthen my relationships with my children or dependents including through referrals and access to parenting supports and family services that help me in my caring role.
- I feel confident that staff understand the importance of protecting my children's wellbeing while respecting my rights as a parent.
- I am asked about the people I care for and feel safe and supported in sharing this information.
- My preferences about who supports my children or dependents, including those in my advance statement of preferences, are heard and considered.
- I am supported to stay connected with my children or dependents while I receive treatment, in ways that matter to me.

- I am offered information, tools and support to help me explain mental health challenges to my children in age-appropriate ways.
- If my child or dependent is also my carer, they are supported in their role and their wellbeing is looked after too.
- I am involved early in planning to ensure my children or dependents are supported and continue to receive the care and attention they need if I am temporarily unable to look after them.

4a. What may this principle mean for **carers, families and supporters**?

As a supporter of a person who is a parent or carer, when the needs, wellbeing and safety of their children, young people or other dependents are protected:

- I feel reassured that the service understands how mental health challenges can affect children and other people who rely on their parent or carer.
- I am encouraged to share any concerns I have about a child, young person or dependent's wellbeing, and I feel listened to.
- I am included in conversations about supporting children or dependents, in a way that respects everyone involved.
- I know that the service can help children, young people and dependents get the right support if they're affected by what's happening in the family.
- I am supported to play a positive role in helping keep family routines and relationships steady when things are tough.
- If I am a child or young person who is also a carer, I am supported in both of those roles in ways that are appropriate for my age and development.

4b. What does this principle mean for a **child, young person or dependent**?

As a child, young person or dependent, when my needs, wellbeing and safety are protected:

- I know there is a clear plan for who will look after me and how my daily life will stay as normal as possible, if my parent or carer is unwell.
- I receive age-appropriate information to help me understand what is happening, as well as information about things that might help me.
- I am supported to stay connected with my parent or carer if they are in hospital. There are appropriate child-friendly spaces in the hospital where I feel safe and welcome if I visit.
- I know how and where to ask for help, if I need it or if I am worried about my parent or carer.

5. How do **treating teams** put this principle into practice?

This section gives an overview of requirements and good practice suggestions for putting the wellbeing of dependents principle into practice. As noted earlier in this guidance, the dignity and autonomy and supported decision making principles must always be considered.

Explore the key topics covered in this section:

- Identify and record information about dependents, including young carers, as early as possible
- Ensure children, young people and dependents are safe including by cocreating and embedding plans for their wellbeing into discharge, crisis, and relapse plans
- Give information, support and referrals to children, young people and dependents - including young carers

Identify and record information about dependents, including young carers, as early as possible

Requirements include:

- At first contact, ask consumers carefully and sensitively about their lives and family connections, including any parenting or caring role, and the wellbeing and needs of children and dependents (Department of Health and Human Services (2018c), p 10). Review this regularly. If the consumer is too unwell or distressed to give information, check with a family member, carer, or nominated support person in the first instance, and revisit with the consumer when possible.
- 📖 Record information about dependents on CMI/ODS (or equivalent system), including names, date of birth, custody arrangements, and any other critical information, alerts or risks (for example, family violence intervention orders) and take reasonable steps to check that the information is still current (for example, checking at regular points) (s 726 accuracy of information principle).
- Identify children, young people and dependents who care for and support the consumer. Recognise that they may have key support responsibilities and be knowledgeable about the consumer's treatment and history. Where the consumer has consented to their involvement, be equipped to have conversations with them in ways that align with their preferences and capacity (Department of Health and Human Services (2018c), p 11).

Good practices may include:

- Where possible, offer a range of ways for people to talk about their lives and responsibilities. For example, involve peer support or any staff the consumer feels most comfortable speaking to.

Ensure children, young people and dependents are safe including by cocreating and embedding plans for their wellbeing into discharge, crisis, and relapse plans

Requirements include:

- 📖 Take all reasonable steps to check if a person has an advance statement of preferences and make all reasonable efforts to follow preferences about the care of their dependents if the consumer is unable to care for them. This could include supporting the consumer to contact the preferred caregiver, or making contact on their behalf if needed, and supporting the consumer to identify and contact other preferred caregivers if they are unavailable.
- With the consent of the consumer, work with the consumer and their family, carer and supporters to identify and help them access services and supports that will help them to maintain their caring role and to meet the needs of their children or other dependents.
- Clearly explain confidentiality and its limitations to consumers, families, carers and supporters - for example, explaining mandatory reporting requirements.
- Be aware of and comply with the requirements of the Child Safe Standards (Commission for Children and Young People, 2023). For example:
  - Be alert to common indicators that children are experiencing harm (Commission for Children and Young People 2023, pp 15-16), such as changes in behaviour, school engagement, emotional wellbeing, or physical health.
  - Where there are concerns for a child or young person's immediate safety or wellbeing, follow reporting requirements including involving Child Protection as indicated.
- Share information in accordance with the Child Information Sharing Scheme (CISS) requirements and other relevant legislation to promote the safety and wellbeing of children and young people. Where safe, appropriate and reasonable to do so, seek the views of the child or young person and family members (including the consumer) who do not pose a risk to the child, about sharing the information.
- Support the right of inpatients to communicate with their children or dependents, in line with their preferences. For example, through visits, phone calls or video calls, emails and letters.

Good practices may include:

- Support parents and caregivers to maintain connection with their children or dependents during treatment, using approaches such as video calls, letters or shared online activities when in-person visits aren't possible.
- Support open, ongoing conversations between parents and their children about mental health and wellbeing, tailored to the child's age and needs.
- Involve multidisciplinary staff in the consumer's treatment planning, for example, Families where a Parent has a Mental Illness (FaPMI) staff, allied health, lived and living experience workforce.

- Regularly discuss the consumer's parenting and caregiving role as part of assessment and treatment planning. This might include:
  - asking the consumer how they experience parenting
  - jointly identifying and building on existing strengths and supports
  - discussing and making referrals including to parenting support programs, family or community support services
  - anticipating when episodes of illness may occur, developing a family crisis or care plan that may include working with family members, carers and community services, and documenting preferences for who will care for or support their dependents if they are unable to do so, and how the consumer would like to maintain connection to their dependents and their caring role during times of illness
  - encouraging the consumer to include cultural or other needs, and discuss how planning can ensure these needs are met (see cultural safety principle)
  - discussing and making referrals to family violence supports (for example, The Orange Door) - see also gender safety principle.
- Encourage and support consumers with dependents to document their preferences in an advance statement of preferences.
- Use available care plan templates (see 'Where can I find more information?') to prompt thinking about the specific and diverse needs and experiences of dependents (including those based on their age and developmental stage), and the information, resources, networks and supports that may be available.
- Give information resources to consumers and offer support and advice to the consumer, family, carer or supporters about how to talk with children or dependents about mental illness in a way that is safe, supportive and developmentally appropriate.
- Identify the needs of expectant parents and check whether they feel they have adequate support to prepare them for parenting. Connect consumers with relevant maternity/maternal and child health services if needed.

Give information, support and referrals to children, young people and dependents - including young carers

Requirements include:

- Where children or young people have a caring role, recognise and involve them as a carer in decisions about the consumer's assessment, treatment and recovery as required by the Act - in line with their preferences, developmental stage and the consumer's preferences. See family and carers principle.
- Make timely referrals, and follow-up where needed, to connect children, young people and other dependents with services that can support their diverse experiences and needs. For example, 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.

Good practices may include:

- Support young carers to access resources or services they may need for their own wellbeing. This may include connecting young carers with a Child and Young Person's Worker via the Families where a Parent has Mental Illness (FaPMI) program. Child and Young Person's Workers can identify support needs and referral options, strengthen existing support networks and help young carers to access further supports, give information and referrals including to peer support, and help with access to financial support and access to transport.
- 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.
- Draw on advice from the lived and living experience workforce and child/family support workers about inclusive and developmentally appropriate engagement.

