



The Voice of Multicultural Victoria

Submission on the new Mental Health and Wellbeing Act

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Introduction

The Ethnic Communities' Council of Victoria (ECCV) welcomes the Victorian Government's commitment to developing a new Mental Health and Wellbeing Act (the Act) and appreciates the opportunity to have input. We congratulate the Victorian Government for its commitment to instituting legislation that will respond to the recommendations made by the Royal Commission into Victoria's Mental Health System (the Royal Commission).

ECCV commends the Victorian Government's acknowledgment of the social determinants of mental health inequities between different population groups. This needs to be further developed and elaborated on, as a general approach is not sufficient to address the determinants of mental health that particularly impact migrant and refugee communities. The Royal Commission reflected the social determinants of mental health as experienced by people from diverse communities in Volume 3 of the Royal Commission's Final Report, "Promoting inclusion and addressing inequities."¹ The direction, priority and intent of the Royal Commission's report must be fully reflected in the Act.

22% of Victorians were born in a non-main English speaking country, with a further 14.2% of Australian-born Victorians having at least one parent born in a non-main English speaking country. The Victorian population has the highest proportion of overseas-born residents of any State or Territory, and this proportion is growing.²

To be fit-for-purpose and to meet the needs of this diverse Victorian community, the Mental Health and Wellbeing Act must include clear requirements for culturally responsive policies and practices. Our recent paper co-authored with Victorian Transcultural Mental Health (VTMH), *Recommendations for a culturally responsive mental health system*,³ outlines the key provisions that need to be reflected in the governing legislation for the Victorian mental health system. Without such provisions the newly reformed mental health legislation may continue to perpetuate the avoidable inequities of the existing system. This will result in the specific mental health needs of people from migrant and refugee communities being overlooked and underserved.

This submission focuses on how human rights, cultural responsiveness, and an intersectional approach can strengthen the Act so that it promotes better mental health outcomes for all Victorians. These approaches will ensure that the mental health system is accessible, fit-for-purpose, and that the workforce, practices and decision makers in the system reflect the diversity of our community, while dismantling barriers and inequities.

These approaches need to be particularly reflected in the sections of the Act that will regulate restrictive interventions and compulsory treatments. To reduce these practices and promote the rights of people living with mental health conditions, the Act must create strict boundaries and disincentives to use restrictive interventions and compulsory treatment.

¹ State of Victoria, *Royal Commission into Victoria's Mental Health System, Final Report*, "Volume 3: Promoting inclusion and addressing inequities," Parl Paper No. 202, Session 2018–21 (document 4 of 6) (2021); available at https://finalreport.rcvmhs.vic.gov.au/wp-content/uploads/2021/02/RCVMHS_FinalReport_Vol3_Accessible.pdf; last retrieved 27/7/21.

² Department of Premier and Cabinet, *Population Diversity in Victoria: 2016 Census – Local Government Areas*, (2018) available at: <https://www.vic.gov.au/sites/default/files/2019-08/Full-Report-Population-Diversity-in-LGAs-2016-Census-Web-version-30May18.PDF>

³ Ethnic Communities' Council of Victoria and Victorian Transcultural Mental Health, "Recommendations for a culturally responsive mental health system," (2021); available at https://eccv.org.au/wp-content/uploads/2021/06/Recommendations-for-a-Culturally-Responsive-Mental-Health-System-Report_ECCV_VTMH_June-2021.pdf, last retrieved 27/7/21.

ECCV is particularly encouraged to see the inclusion of supported decision making and advocacy mechanisms to strengthen the protections of human rights. Along with stronger data collection and governance mechanisms, this will create a strong suite of tools to increase capacity of the mental health system to be person-centred, culturally safe, accessible and inclusive.

In order to reflect the needs of the community, there need to be specific mechanisms in mental health system governance structures to promote the needs and rights of people from migrant and refugee backgrounds. These mechanisms will be necessary on an ongoing basis to make the reform process effective and to enable ongoing improvement.

ECCV offers these recommendations to increase the effectiveness and responsiveness of the Act, and to ensure the rights of people from migrant and refugee backgrounds are embedded in all aspects of the mental health system.

About ECCV

The Ethnic Communities' Council of Victoria (ECCV) is the peak body for people from migrant and refugee backgrounds in Victoria. ECCV works closely with over 220 member organisations including ethnic associations, multicultural service providers, and eight regional ethnic communities' councils. Since 1974 ECCV has been advocating for human rights, freedom, respect, equality and dignity for migrant and refugee communities, and for a socially cohesive and inclusive Victorian community. ECCV has a strong history in advocating for the rights of migrant and refugee communities, informing industry practice and influencing Federal, State and Local governments on a range of issues including culturally responsive approaches, anti-racism action, equitable access to services and socially just policy.

In 2020 ECCV was commissioned by the (then) Department of Health and Human Services to prepare a policy paper on mental health of CALD communities in relation to the COVID-19 pandemic. ECCV partnered with Victorian Transcultural Mental Health to develop the [*Recommendations for a culturally responsive mental health system*](#) policy paper.

ECCV has also been funded by the Department of Health to communicate about the Royal Commission to our members and to CALD communities more broadly.

About this submission

In preparing this submission ECCV consulted with member organisations and sector partners including Victorian Transcultural Mental Health, the Victorian Refugee Health Network, the Multicultural Centre for Women's Health, Mental Health Victoria, Foundation House, Jewish Care, Victoria Legal Aid and the Australian Muslim Women's Centre for Human Rights. ECCV thanks our members and stakeholders for their important contributions to this submission.

A note on terminology

The term 'people from migrant and refugee backgrounds' is used in this submission to refer to people and communities who have entered Australia through a variety of pathways, including through humanitarian, family, and skilled migration pathways. ECCV uses this term to refer to people with backgrounds and ancestry that is not part of the dominant Anglo-Celtic Australian population. This term is inclusive of people seeking asylum in Australia, people on temporary visas, undocumented migrants, and people born in Australia.

Summary of recommendations

1. That the principles in the Mental Health and Wellbeing Act are amended to specify that mental health services and decision makers are required to:
 - ensure that services are provided in a manner that is safe, sensitive and responsive to consumers' needs and experiences and upholds people's rights
 - uphold the right of consumers, carers and families to access professionally trained interpreters and translated written material whenever they require
 - uphold the right of any person to access mental health care, regardless of visa status or lack thereof, and regardless of financial means
 - provide culturally responsive mental health treatment and support to people from migrant and refugee backgrounds which addresses their needs, circumstances, understandings of mental health, experiences of trauma, and approaches to help-seeking, as well as supporting a diverse and holistic range of mental health and wellbeing approaches
 - ensure that mental health treatment and support to people from migrant and refugee backgrounds is culturally safe, including removing barriers, engaging respectfully, seeking informed consent, using language services when required, and reviewing the service environment, practices, approaches and procedures to make services welcoming and equitable
 - apply an intersectional approach to address the multiple and interacting forms of discrimination and inequality that can affect individuals' mental health, such as the discrimination and marginalisation related to gender inequality, homophobia or disability
 - work in collaboration to co-design and co-produce mental health supports with people with lived experience, carers and with the broader community including community-based advocates and organisations
 - better reflect the diversity of the community in the mental health system workforce, leadership and governance.
2. That the Mental Health and Wellbeing Act specifies that the new non-legal advocacy service is required to have specialist multicultural expertise, uphold human rights, adhere to culturally and gender safe practice, reflect the diversity of the community, and recognise a broad range of community advocates, including families, faith leaders and community elders.
3. That the Mental Health and Wellbeing Act requires that the non-legal advocacy service must work with interpreters, including offering access to an interpreter of the consumer's preferred gender, whenever requested, and engaging an interpreter whenever required for communication.
4. That the Mental Health and Wellbeing Act specifies that consumers can request any written documents or records to be made available and explained in the consumer's preferred language.
5. That the Mental Health and Wellbeing Act defines nominated persons broadly to include any person trusted by the consumer, which may include community elders, faith leaders or interpreters.
6. That the Mental Health and Wellbeing Act specifies that mental health services must collect data on the demographic profile of consumers with their consent. This should include data sets relevant to people from migrant and refugee backgrounds such as:
 - Cultural background or ancestry
 - Country of birth
 - Length of time in Australia
 - Languages spoken
 - Need for interpreter
 - Religion