Tips for talking about the wellbeing of dependents

- Ask consumers, carers, families, supporters and dependents:
  - what has helped in the past
  - what would help now, including what helps dependents to feel supported, safe and secure
  - what is important to maintain in their family's normal routines, relationships or activities and
  - how they wish to stay connected during an admission.
- Where appropriate, invite dependents (who may also provide care or support to others) to share what they need to feel safe, supported and included.
- Explain the supports available (for example, parenting supports or services, supports for children of parents with a mental illness).
- Show interest in the consumer's parenting or caregiving role, and the people they care for: *Can you tell me a bit about who you care for or who depends on you? How are things going for them?*
- Reassure parents and caregivers that you are there to support them in maintaining their caring role.
- Be aware that consumers may hesitate to share their parenting or caring needs due to concerns about child protection involvement. Acknowledge these fears and be open and clear about any reporting requirements and the reasons for them.
- Ask consumers who they would like to be involved in caring for their dependents, and if they have or would like to make an advance statement of preferences including these wishes.
- Involve the consumer's family, carers, and supporters and seek their perspectives - for example, on the family's routines, strengths, ways to support the wellbeing of dependents or any safety concerns. *What helps the child/young person/dependent to cope, and how can we support them? Do you have any worries about their wellbeing or safety?*

6. How might **services reflect** on practice?

- How do we identify whether consumers have children or other dependents?
- How do we respond to any safety needs or other immediate needs?
- How do we ensure we safely and sensitively explore and meet dependents' diverse ongoing needs?
- How do we make sure that supports are available to consumers' children and/or other dependents?
- How do we identify whether dependents may also be young carers, and talk to them about what supports they may find helpful?

7. **Scenario:** supporting parents to protect their child's wellbeing[24]

What happened?

Jack, a young dad, needed to be admitted for inpatient care. He was very worried that his son Blake, who was in grade 1, would not understand what was happening.

What actions did the service take?

The treating team asked Jack if he would like to meet with a FaPMI worker, who could help to explain what was happening in an age-appropriate way to Blake. The service brought Jack, his partner Lily (Blake's mother), and Blake together to explain what was happening. The service was also able to help the family plan for what would happen while Jack was in hospital - for example, helping them to develop a roster of extended family to support school drop offs and pickups, planning for how Jack and Blake would be able to talk on the phone or Facetime, and for Blake to visit Jack in hospital.

The service explained that, if Jack and Lily wanted their help, they could also help them to talk to Blake's school about what was happening, or give Lily a carer's certificate if she needed to visit the hospital during work hours.

Reflections from Commission lived and living experience staff

Jack's concern for Blake was increasing his stress around being admitted. Having help from the service to make sure he understood what was happening and that he felt well-supported despite the disruption to his daily routine not only helped Blake, it helped Jack to feel positive about having the treatment he needed.

Which other principles were engaged?

Mental health and wellbeing principles: families and carers, diversity of care, dignity and autonomy

How would you approach this situation?

What might you do differently?

8. Where can I find **more information?**

Commission for Children and Young People (2023) *A guide for creating a child safe organisation* https://ccyp.vic.gov.au/assets/resources/New-CSS/A-guide-for-creating-a-Child-Safe-Organisation-27.04.23.pdf

Department of Health and Human Services (2018c) *Working together with families and carers: Chief Psychiatrist's guideline* https://www.health.vic.gov.au/chief-psychiatrist/working-together-with-families-and-carers

Websites:

Emerging Minds https://emergingminds.com.au/

https://www.latrobe.edu.au/research/centres/health/bouverie/practitioners/specialist-areas/fapmiprogram https://www.latrobe.edu.au/research/centres/health/bouverie/practitioners/specialist-areas/fapmi

Children of Parents with Mental Illness - Pathways of care resource https://www.copmi.net.au/resources/pathways-of-care-resource/

Satellite Foundation https://www.satellitefoundation.org.au/

Little Dreamers Wellbeing Hub https://www.littledreamers.org.au/programs/dreamers-hub/

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[24] Note: The scenarios in this guidance are adapted from real examples. These simple scenarios focus on the application of one principle and are intended to show that applying the principles is not always complicated. Scenarios that address the principles in more complex situations and ways are available in implementation resources on the Commission's website.

Part Three: Supporting services to comply with the principles

The Commission is committed to working with consumers, carers, families, supporters and kin, and mental health and wellbeing service providers to support services put the principles into practice.

This includes developing a suite of implementation resources that support mental health service providers to put the principles into practice, available on the Commission's website. We will also support services by:

- promoting discussion and understanding about the principles and what it means to give proper consideration and make all reasonable efforts to comply with them, to build a shared understanding between the Commission, mental health and wellbeing service providers, consumers, carers, families, supporters and kin.
- promoting good practices where we see them, to encourage cross-service learning.
- taking appropriate action - which may range from education and support to compliance action - if we are satisfied that mental health and wellbeing service providers have not made reasonable efforts to comply with the principles.

Complaints and our compliance approach

We manage all complaints through the lens of compliance with the Act and its principles, including whether a service has made reasonable efforts to comply with the principles. This applies regardless of the complaint resolution approach used, from informal (early) resolution through to our most formal process, investigation, and when considering compliance action including requesting an undertaking or issuing a compliance notice.

As stated in *Our approach to complaint handling and compliance monitoring* (Mental Health and Wellbeing Commission 2024b, p 1), we use complaint processes that educate services and empower consumers, families, carers and supporters about their rights, with a particular focus on elevating the principles within the Act. We also welcome requests from services seeking education or discussions about the Commission's complaint process, including how we apply the principles.

Applying the principles in early resolution

In early resolution, which we generally use where a complaint does not raise significant concerns of safety or quality, our approach may include:

- identifying which principles apply to the complaint
- asking the service provider to explain how they considered the principles in relation to the issues raised
- providing education, support and suggestions to the service and discussing improvements that could arise from the complaint with the complainant, consumer and service. This may include individual improvements such as changes to better respond to a person's treatment preferences, or systemic improvements such as training or changes to policies, processes, or environment.

Applying the principles in formal resolution and investigations

Where a complaint is unable to be resolved in early resolution or the concerns raise significant concerns of safety or quality, we use the above approaches and may also use more formal processes including:

- Formal resolution (detailed review) - this involves reviewing the complaint in detail including requesting documents and information from the service. A detailed review may result in an Improvement Advice, or a suggestion that the service provide an undertaking to take remedial action to address the concerns identified in the complaint.
- Investigation - an investigation is a formal, detailed and resource-intense examination, often used for large or highly complex matters and may take over a year to complete. In investigations, the Commission makes findings about issues of quality and safety. In most cases recommendations are provided to the relevant mental health and wellbeing service provider, and may also be made to other bodies such as the Department of Health, Chief Psychiatrist or the Chief Officer for Mental Health and Wellbeing.[25]
- We may also suggest the service offer an undertaking or may issue a compliance notice if satisfied there has been a contravention of the Act, including the principles, or regulations.

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[25] See s 415(w) for a list of who the Commission may make recommendations to.

When can a compliance notice be issued?

The Act limits the circumstances in which the Commission can issue a compliance notice. Compliance notices can only be issued in three situations (s502):

1. Where a service provider has given the Commission an undertaking, and has failed to comply with it.
2. Where the Commission has conducted an investigation or a follow up investigation, and is satisfied that the service provider has contravened the Act or regulations.
3. Where the service provider acknowledges it has contravened the Act or regulations and has not given the Commission an undertaking.