- Gender (including transgender status)
7. That the Mental Health and Wellbeing Act specifies that consumers' data must be collected in a consistent and culturally safe way. This must include an explanation of why personal information will be collected, and how it will be used.
 8. That the Mental Health and Wellbeing Act includes specific requirements for data security and protection of consumers' personal and health information, including requirements for court orders for agencies (including Victoria Police or the Department of Families, Fairness and Housing) to access mental health records.
 9. That the Mental Health and Wellbeing Act specifies that clinicians making compulsory assessment or treatment decisions must explore a broad range of treatment and non-treatment supports, and that clinicians pursue compulsory assessment or treatment only if all other options have been exhausted.
 10. That the Mental Health and Wellbeing Act specifies that:
 - non-legal advocates and support persons must be notified if compulsory assessment or treatment are to be used
 - any specific needs or considerations raised by the support person and/or advocate on behalf of the person are recorded and addressed by clinicians who are administering the assessment or treatment.
 11. The Chief Officer for Mental Health and Wellbeing is required to report annually on progress towards ending the use of seclusion and restraint to the Victorian Parliament.
 12. That the Mental Health and Wellbeing Act includes a provision to establish a Chief Practitioner for monitoring the use of restrictive interventions, promoting alternative and less invasive approaches, and promoting the rights of people who are subjected to restrictive interventions.
 13. That the Mental Health and Wellbeing Act specifies that clinicians are required to engage professionally trained interpreters and provide written material translated into the person's preferred language when the person, or their nominated advocate, carer, and/or support person identify that this is required, or if this is recommended by another clinician or service provider.
 14. That the Mental Health and Wellbeing Act specifies that clinicians are required to identify cultural and community-based support options relevant to the person and seek to engage these supports before using seclusion and/or restraint.
 15. That the Mental Health and Wellbeing Act includes specific requirements for the Mental Health and Wellbeing Commission, the Regional Mental Health and Wellbeing Boards and the Statewide and Regional Multiagency Panels to reflect the diversity of the Victorian community by including targets for the cultural and linguistic diversity of membership of these bodies.
 16. That the Mental Health and Wellbeing Act includes a provision to establish a Commissioner for Migrant and Refugee Communities' Mental Health with specific oversight powers relating to culturally safe practices.
 17. That the Mental Health and Wellbeing Act establishes a Migrant and Refugee Reference Group to support the proposed Commissioner for Migrant and Refugee Communities' Mental Health, which will:

- Advise and inform the other governance bodies on matters relating the mental health needs of consumers from migrant and refugee backgrounds
 - Assess and advise upon the cultural safety of policies, practices and programs in the mental health system
 - Make recommendations to the Chief Officer for Mental Health and Wellbeing as needed.
18. That the Mental Health and Wellbeing Act specifies that membership of the Migrant and Refugee Mental Health Reference Group must comprise:
- Representative bodies for migrant and refugee communities, including ECCV
 - Specialists in migrant and refugee mental health including community advocates, clinicians and service providers
 - Specialists with expertise across a range of issues such as gender, disability, and the needs of LGBTIQ+ communities
 - Consumers from migrant and refugee backgrounds who have lived experience of using the mental health system.
19. That legislation establishing the Collaborative Centre for Mental Health and Wellbeing includes a provision requiring the Centre to work with people from diverse cultural and linguistic backgrounds who have lived experience using the mental health system, and multicultural and ethno-specific community organisations.
20. That the Mental Health and Wellbeing Act includes a provision for the Minister and the Victorian Government to allocate resources to agencies specialising in working with people from migrant and refugee backgrounds to:
- Develop and deliver culturally and gender responsive mental health and wellbeing programs and services
 - Support and strengthen capacity of people from migrant and refugee backgrounds with lived experience of mental health conditions to participate in mental health system governance, co-design and co-production.

Objectives and principles of the new Act

Question 1: Do you think the proposals meet the Royal Commission's recommendations about the objectives and principles of the new Act?

ECCV welcomes the new Mental Health and Wellbeing Act. ECCV is encouraged to see that steps have been made to adopt a social determinants approach that acknowledges structural inequities such as racism and discrimination in accessing and using the mental health system.

However, the social determinants of mental health that particularly impact migrant and refugee communities are not strongly featured in the development of this Act, despite being identified as areas for priority action in the Royal Commission's final report. In order to be fit for purpose – that is, to meet the mental health needs of all Victorians in a community that is defined by its diversity, the Act would benefit from including several recommendations from the Royal Commission that support people from migrant and refugee backgrounds.

Recommendation 15 describes the establishment of 'community collectives' for supporting mental health and wellbeing in local government areas. ECCV welcomes this initiative, as we believe that such 'community collectives' could provide people from migrant and refugee backgrounds an equitable and accessible way to become directly involved in the co-production of mental health supports and services in their local communities. However, this community-based approach to mental health and wellbeing does not currently appear in the proposed aims and objectives of the new Act.

Recommendation 41 from the Royal Commission outlines a commitment to addressing stigma and discrimination through the design and delivery of anti-stigma programs. From our consultations with migrant and refugee communities, our member organisations and collaborations with our project partners in the mental health space, we acknowledge that much work needs to be done in order to understand the cultural determinants and diverse lived experiences of stigma.

When progressed, this work could enhance the cultural responsiveness of mental health policy, practice and services so that the overall mental health system can become better able to respond to the needs of all Victorians. However, while we acknowledge that anti-stigma work will be legislated in the Act as one of the functions of the new Mental Health and Wellbeing Commission, at present the Act does not address stigma explicitly in any part of its aims or objectives.

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

As a foundational principle, ECCV believes that the new Act should be grounded explicitly in a rights-based approach that prioritises the needs of people experiencing avoidable disadvantages towards greater mental health equity. Many of these avoidable disadvantages are due to structural racism or discrimination. These may be experienced as barriers to accessing or using mental health services such as the expectation for consumers to have English-language proficiency, or the use of Western-centric models of treatment that do not recognise the diversity of understandings of mental health that are held in the community.

The principles also need to reflect an intersectional approach. That is, the Act must recognise the impact of discrimination, inequality and barriers on people from migrant and refugee backgrounds, including the combined and overlapping impacts of multiple forms of discrimination. Systemic inequality, stigma, barriers and discrimination based on race, gender, economic status, sexual orientation, transgender status, age, visa status, religion, disability, ethnicity, intersex variation, participation in sex work, and a range of other factors can affect experiences of mental health, mental health conditions, and access to mental health support.

Accordingly, the Act should therefore specifically identify the human rights that it seeks to fulfil, which we suggest is the right that all people who use the mental health system can expect to receive the highest available standard of health. To further strengthen and articulate the Act's commitment to cultural safety and intersectionality, it should also reference relevant rights instruments and legislation, such as the Victorian Gender Equality Act⁴ and the UN Convention on the Rights of Persons with Disabilities.⁵

As emphasised in our recent paper co-authored with Victorian Transcultural Mental Health (VTMH), "[Recommendations for a culturally responsive mental health system](#)," ECCV remains concerned that by aggregating all categories of diversity into a single approach, the Act stands the risk of overlooking and hence failing to respond to the needs of people from specific populations. ECCV proposes that the key recommendations from the aforementioned paper are used to inform the drafting of the Act's objectives and principles.

Accordingly, the proposed wording of Principle 8 should be re-worded from the current proposed wording that mental health services and decision-makers should:

“recognise people receiving mental health and wellbeing services may have specific diversity-related needs and experiences (as to age, disability, neurodiversity, culture, language, communication, religion, race, gender, gender identity, sexual orientation or other matters) and ensure that services are provided in a manner that is safe, sensitive and responsive to these needs and experiences and upholds people's rights.”

The proposed wording reproduces language that refers to 'diversity' as a category in itself, usually represented in contrast to an equally poorly described 'mainstream' population. The use of this language is inaccurate and vague, and has the disadvantage of aggregating together all people who are seen to have backgrounds, identities and experiences that differ from an assumed mainstream population. Describing any needs as "diversity-related" is othering, paternalistic and potentially stigmatising, and creates the risk of these needs not being considered the responsibility of mainstream services. This approach to diversity reproduces existing stigma and exclusion.

As outlined in our joint paper with VTMH, 'diversity' is not an intrinsic quality held by individuals, nor is it a suitable category for distinct and separate groups of people. Instead, 'diversity' is a defining characteristic of a broader community. In this regard, the quality of 'diversity' very aptly describes the Victorian community as a whole.

The culturally responsive mental health system that we envisage would not respond to 'diversity-related needs,' but rather would be based on a fully intersectional model of person centred care. Accordingly, people and groups who experience disadvantage and specific barriers to accessing mental health services, such as many people from migrant and refugee backgrounds, must be specifically mentioned in the Act. Key principles to reflect the needs of people from migrant and refugee backgrounds in the Act include the need for cultural and gender responsiveness, access to language services as a right, cultural safety, and an intersectional approach.