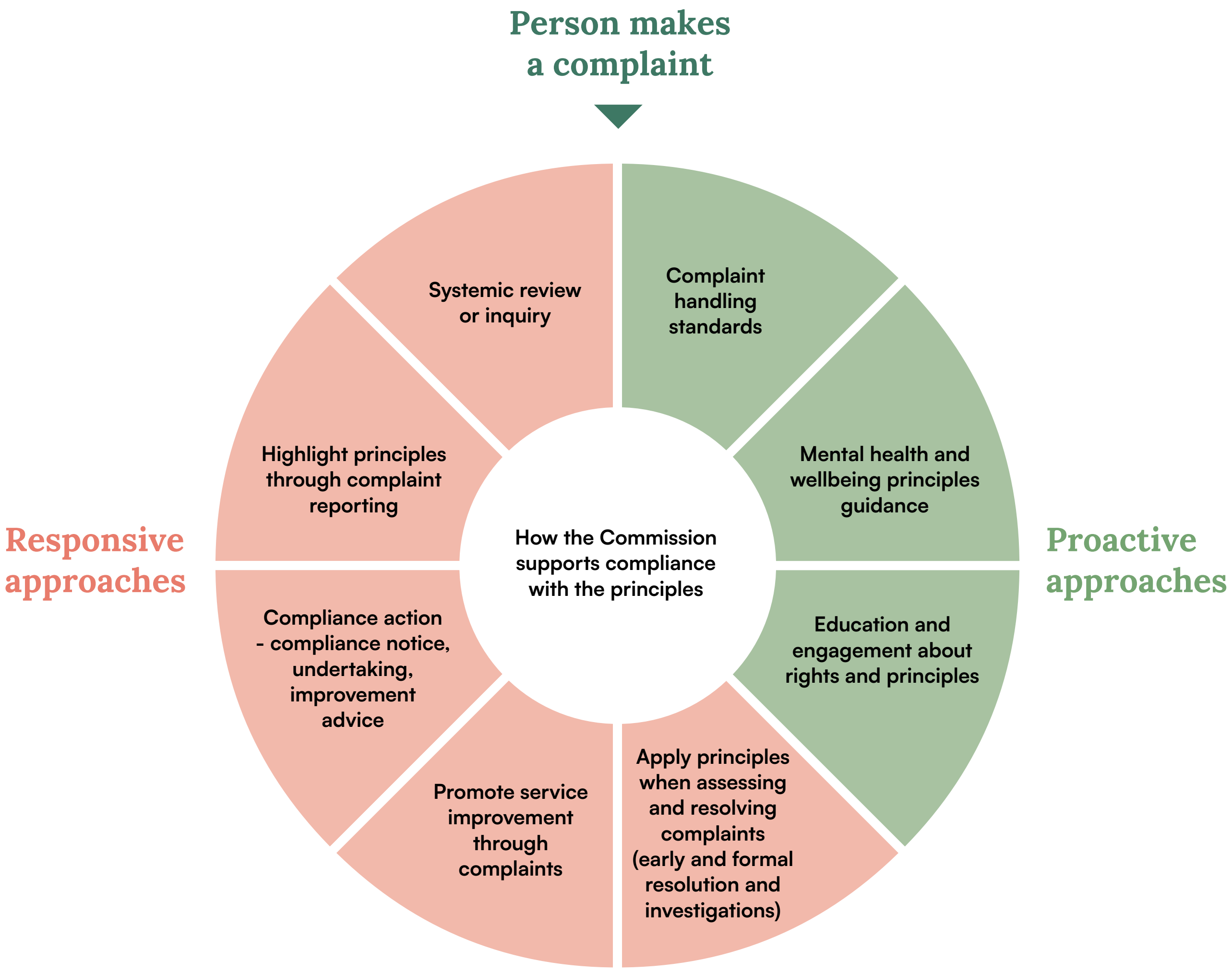
Compliance notices will only be issued for **clear and serious contraventions of the Act or regulations** if it is appropriate in all the circumstances of the complaint. When assessing this, the Commission will consider a range of criteria, including, but not limited to, the following:

- the contravention is clear and relates to specific breaches of the Act or regulations
- the seriousness of the contravention
- the contravention can adequately be rectified through issuing a compliance notice
- the matter relates to significant issues regarding the safety and rights of an individual as defined by the Act
- that previous investigations and formal reviews highlight that the matter relates to the same or similar issues of noncompliance and no reasonable attempts by the service to improve or mitigate the concerns have been demonstrated.
- the approach of the service demonstrates an unwillingness toward the need to improve or comply, including, but not limited to, demonstration of deliberate defiance of the Act or the recommendations of the Commission, or unwillingness to offer an undertaking.

Not all these criteria are necessary to decide to issue a compliance notice and the Commission will consider all the facts relevant in each circumstance.

Figure 4 is a visual representation of the approaches the Commission uses to support compliance with the principles. This includes proactive approaches such as issuing this guidance, developing complaint handling standards, and providing education and engagement about rights and principles. It also includes responsive approaches, which focus on how we hold services accountable for complying with the principles.

Figure 4: Supporting compliance with the principles



Complaint handling standards

The Commission is currently preparing complaint handling standards in accordance with our function under s 415(o) of the Act. The standards will align with this guidance and relevant national standards. Mental health and wellbeing service providers will be required to ensure that their processes for receiving, managing and resolving complaints about the provision of mental health and wellbeing services comply with the complaint handling standards.

Conducting inquiries and systemic reviews

Inquiries and systemic reviews are one lever that the Commission can use to explore systemic issues associated with the performance, quality and safety of Victoria's mental health and wellbeing system and the mental health and wellbeing of the Victorian community, which may include whether and how mental health and wellbeing service providers are complying with the principles. Our *Exploring Issues through Inquiries and Systemic Reviews Guide* (Mental Health and Wellbeing Commission, 2024c, p 13) sets out our approach to determining areas for systemic review or inquiry. In deciding what issues to explore the Commission considers:

- the views of people with lived and living experience of mental illness and psychological distress, and carers, families, supporters and kin
- likely impact or opportunity to improve outcomes for consumers, either directly or indirectly
- whether the issue is systemic and persistent
- the extent of harm experienced (either harm to a number of people and/or severe harm)
- whether and to what extent the issue is aligned with our objectives, functions and strategic priorities
- relevance of the issue to consumers, carers, families, supporters and kin, mental health and wellbeing service providers and their workforces, government and the community.

The Commission welcomes feedback from the public about possible areas for systemic review or inquiry, which may relate to the principles either as a standalone focus (whether or how mental health and wellbeing service providers are complying with the principles) or in relation to a specific topic (how services are applying the principles in relation to that topic).

Monitoring and reporting

The Commission's functions relating to monitoring and reporting are set out in the Act, and we are currently awaiting advice about whether and how those functions may change. We give proper consideration to the mental health and wellbeing principles in carrying out these functions.

Lived experience

The Commission is committed to embedding lived and living experience leadership and perspectives. Being driven by lived and living experiences is critical to our work to uphold rights and promote ongoing improvement to the mental health and wellbeing system.

The Commission's functions relating to lived experience are set out in the Act, and we are currently awaiting advice about whether and how those functions may change. We will give proper consideration to the mental health and wellbeing principles in carrying out these functions.

Part Four: Appendices

Appendix One:
Who we worked with

The Commission would like to sincerely thank the following contributors for their invaluable input into the development of this guidance:

Service network members
Albury Wodonga Health
Alfred Health including WREN
Austin Health
Barwon Health
Benalla/Wangaratta/Mansfield Local
Bendigo Health
Brimbank Local
Eastern Health
Forensicare
Grampians Health
Goulburn Valley Health
Latrobe Regional Hospital
Mercy Health
Monash Health
Northern Health
Orygen Specialist Service
Royal Children's Hospital
Royal Melbourne Hospital Mental Health Services
Spectrum, Personality Disorder and Complex Trauma
South West Healthcare
St Vincent's Hospital
Western Health

Sector partner network members
Centre for Mental Health Learning
Independent Mental Health Advocacy
Office of the Chief Psychiatrist
Safer Care Victoria
Tandem
Victorian Mental Illness Awareness Council
Victorian Transcultural Mental Health

Consultation partners
Aboriginal Justice Caucus
Balit Murrup Unit - Aboriginal Social and Emotional Wellbeing, Mental Health and Wellbeing Division, Department of Health
Bendigo and District Aboriginal Cooperative
Bouverie Centre
Commissioner for Children and Young People
Commissioner for LGBTIQA+ Communities
Ethnic Communities Council Victoria
Department of Families, Fairness and Housing
FACTORS Law and Policy research team
Family Safety Victoria
First Nations team, Independent Mental Health Advocacy
Foundation House
IMHA and CMHL Principles in Practice project team
Mental Health Tribunal, Senior Advisor, Lived Experience and Tribunal Advisory Group
Nexus Integrated Care, St Vincent's Hospital
Satellite Foundation
Self Help Addiction Resource Centre
Transforming Trauma Victoria
Yooralla/Berry Street
Victorian Aboriginal Legal Service
Victorian Equal Opportunity and Human Rights Commission

Appendix Two: Definitions

*Where a definition is drawn from the Act, the reference is included at the end.

ACCO means Aboriginal Community Controlled Organisation

ACCHO means Aboriginal Community Controlled Health Organisation

appropriate supports are measures that can reasonably be provided to a person to help them make and participate in decisions, understand information and their rights, and communicate their views, preferences, questions or decisions.

Appropriate supports include:

- accessible communication, for example, interpreters, using accessible formats, styles and modes (including technology) and tailoring communications to literacy, developmental and cultural needs.
- communicating in an appropriate physical or sensory environment
- allowing and enabling the person's family members, carers, supporters or advocates to be present either in person or remotely
- providing appropriate spaces for a person to communicate with their support people (s 6).

authorised psychiatrist means a person appointed by the governing body of a designated mental health service under section 328 of the *Mental Health and Wellbeing Act 2022 (Vic)* (s 3(1)).

bodily restraint means physical restraint or mechanical restraint of a person (s 3(1)).

carer means a person, including a person under the age of 18 years, who provides care to another person with whom they are in a care relationship (per s 3 of the *Carers Recognition Act 2012*). This definition does not include a parent caring for a person under the age of 16 (s 3(1)).

See page 7 'Note on language' for discussion of other terms and perspectives.

carers, families, supporters and kin refers to people who support those who are accessing, or trying to access, mental health and wellbeing services. At times this document also uses the term 'family, carers and supporters' where this is a direct Act reference.

care relationship has the meaning given in s 4 of the *Carers Recognition Act 2012 (Vic)*. (1) A person is in a care relationship if he or she provides another person, or receives from another person, care because one of the persons in the relationship

- has a disability
- is older
- has a mental illness
- has an ongoing medical condition (including a terminal or chronic illness or dementia).

(2) Despite subsection (1), the following relationships are also care relationships for the purposes of this Act:

- a relationship where an individual has custody and guardianship of a child under a permanent care order made under Part 4.10 of the *Children, Youth and Families Act 2005*; and
- a relationship where a child is placed with an individual who provides care to that child under a childcare agreement made under Part 3.5 of the *Children, Youth and Families Act 2005*; and
- a relationship where a child is placed with an individual who provides care to that child under a protection order made under Part 4.9 of the *Children, Youth and Families Act 2005*.

(3) For the purposes of this Act, a person is not in a care relationship with another person merely because he or she:

- is the spouse, or the domestic partner within the meaning of the *Children, Youth and Families Act 2005*, of the other person; or
- is the parent, child or other relative of the other person; or (c) lives with the other person.

(4) Despite anything to the contrary in this section, a person is not in a care relationship for the purposes of this Act if he or she provides care to another person:

- under a contract of service or a contract for the provision of services; or
- under an employment contract; or
- in the course of doing voluntary work for a community organisation; or
- as part of the requirements of an education course or training.

(5) A person described in subsection (1) or (2) may be in a care relationship even if the person receives funding from either the Commonwealth or State Government in relation to carrying out the role of a carer.

chemical restraint is a restrictive intervention where a person is given a drug for the primary purpose of controlling their behaviour. It does not include giving a drug for the purpose of mental health or medical treatment (s 3(1)).

clinical mental health service provider A designated mental health service or a mental health and wellbeing service provided in a custodial setting. It also includes any other entity or class of entity prescribed under the *Mental Health and Wellbeing Regulations 2023* (s 3(1)).

consumer means a person who:

- has received or is receiving mental health and wellbeing services from a mental health and wellbeing service provider
- was assessed by an authorised psychiatrist and was not provided with treatment
- sought or is seeking mental health and wellbeing services from a mental health and wellbeing service provider and was not or is not provided with those services (s 3(1)).

See page 7 'Note on language' for discussion of other terms and perspectives.

decision making principles for treatment and interventions are the principles set out in Part 3.1 of the Act. These are specific principles to promote the rights of people subject to compulsory assessment and treatment and restrictive interventions. They include:

- care and transition to less restrictive support principle
- consequences of compulsory assessment and treatment and restrictive interventions principle
- no therapeutic benefit to restrictive interventions principle
- balancing of harm principle and
- autonomy principle.

designated mental health service A public hospital, public health service, denominational hospital, privately operated hospital or a private hospital within the meaning of section 3(1) of the *Health Services Act 1998* that has been prescribed in the *Mental Health and Wellbeing Regulations 2023*; the Victorian Institute of Forensic Mental Health (also known as Forensicare); a service that is temporarily declared to be a designated mental health service under the Act, or a declared operator.

electroconvulsive treatment (ECT) means the application of electric current to specific areas of a person's head to produce generalised seizure (s 3(1)).

A medical treatment which involves applying a brief electrical current to a person's head (while they are under anaesthesia) to induce a controlled seizure. It is used to treat certain mental health conditions often alongside other treatments.

family May refer to family of origin and/or family of choice. We acknowledge Tandem's definition of family as 'significant people who play a supporting role in someone's life', and that family can look different for everyone. See page 7 'Note on language' for discussion of other terms and perspectives.

family carer lived experience workforce refers to a person employed in a designated 'family carer lived experience' (FCLE) role, who is employed to work from the perspective of lived experience in supporting someone with mental health challenges. Designated roles include all positions that require family carer lived experience as a key criterion regardless of position type or setting. FCLE workers use their family carer lived experience as their primary source of knowledge.

Family carer workers may provide direct support through peer support or advocacy, or indirectly through leadership, system advocacy, education, and research. These are designated positions which are firmly focused on and informed by the FCLE workforce priorities, perspectives, and discipline. In accordance with the family carer lived experience framework, we use the words 'family carer' to describe the workforce, as this respects both those who prefer to identify by their relationship and those who prefer to identify as a carer.

family violence is behaviour by a person towards a family member that:

- is physically, sexually, emotionally, psychologically, or economically abusive or
- is coercive or in any other way controls or dominates the family member and causes that family member to feel fear for the safety or wellbeing of that family member or another person or
- causes a child to hear or witness or otherwise be exposed to the effects of such behaviour.

Behaviour may be family violence even if it is not considered a criminal offence.

(s 3(1) of the Act and s 5 of the *Family Violence Protection Act 2008* (Vic)).

FaPMI refers to the Families where a Parent has a Mental Illness program.

guardian means a person appointed in a guardianship order as a guardian in relation to one or more specified personal matters under the *Guardianship and Administration Act 2019* (Vic) (GA Act) (s 3(1) of the Act and s 3(1) GA Act).

information sharing principles means the principles set out in Division 1 of Part 17.1 of the Act (s 3(1)) and must be given proper consideration by an entity who makes a decision, performs a function or exercises a power related to the disclosure, use or collection of health information or personal information under the Act. They include:

- Disclosure, collection and use of information principle
- Dignity of person paramount principle
- Aboriginal and Torres Strait Islander information principle
- Accessibility of information principle
- Accuracy of information principle.

inpatient means a patient who is detained in a designated mental health service (s 3).

leadership role A leadership role is one which sets direction for others, who manages or leads others, or who has influence and accountability over decision making in relation to mental health and wellbeing supports, systems, practices and delivery.

leadership is the ability to mobilise others to achieve important outcomes. Leadership is an activity that can be exercised by anyone at any time, and does not require a formal role.

LGBTIQA+ The Victorian Government uses the acronym LGBTIQA+ (lesbian, gay, bisexual, trans and gender diverse, intersex, queer and asexual). This is an inclusive umbrella abbreviation of diverse sexualities, genders and sex characteristics.' (As stated in Vic Gov 2025 LGBTIQA+ Language guide) see hyperlink https://www.vic.gov.au/sites/default/files/2025-02/LGBTIQA-inclusive-language-guide.pdf

lived and living experience People with lived and living experience identify either as someone who is living with (or has lived with) mental illness or psychological distress, or someone who is caring for or otherwise supporting (or has cared for or otherwise supported) a person who is living with (or has lived with) mental illness or psychological distress. People with lived and living experience are sometimes referred to as 'consumers' or 'carers'. The Commission acknowledges that the experiences of consumers and carers are different.

lived and living experience workforce is used to refer to any lived and living experience workforce as defined by the lived and living experience workforce frameworks (see Appendix Three). This includes workers who provide support directly to consumers, families and carers through peer support or advocacy, or indirectly through leadership, consultation, system advocacy, education, training or research.

mechanical restraint is a restrictive intervention involving the use of a device to prevent or restrict a person's movement (s 3(1)).

mental health advocate means a person who is employed or engaged by a non-legal mental health advocacy service provider to provide non-legal assistance to a consumer including to: understand information regarding their assessment, treatment, care and recovery or; make decisions regarding their assessment, treatment and care; or understand and exercise their rights under the Act (s 3(1) and 45).