The complexity of how mental health is viewed and experienced in diverse cultures and religious groups influences not only the lived experience of mental health conditions, but also help seeking behaviours and preferred support structures. A culturally responsive mental health system needs to

⁴ State of Victoria, Commission for Equality in the Public Sector, "Gender Equality Act 2020"; available at <https://www.genderequalitycommission.vic.gov.au/about-gender-equality-act-2020>, (2020); last retrieved 27/7/21.

⁵ United Nations, Department of Economic and Social Affairs (Disability), "Convention on the Rights of Persons with Disabilities," (2007); available at <https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/convention-on-the-rights-of-persons-with-disabilities-2.html>, last retrieved 27/7/21.

take into consideration multiple and intersecting factors stemming from consumers' lived experience, personal identifications and experiences of discrimination. Some of these factors include:

- culturally specific explanatory models of mental health and wellbeing which may or may not be congruent with the dominant western biomedical model
- diverse help-seeking approaches including engaging with trusted sources of community support such as faith leaders, community elders and advocates
- pre-migration experiences of trauma and traumatic stress
- experiences of gender-based violence or trauma – migrant and refugee women who have come from conflict, crisis or trauma backgrounds may be again adversely impacted by the mental health system and supports
- settlement and acculturation challenges
- a broad range of family arrangements, which may shift through migration and settlement processes, creating tensions in family and inter-generational relationships
- engaging in a range of practices and supports that promote mental health and wellbeing, which may involve culturally-specific and innovative practices, supports and approaches
- various levels of English proficiency
- lower levels of health literacy
- different visa status, such as international students whose temporary visa status excludes them from accessing Commonwealth Government funded services
- experiences of gender, age, sexuality, level of education
- intersecting factor such as immigration status and gender - for example, research shows that insecure/ precarious immigration status risk factor for mental health conditions for migrant and refugee women (in particular, perinatal mental health conditions).
- cost and eligibility

Cultural responsiveness includes not only adapting and delivering services in a manner that reflects and addresses these factors, but also the dismantling and removal of all barriers to access, including structural barriers. A diverse and holistic range of approaches to respond to mental health needs also need to be supported by the Act, including community-based and culturally and gender specific responses. The Act must create an enabling environment for the mental health system to respond to these factors and to promote a diverse range of supports to meet the needs of people from migrant and refugee backgrounds.

Access to professional interpreters who are trained in mental health needs to be reflected in the principles under the Act. Access to communication is fundamental to understanding and exercising other rights and provisions in the Act. The Act must uphold the right of consumers to access interpreters, and includes provisions for interpreters to be sufficiently funded, trained in mental health and included as integral parts of integrated mental health clinical teams.

Culturally and linguistically responsive communication does not depend solely upon access to interpreting services. Some of the other key aspects of culturally responsive communication that should be considered within the Act include:

- The role of bicultural health educators in mental health service delivery
- The provision of translated and in-language resources
- More investment in education and awareness programs to build mental health literacy
- The need for gender responsiveness and sensitivity in communication, such as allowing consumers to nominate the gender of health educators and interpreters that they feel safest with.

Cultural safety for people from migrant and refugee backgrounds must be included in the principles in the Act. Victorian Transcultural Mental Health defines cultural safety as:

Cultural safety involves acknowledging how power operates in mental health service systems and in consumer-practitioner relationships. It also includes taking steps to avoid imposing one's own cultural values on others. Threats to a consumer's cultural safety when receiving mental health care include: not being able to communicate with practitioners, not being listened to, not being respected and not being able to involve trusted family or friends.

We are working in an increasingly diverse and complex service environment. Power operates in health service delivery and can be the source of lasting harm and distress. The assumptions that professionals and services wittingly and unwittingly hold can have serious consequences for individuals, families and communities. When professionals and organisations examine their assumptions and understand the historical and social contexts in which they operate, the quality of care that they provide improves.

Practising cultural safety in mental health care provision demands that we critique and transform how power is embedded within knowledge paradigms, professional practices, institutional structures, policy directives and funding priorities.⁶

Cultural safety is particularly needed to address the impacts of racism and discrimination on people from migrant and refugee backgrounds. This includes systemic racism within the mental health system. The Act must include a commitment to develop the capability of the mental health workforce to deliver culturally safe and responsive care, and enable mechanisms that will ensure services are more representative of the cultural diversity of the community.