Mental Health and Wellbeing Connect Centres are dedicated to people who are supporting someone living with mental health and substance use challenges or psychological distress. They aim to provide families, carers and supporters of all ages with the vital networks they need to keep caring for their loved one, while still looking after their own wellbeing. https://www.betterhealth.vic.gov.au/mental-health-and-wellbeing-connect

Mental Health and Wellbeing Locals are services that offer care and support for people aged 26 years and over who are experiencing mental health or wellbeing concerns https://www.health.vic.gov.au/mental-health-services/mental-health-and-wellbeing-locals

mental health and wellbeing professional means a person who performs duties in connection with the provision of mental health and wellbeing services as a:

- registered medical practitioner, psychologist, nurse or enrolled nurse, paramedic, occupational therapist or a
- social worker in Victoria whose qualifications make them eligible to be a member of the Australian Association of Social Workers
- counsellor who has completed a Bachelor or Master of Counselling and is a member of the Australian Counselling Association or the Psychotherapy and Counselling Federation of Australia
- a person employed or engaged in a prescribed role that requires them to have lived experience as a person with lived experience of mental illness or carer of a person living with mental illness
- psychosocial support workers and allied health professionals of a prescribed class.

(S 3(1) and regulation 17 *Mental Health and Wellbeing Regulations 2023*)

mental health and wellbeing service refers to a service performed for the primary purpose of improving or supporting a person's mental health and wellbeing, assessing or providing treatment, care or support to a person for mental illness or psychological distress or providing care or support to a family member, carer or supporter of a person with mental illness or psychological distress. It does not include mental health and wellbeing advocacy services (s3(1)).

mental health and wellbeing service provider is an entity (other than an individual) that:

- receives funding from:
  - the State for the primary purpose of providing mental health and wellbeing services; or
  - another entity (other than an individual), being funding that was received by the other entity from the State for the primary purpose of providing mental health and wellbeing services; and is provided to the entity for a purpose that is consistent with the funding arrangement or agreement between the State and the other entity; and
- employs or engages a mental health and wellbeing professional in connection with providing the mental health and wellbeing services (s3(1)).

The Act also allows for regulations to be made to exclude providers or classes of provider from, this definition. The *Mental Health and Wellbeing Regulations 2023* exclude a number of entities from this definition, including:

- schools, children's services, and education and care services, along with the providers of services to children, students or staff of these services
- the Department of Education
- a court or tribunal, or other entity that exercises a function that is of a judicial or quasi-judicial nature
- a provider of a workplace mental health and wellbeing support service (such as an employee wellbeing support program) to the extent of the provision of that service (regulation 19, *Mental Health and Wellbeing Regulations 2023*).

mental health and wellbeing system Mental health and wellbeing does not refer simply to the absence of mental illness but to creating the conditions in which people are supported to achieve their potential. This approach requires focus on the strengths and needs that contribute to people's wellbeing. To better reflect international evidence about the need to strike a balance between hospital based services and care in the community, the types of treatment, care and support the future system offers will need to evolve and be organised differently to provide each person with dependable access to mental health services and links to other supports they may seek. The addition of the concept of 'wellbeing' represents a fundamental shift in the role and structure of the system.

mental illness means a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory.

A person is not to be considered to have mental illness by reason only of any one or more of the following:

a) that the person expresses or refuses or fails to express a particular political opinion or belief;

b) that the person expresses or refuses or fails to express a particular religious opinion or belief;

c) that the person expresses or refuses or fails to express a particular philosophy;

d) that the person expresses or refuses or fails to express a particular sexual preference, gender identity or sexual orientation;

e) that the person engages in or refuses or fails to engage in a particular political activity;

f) that the person engages in or refuses or fails to engage in a particular religious activity;

g) that the person has engaged in a certain pattern of sexual behaviour;

h) that the person engages in conduct that is contrary to community standards of acceptable conduct;

i) that the person engages in illegal conduct;

j) that the person engages in antisocial behaviour;

k) that the person is intellectually disabled;

l) that the person uses drugs or alcohol;

m) that the person has a particular economic or social status or is a member of a particular cultural or racial group;

n) that the person is or has previously been involved in family conflict;

o) that the person is experiencing or has experienced psychological distress;

p) that the person has previously been diagnosed with, or treated for, mental illness.

(3) Subsection (2)(l) does not prevent the serious temporary or permanent physiological, biochemical or psychological effects of using drugs or alcohol from being regarded as an indication that a person has mental illness (s 4).

multidisciplinary teams bring together the expertise and skills of different workforces, roles and professionals (including those with lived and living experience). For the purposes of this framework, a multidisciplinary team is one that involves diverse expertise, and in which all expertise is valued, in order to provide care, support and treatment collaboratively and compassionately.

neurosurgery for mental illness means, for treatment purposes:

- any surgical technique or procedure by which one or more lesions are created in a person's brain
- the use of intracerebral electrodes to create one or more lesions in a person's brain or
- the use of intracerebral electrodes to stimulate a person's brain without creating a lesion (s 3).

nominated support person means a nominated support person under Part 2.6 of the Act. The role of a nominated support person in relation to a patient is:

- to advocate for the views and preferences expressed by the patient, including preferences provided in the advance statement of preferences; and
- to support the patient to make and participate in decisions; and
- to advocate for any appropriate supports that would assist the patient to communicate and participate in decision making; and
- to support the patient to understand information and decisions; and
- to support the patient to communicate their views, preferences, decisions, questions or concerns; and
- to receive information, and be consulted, about the patient in accordance with this Act; and
- to support the patient to exercise any rights the patient has under this Act (s 3(1) and s 61).

patient means a person receiving compulsory treatment or assessment under the *Mental Health and Wellbeing Act 2022* (Vic). It also includes security patients and forensic patients (s3(1)).

peer-support workers Peer-support workers use their own recovery experiences to support others to navigate their recovery journeys.

psychological distress One measure of poor mental health, which can be described as feelings of tiredness, anxiety, nervousness, hopelessness, depression and sadness. This is consistent with the definition accepted by the National Mental Health Commission.

reflective practice is a process of learning through and from experience to gain new insights via:

- reflection on experiences of delivering care, treatment and support to consumers, families, carers and supporters
- examining and critically reflecting on assumptions underlying everyday practices
- reflecting on challenging interpersonal dynamics.

restrictive interventions means seclusion, bodily restraint (physical or mechanical) or chemical restraint (s 3(1)).

seclusion means a restrictive intervention involving the sole confinement of a person to a room or any other enclosed space from which it is not within the control of the person to leave (s 3(1)).

social and emotional wellbeing refers to being resilient, being and feeling culturally safe and connected, having and realising aspirations, and being satisfied with life. This is consistent with Balit Murrup, Victoria's Aboriginal social and emotional wellbeing framework.

substance use, gambling and addictive behaviours Substance use means the use of alcohol, tobacco or other drugs (prescription or illicit). Substance use may become harmful to a person's health and wellbeing or can have other impacts on someone's life or that of their family and broader social network. Addictive behaviours, including gambling, means compulsive behaviours outside of a person's control, even when it has harmful effects on that person or their family.

supervision refers to a facilitated exchange between practicing professionals to enable the development of professional skills and a supported space for the individual [worker] to reflect on their professional practice in such a way that growth, development and learning are promoted.

supported decision making The process of supporting persons receiving mental health and wellbeing services to make decisions and to be involved in decisions about their assessment, treatment and recovery including when they are receiving compulsory treatment. In making a decision, the views and preferences of the person receiving mental health and wellbeing services are to be given priority (s 19).

supporters are not defined in the Act, however, are interpreted in this guidance to mean a person who supports a person during their treatment journey. Supporters may include friends, neighbours, traditional healer, faith or culturally-based support, cultural leaders/ elders, or First Nations Elders.

trauma-informed approaches recognise the possibility of the ongoing effects of past and current trauma in the lives of everyone seeking support and how this can affect the way people seek help. The Blue Knot Foundation describes the principles of being trauma-informed as safety, trustworthiness, choice, collaboration and empowerment.

treatment for mental illness means using professional skills to remedy or alleviate a person's mental illness or the symptoms and reduce the ill effects of the person's mental illness. It includes electroconvulsive treatment and neurosurgery for mental illness. Detention is not treatment (s 5).

treatment, care and support This phrase presents treatment, care and support as fully integrated, equal parts of the way people will be supported in the future mental health and wellbeing system. In particular, wellbeing supports (previously known as 'psychosocial supports') that focus on rehabilitation, wellbeing and community participation will sit within the core functions of the future system.

victim survivor Describes people - including adults, children and young people who have direct firsthand experience of family violence, as well as immediate family members of those who have lost their lives to family violence. This term acknowledges the ongoing effects and harm caused by abuse and violence as well as honouring the strength and resilience of people with lived experience of family violence.

Appendix Three: Related frameworks, guidance and training

Principles in practice project

The CMHL and IMHA have collaborated on the *Principles in Practice* (PiP) project, which gave training to mental health and wellbeing service providers about how to embed the mental health and wellbeing principles and the seven principles of *Our workforce our future* into everyday practice. CMHL, IMHA and the Commission have worked closely on both the PiP project and the development of these guidelines, to ensure they are aligned.

IMHA offers both Supported Decision Making (SDM) and PiP workshops to all designated mental health services workforces depending on capacity. IMHA also has e-learning online. To discuss a workshop or organise access to IMHA's e-learning, please contact IMHAAdmin@imha.vic.gov.au.

IMHA plain language guide to the principles

IMHA has developed a plain language guide to the mental health and wellbeing and decision making principles. This has been considered in developing this guidance and phrasing from the plain language guide has been used in several principles. It is a valuable resource for mental health and wellbeing service providers to share widely with consumers, carers, families, supporters and kin.

Tandem's plain language information kit - Your rights

Tandem has prepared plain language information for families, carers and supporters to understand their rights in the mental health and wellbeing system. We have considered and referred to this kit in developing this guidance. We encourage mental health and wellbeing service providers to share these accessible resources with carers, families, supporters and kin.

Our workforce our future: A capability framework for Victoria's mental health and wellbeing workforce

Our workforce our future (Department of Health 2023a) and its associated implementation guide, was developed in response to recommendation 58 of the Royal Commission. It sets out the collective knowledge, skills and ways of working the mental health and wellbeing workforce needs to deliver quality care, support and treatment. It outlines 7 principles and 15 capabilities that are essential to the vision of a mental health and wellbeing service system that supports people to achieve the best possible mental health and wellbeing. Applying these principles and building these capabilities will also support application of the principles.

Lived and living experience workforce frameworks

There are 5 guiding documents for the Victorian lived and living experience workforce that were funded by the Department of Health and developed by peak bodies, being the:

- *Mental Health Consumer Lived Experience Workforce Discipline Framework*
- *Mental Health Family Carer Lived Experience Workforce Discipline Framework*
- *Harm Reduction Lived and Living Experience Workforce Discipline Framework*
- *Alcohol and Other Drug (AOD) Lived Experience Workforce Discipline Framework*
- *Alcohol and Other Drug (AOD) Family Lived Experience Workforce Discipline Framework*.

There are also *National Lived Experience (Peer) Workforce Development Guidelines* developed by the National Mental Health Commission.

Mental health and wellbeing outcomes and performance framework

The mental health and wellbeing outcomes and performance framework (Department of Health 2024d) aims to measure the impact of the mental health and wellbeing system, and the difference that it makes for Victorian consumers, families and carers. The vision of the framework, of a 'mental health and wellbeing system that delivers inclusive, personalised, compassionate, integrated care so all Victorians are supported to live and experience the life they want' (Department of Health 2024d, p 12) aligns strongly to the intended outcomes of the mental health and wellbeing principles.

National Safety and Quality Health Service Standards

The National Safety and Quality Health Services standards (NSQHS standards) (Australian Commission on Safety and Quality in Healthcare 2021) provide a nationally consistent statement of the level of care consumers can expect from health services (including designated mental health services). Health services are accredited against these standards and may be assessed at any time during a three-year accreditation cycle. The guidance for individual principles notes links between each principle and the standards.

National Safety and Quality Mental Health Standards for Community Managed Organisations

The voluntary National Safety and Quality Mental Health Standards for Community Managed Organisations (NSQMHCMO Standards) (Australian Commission on Safety and Quality in Healthcare 2022) will 'help provide safety and quality assurance for consumers, their families and carers and best practice guidance for community managed service providers'.

Appendix Four: References

Ahad AA, Sanchez-Gonzalez M, Junquera P. Understanding and Addressing Mental Health Stigma Across Cultures for Improving Psychiatric Care: A Narrative Review. Cureus. 2023 May 26;15(5):e39549. doi: 10.7759/cureus.39549. PMID: 37250612; PMCID: PMC10220277.

Arnstein, S. (1969.) A ladder of citizen participation. Journal of the American Planning Association, 35(4), 216-224.

Australian Health Practitioner Regulation Agency (2020) The National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025 https://nacchocommunique.com/wp-content/uploads/2020/02/aboriginal-and-torres-strait-islander-cultural-health-and-safety-strategy-2020-2025-1.pdf

Australian Commission on Safety and Quality in Healthcare (2021) *National Safety and Quality Health Service Standards* https://www.safetyandquality.gov.au/standards/nsqhs-standards

Australian Commission on Safety and Quality in Healthcare (2022) *National Safety and Quality Mental Health Standards for Community Managed Organisations* https://www.safetyandquality.gov.au/publications-and-resources/resource-library/national-safety-and-quality-mental-health-standards-community-managed-organisations-2022

Carroll A and McSherry B (2020) 'Risk management in the era of recovery and rights' BJPsych Advances (2020), page 1 of 11 doi: 10.1192/bja.2020.88

Commission for Children and Young People (2023) *A guide for creating a child safe organisation* https://ccyp.vic.gov.au/assets/resources/New-CSS/A-guide-for-creating-a-Child-Safe-Organisation-27.04.23.pdf

Commission for Children and Young People (2024) *Understanding cultural safety for Aboriginal children and young people: a guide for implementing Child Safe Standard 1* https://ccyp.vic.gov.au/assets/resources/New-CSS/Understanding-cultural-safety-CSS1-guide.pdf

Daya, I *The participation ladder: a consumer/survivor lens* https://www.indigodaya.com/wpcf7_captcha/2020/10/Participation-ladder_consumer_survivor-lens-2.pdf Accessed 14 September 2025

Department of Families, Fairness and Housing (2018) *Recognising and supporting Victoria's carers: Victorian carer strategy 2018-2022* https://www.dffh.vic.gov.au/publications/recognising-and-supporting-victorias-carers-victorian-carer-strategy-2018-22

Department of Families, Fairness and Housing (2023) *Our equal state: Victoria's gender equality strategy and action plan 2023-2027* https://www.vic.gov.au/sites/default/files/2025-02/our-equal-state-victorias-gender-equality-strategy-and-action-plan-2023-2027.pdf

Department of Families, Fairness and Housing (2025) *LGBTIQA+ inclusive language guide* https://www.vic.gov.au/inclusive-language-guide

Department of Health (2011a) *Framework for recovery-oriented practice* https://healthsciences.unimelb.edu.au/__data/assets/pdf_file/0011/3391175/framework-recovery-oriented-practice.pdf

Department of Health (2013) *Providing a safe environment for all: framework for reducing restrictive interventions* https://www.health.vic.gov.au/practice-and-service-quality/framework-for-reducing-restrictive-interventions

Department of Health (2014) *Criteria for searches to maintain safety on an inpatient unit - for patients, visitors and staff* https://www.health.vic.gov.au/chief-psychiatrist-guidelines/criteria-for-searches-to-maintain-safety-in-an-inpatient-unit

Department of Health (2021) *Mental Health Lived Experience Engagement Framework* https://www.health.vic.gov.au/publications/mental-health-lived-experience-engagement-framework

Department of Health (2023a) *Our workforce our future* https://content.health.vic.gov.au/sites/default/files/2023-12/our-workforce-our-future.pdf.pdf

Department of Health (2023b) *Interim Chief Psychiatrist's guidance - decision making principles for treatment and interventions* https://www.health.vic.gov.au/chief-psychiatrist/decision-making-principles-for-treatment-and-interventions-mental-health-and-wellbeing-act-2022