The principles of the Act also need to reflect an intersectional approach that underscores a commitment to understanding and eliminating the multiple and combined factors of discrimination and inequality that have led to systematic mental health inequity. The Act must place the onus on the mental health system to dismantle these barriers, respond to the impacts of multiple, cumulative and combined inequity on consumers' mental health, and contribute to an inclusive and equitable society where avoidable inequalities no longer result in negative mental health outcomes.

In particular the Act must ensure that any person in Victoria can access Victorian mental health services regardless of immigration status. A major barrier for many people from migrant and refugee backgrounds to accessing mental health are strict eligibility requirements. This especially affects people on temporary visas, asylum seekers, and undocumented migrants, who are already more likely to experience a range of traumas, challenges and inequities that create mental health concerns.

The Royal Commission stated in **Recommendation 34(1)** that the Victorian Government should "ensure the active engagement of Victoria's diverse communities throughout the process of planning, implementing and managing the reformed mental health and wellbeing system." We propose that this recommendation is incorporated into the Act as one of its guiding principles. In order to promote the voices of people from migrant and refugee backgrounds with lived experience of mental health conditions, and to address systemic health inequality, the Act must support co-design and co-production of mental health services. This includes developing and applying a strengths-based model of co-production for mental health services with migrant and refugee communities, to draw upon lived experiences of community mobilisation and mutual support.

⁶ Victorian Transcultural Mental Health, 'Principles Guiding Our Work', available at: <https://vtmh.org.au/guiding-principles/>

The principles in the Act must therefore support building partnerships with people with lived experience, ethno-cultural and multicultural organisations, community leaders and advocates to design and deliver mental health services, while at the same time being sure not to inadvertently cause secondary mental health harms and avoiding the reinforcement or perpetuation of unequal power relations. Diversity of treatment, care and support similarly requires improved coordination and collaboration between different services, as outlined in the Royal Commission recommendations.

The principles must also commit to ensuring that all decision-making bodies are representative of the diversity of the community. We note that the [Expert Advisory Group](#) established by the Department of Health to inform the development of the new Act does not currently reflect the diversity of the community, nor does it appear to include any members with specialist expertise in multicultural mental health. To give effect to cultural safety, cultural responsiveness, and an intersectional approach, mental health services and mental health decision makers must reflect the diversity of the community.

ECCV therefore proposes that the principles under the Act are amended to reflect a contemporary approach that addresses the diverse range of needs across the whole community.

Recommendation 1

That the principles in the Mental Health and Wellbeing Act are amended to specify that mental health services and decision makers are required to:

- ensure that services are provided in a manner that is safe, sensitive and responsive to consumers' needs and experiences and upholds people's rights
- uphold the right of consumers, carers and families to access professionally trained interpreters and translated written material whenever they require
- uphold the right of any person to access mental health care, regardless of visa status or lack thereof, and regardless of financial means
- provide culturally responsive mental health treatment and support to people from migrant and refugee backgrounds which addresses their needs, circumstances, understandings of mental health, experiences of trauma, and approaches to help-seeking, as well as supporting a diverse and holistic range of mental health and wellbeing approaches
- ensure that mental health treatment and support to people from migrant and refugee backgrounds is culturally safe, including removing barriers, engaging respectfully, seeking informed consent, using language services when required, and reviewing the service environment, practices, approaches and procedures to make services welcoming and equitable
- apply an intersectional approach to address the multiple and interacting forms of discrimination and inequality that can affect individuals' mental health, such as the discrimination and marginalisation related to gender inequality, homophobia or disability
- work in collaboration to co-design and co-produce mental health supports with people with lived experience, carers and with the broader community including community-based advocates and organisations
- better reflect the diversity of the community in the mental health system workforce, leadership and governance.

Non-legal advocacy and supported decision-making

Question 3: Do you think the proposals meet the Royal Commission’s recommendations about non-legal advocacy?

ECCV welcomes the inclusion of the proposals relating to non-legal advocacy in the new Act. The proposal that this will be an opt-out model will ensure that it will reach consumers who are unlikely to proactively reach out for this type of support, particularly people from migrant and refugee backgrounds.