Department of Health (2023c) *Health information statement template* https://www.health.vic.gov.au/mental-health-and-wellbeing-act-handbook/information-sharing

Department of Health (2023d), *Improving sexual safety in mental health and wellbeing services: Chief Psychiatrist's guideline* https://www.health.vic.gov.au/chief-psychiatrist/improving-sexual-safety

Department of Health (2024a) *Restrictive interventions: Chief Psychiatrist's guideline* https://www.health.vic.gov.au/chief-psychiatrist/chief-psychiatrists-restrictive-interventions

Department of Health (2024b) *Chief Psychiatrist's reporting directive for restrictive interventions* https://www.health.vic.gov.au/chief-psychiatrist/chief-psychiatrists-restrictive-interventions

Department of Health (2024c) *White paper: on the principles of risk assessment* https://www.health.vic.gov.au/chief-psychiatrist/white-paper-on-the-principles-of-mental-health-risk-assessment

Department of Health (2024d), *Mental Health and wellbeing outcomes and performance framework* https://www.health.vic.gov.au/mental-health/research-and-reporting/mental-health-and-wellbeing-outcomes-and-performance-framework

Department of Health (2025a) *Understanding and reporting chemical restraint: a factsheet for prescribing clinicians* https://www.health.vic.gov.au/chief-psychiatrist/understanding-reporting-chemical-restraint

Department of Health (2025b) *Implementing the MARAM framework in mental health and wellbeing services* - Chief Psychiatrist's guideline https://www.health.vic.gov.au/chief-psychiatrist/maram-framework-mental-health-wellbeing-services

Department of Health (2025) Equally well in Victoria. (Publication imminent)

Department of Health (2025d) *Bridging the Gender Pain Gap: The Inquiry into Women's Pain Report 2025* https://www.health.vic.gov.au/inquiry-into-womens-pain

Department of Health and Human Services (2016) *Safewards handbook: training and implementation resource for Safewards in Victoria* https://www.safercare.vic.gov.au/sites/default/files/2025-04/Safewards%20Victoria%20Handbook%202016.pdf

Department of Health and Human Services (2017a) *Balit Murrup: Aboriginal social emotional wellbeing framework 2017-2027* https://www.health.vic.gov.au/publications/balit-murrup-aboriginal-social-emotional-wellbeing-framework-2017-2027

Department of Health and Human Services (2017b) *Korin Korin Balit-Djak: Aboriginal health, wellbeing and safety strategic plan 2017-2027* https://www.dffh.vic.gov.au/sites/default/files/documents/202302/korin-korin-balit-djak.pdf

Department of Health and Human Services (2018c) *Working together with families and carers: Chief Psychiatrist's guideline* https://www.health.vic.gov.au/chief-psychiatrist/working-together-with-families-and-carers

Department of Health and Human Services (2019a) *Mental Health Intensive Care Framework* https://www.safercare.vic.gov.au/publications/mental-health-intensive-care-framework

Department of Health and Human Services (2019) *Equally well in Victoria - Physical Health Framework for Specialist Mental Health Services* https://nla.gov.au/nla.obj-1485820324/view

Department of Health and Human Services (2020) *Aboriginal and Torres Strait Islander Cultural safety framework* https://www.health.vic.gov.au/publications/aboriginal-and-torres-strait-islander-cultural-safety-framework-part-1

Edwige, V and Gray, P (2021) *Significance of Culture to Wellbeing, Healing and Rehabilitation* https://indigenouspsyched.org.au/resource/significance-of-culture-to-wellbeing-healing-and-rehabilitation/

Family Safety Victoria (2018) *Family Violence Multi-Agency Risk Assessment and Management (MARAM) Framework* https://www.vic.gov.au/family-violence-multi-agency-risk-assessment-and-management

Harm Reduction Victoria (2025) *Harm Reduction Lived Experience Framework* https://www.hrvic.org.au/_files/ugd/ebb8bf_f1d2347fd1c64956a7793998530767a1.pdf?index=true

Hawton K, Lascelles K, Pitman A, Gilbert S and Silverman M (2022) 'Assessment of suicide risk in mental health practice: shifting from prediction to therapeutic assessment, formulation and risk management', *The Lancet*, 9(11):922-928.

International Association for Public Participation (1999) *Spectrum of Public Participation* https://cdn.ymaws.com/www.iap2.org/resource/resmgr/pillars/iap2_spectrum_2024.pdf

Independent Mental Health Advocacy (2025) *Mental Health and Wellbeing Act Principles - Plain Language guide* https://www.imha.vic.gov.au/sites/default/files/2025-06/imha-principles-mental-health-wellbeing-act-may-2025.pdf

International Association for Public Participation (1999) *Spectrum of Public Participation* https://cdn.ymaws.com/www.iap2.org/resource/resmgr/pillars/spectrum_8.5x11_print.pdf

Lowitja Institute (2025) *Co-design Versus Faux-design of Aboriginal and Torres Strait Islander Health Policy: A Critical Review* https://www.lowitja.org.au/wp-content/uploads/2025/06/Lowitija-Institute-Co-design-Review.pdf

Mental Health Coordinating Council (2022) *Recovery Oriented Language Guide* https://mhcc.org.au/wp-content/uploads/2022/07/Recovery-Oriented-Language-Guide-Mental-Health-Coordinating-Council-2022.pdf

Mental Health and Wellbeing Commission (2024a) *Strategic Direction: Establishing the Commission* <https://www.mhwc.vic.gov.au/sites/default/files/2023-10/MHWC001-Strategic-Direction-FA2-LR.pdf

Mental Health and Wellbeing Commission (2024b) *Our approach to complaint handling and compliance monitoring* https://www.mhwc.vic.gov.au/our-approach-complaint-handling-and-compliance-monitoring

Mental Health and Wellbeing Commission (2024c) *Exploring Issues through Inquiries and Systemic Reviews Guide* https://www.mhwc.vic.gov.au/exploring-issues-through-inquiries-and-systemic-reviews

Mental Health and Wellbeing Commission (2025a) *Lived experience plan* https://www.mhwc.vic.gov.au/sites/default/files/2025-02/Lived-Experience-plan.pdf

Mental Health and Wellbeing Commission (2025b) *Guidelines for trauma-informed mental health complaints resolution* https://www.mhwc.vic.gov.au/sites/default/files/2025-06/Trauma-Informed-Guidelines.pdf

National Mental Health Commission (2016) *Equally Well consensus statement: Improving the physical health and wellbeing of people living with mental illness in Australia* https://www.mentalhealthcommission.gov.au/sites/default/files/2024-03/equally-well-consensus-statement_1.pdf

Our consumer place (2012) - Psychobabble: the little red book of psychiatric jargon https://www.ourcommunity.com.au/files/OCP/PsychobabbleFeb2012.pdf

Perkins R and Repper J (2016) ‘Recovery versus risk? From managing risk to the co-production of safety and opportunity’, Mental Health and Social Inclusion, 20(2):101-109.

Roper, C, Grey, F and Cadogan, E (2018) *Coproduction: putting principles into practice in mental health contexts* https://healthsciences.unimelb.edu.au/__data/assets/pdf_file/0007/3392215/Coproduction_putting-principles-into-practice.pdf

Royal Australia and New Zealand College of Psychiatrists position statement (2023) *Sexual safety in mental health services in Australia and New Zealand* https://www.ranzcp.org/clinical-guidelines-publications/clinical-guidelines-publications-library/sexual-safety-mental-health-services-au-nz

Royal Commission into violence, abuse, neglect and exploitation of people with disability (2023) *Final report - Volume three, Nature and extent of violence, abuse, neglect and exploitation* https://disability.royalcommission.gov.au/publications/final-report-volume-3-nature-and-extent-violence-abuse-neglect-and-exploitation

So, N, et al (2024) *The importance of cultural humility and cultural safety in health care* Med J Aust 2024; 220 (1): 12-13. https://pubmed.ncbi.nlm.nih.gov/38049948/

Safer Care Victoria (2024a) *Victorian Clinical Governance Framework* https://www.safercare.vic.gov.au/best-practice-improvement/clinical-governance/framework

Safer Care Victoria (2024b) *Victorian Safety Culture Guide* https://www.safercare.vic.gov.au/publications/victorian-safety-culture-guide

Safer Care Victoria (2024c) *Quality improvement toolkit* https://www.safercare.vic.gov.au/best-practice-improvement/quality-improvement/toolkit

Self Help Addiction Resource Centre (2025) *Alcohol and Other Drug (AOD) Family Lived Experience Workforce Discipline Framework* https://www.sharc.org.au/wp-content/uploads/2025/03/AOD-Family-Lived-Experience-Workforce-Discipline-Framework.pdf

Self Help Addiction Resource Centre (2025) *Alcohol and Other Drug (AOD) Lived Experience Workforce Discipline Framework* https://www.sharc.org.au/wp-content/uploads/2025/03/AOD-Lived-Experience-Workforce-Discipline-Framework.pdf

State of Victoria (2021) *Royal Commission into Victoria's Mental Health System, Final Report* https://www.vic.gov.au/royal-commission-victorias-mental-health-system-final-report

Tandem and the Carer Lived Experience Workforce (2025) *Mental Health Family Carer Lived Experience Workforce Discipline Framework* https://tandemcarers.org.au/Common/Uploaded%20files/Publications/Mental%20Health%20Family%20Carer%20Lived%20Experience%20Discipline%20Framework.pdf

University of Melbourne (2025) *Mental Health Consumer Lived Experience Workforce Discipline Framework* https://healthsciences.unimelb.edu.au/__data/assets/pdf_file/0020/5242142/384076-DOH-MH-Consumer-framework-WEB-WCAG-5.0.pdf

Victorian Equal Opportunity and Human Rights Commission (2008) *From Principles to Practice: Implementing the human rights-based approach in community organisations*

Victorian Equal Opportunity and Human Rights Commission (2021), *Building Victoria's human rights culture* https://www.humanrights.vic.gov.au/resources/guide-to-building-human-rights-culture/

Victorian Mental Illness Awareness Council (2019) *VMIAC declaration* https://www.vmiac.org.au/wp-content/uploads/The-VMIAC-Declaration_01-Nov-2019.pdf

Victorian Mental Illness Awareness Council (2022). *How safe is my hospital? The Seclusion Report #3*. Version 2.2. www.vmiac.org.au/vmiac-seclusion

Wade, C (2020) *Parental mental health and parenting: how are they related?* via Emerging minds https://emergingminds.frmdv.com/resources/parental-mental-health-and-parenting-how-are-they-related/

Williams, R. (1999), *Cultural safety - what does it mean for our work practice?* Australian and New Zealand Journal of Public Health, 23: 213-214. https://doi.org/10.1111/j.1467-842X.1999.tb01240.x

Zoe Belle Collective and Royal Melbourne Hospital (2021) *Transgender and gender-diverse inclusive-care guide for hospital-based healthcare professionals* https://www.thermh.org.au/files/documents/Corporate/transgender-gender-diverse-inclusive-care-guide-health-care-professionals.pdf Accessed 12 September 2025

Human rights instruments

Universal Declaration of Human Rights, adopted 10 December 1949 https://www.ohchr.org/sites/default/files/UDHR/Documents/UDHR_Translations/eng.pdf

International Covenant on Civil and Political Rights, adopted 16 December 1966 https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-civil-and-political-rights

International Covenant on Economic, Social and Cultural Rights, adopted 16 December 1966 https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-economic-social-and-cultural-rights

United Nations Convention on the Rights of Persons with Disabilities, adopted December 13, 2006 https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-persons-disabilities

United Nations Convention on the Rights of the Child adopted 20 November 1989 https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-child

United Nations Declaration on the Rights of Indigenous Peoples, adopted 13 September 2007 https://www.ohchr.org/en/indigenous-peoples/un-declaration-rights-indigenous-peoples

Legislation

Change or Suppression (Conversion) Practices Prohibition Act 2021 (Vic).

Charter of Human Rights and Responsibilities Act 2006 (Vic)

Equal Opportunity Act 2010 (Vic)

Mental Health and Wellbeing Act 2022 (Vic)

Explanatory memorandum to the Mental Health and Wellbeing Bill 2022

Racial and Religious Tolerance Act 2001 (Vic)

Case law

Kracke v Mental Health Review Board & Ors (General) [2009] VCAT 646

UVX v Mental Health Tribunal (Human Rights) [2024] VCAT 102, 63

Notes:

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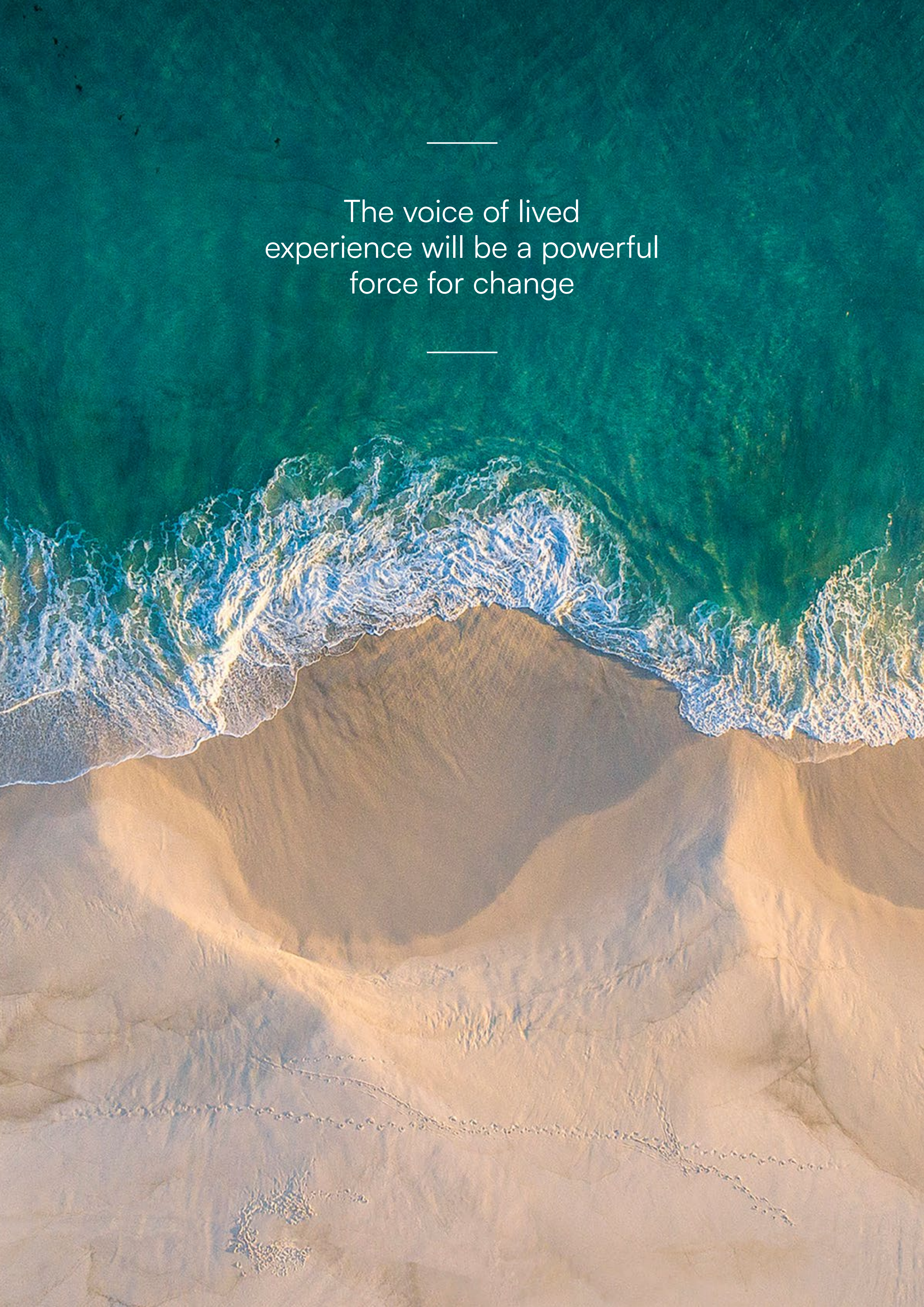

The voice of lived experience will be a powerful force for change

Mental Health
and Wellbeing
Commission