In order to work effectively with all consumers from migrant and refugee backgrounds, the new non-legal advocacy services to be established under the Act need to include specialist multicultural expertise. This must include multilingual staff, specific and targeted communication strategies for reaching migrant and refugee communities, partnerships with multicultural and ethno-specific organisations and cultural and gender expertise among their governance and leadership.

Consumers from migrant and refugee backgrounds often look for support from a broad range of non-legal advocates, including extended family members, bicultural educators, community leaders, faith leaders and accredited interpreters. We recommend therefore that the definition of non-legal advocacy in the Act should include community leaders/advocates, elders, extended families, faith leaders, chosen families and peer advocates. These community advocates, alongside existing consumer-centred mental health advocacy services such as the Independent Mental Health Advocacy service (IMHA), need to be appropriately supported, trained and resourced to undertake this advocacy role.

Recommendation 2

That the Mental Health and Wellbeing Act specifies that the new non-legal advocacy service is required to have specialist multicultural expertise, uphold human rights, adhere to culturally and gender safe practice, reflect the diversity of the community, and recognise a broad range of community advocates, including families, faith leaders and community elders.

Special mention about accessing accredited interpreters should also be included in the Act’s provisions for non-legal advocacy. Access to a professionally trained and accredited interpreter (who is not a family member) is essential to ensure that this function of non-legal advocacy is effective and ethical, and that non-legal advocacy is accessible to people who do not speak English as a first language. Specifically outlining the role of interpreters in the Act is in line with the recommendations of the Royal Commission to build the capacity of non-legal advocates within the mental health system.

Having access to interpreters also meets the requirement that there are “no restrictions placed on a consumer’s right to communicate with an advocate,” as using an interpreter will support consumers to engage with non-legal advocates. If consumers are unable to communicate effectively with their non-legal advocates, then their rights are being infringed compared to other consumers. This would constitute a form of systemic discrimination.

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

From our work in the multicultural mental health sector we know that interpreters are underutilised in mental health service provision, and in health care settings in general. The Royal Commission’s findings back this up, with Volume 3 of the Final Report acknowledging that interpreters were vastly underutilised across all types of care and treatment settings in the mental health system. One example cited by the Royal Commission was that less than half of interpreter services within health settings in 2015–16 were delivered by interpreters with professional NAATI accreditation. There are a number of

reasons for this, including not enough interpreters for all language needs, service providers not knowing how to work with interpreters, limited after hours availability, interpreters lacking experience in the area of mental health and the perceived prohibitive cost to service providers of booking interpreters for their clients.

Recommendation 34(5) from the Royal Commission’s Final Report recommended that digital technologies are developed to “support the delivery of language services that assist access to and engagement with mental health and wellbeing.” We propose that this recommendation is included in the Act but that it is expanded to include:

- Requiring mental health service providers to ask consumers at their first point of contact if they need an interpreter, including the preferred gender of the interpreter.
- Working with an interpreting services at any point in the course of care or treatment as required by the consumer.
- A commitment from government to properly resource the interpreter workforce so that the specific needs of consumers in all mental health settings can be fully and equitably met.

The Act will need to include clear and direct provisions that uphold the rights of consumers and service providers to have the choice to work with an interpreter of their preferred gender, free of charge, whenever this is required. Asking if the consumer wants to use an interpreter must be part of the process of consumers receiving, or at risk of receiving, compulsory treatment.

Recommendation 3

That the Mental Health and Wellbeing Act requires that the non-legal advocacy service must work with interpreters, including offering access to an interpreter of the consumer’s preferred gender, whenever requested, and engaging an interpreter whenever required for communication.

Additionally, the capacity of the Act to support people from migrant and refugee backgrounds in using non-legal advocacy could be strengthened if the role and purpose of non-legal advocacy is communicated in a culturally responsive and safe manner. A corollary of this proposal is that all advocates, both legal and non-legal, should also be sufficiently trained on how to advocate on behalf of clients from migrant and refugee backgrounds in a culturally safe and appropriate manner. As proposed by the Victorian Refugee Health Network, this would include ensuring that all advocates are sensitised to specific issues such as:

- the impacts of trauma on individuals and families
- family separation
- low mental health literacy
- poor understanding of the Victorian health systems
- factors associated with psychosocial disadvantage such as lack of social support, loneliness, social disruption caused by migration, difficult work environments and experiences of discrimination

The Act must therefore contain provisions for all advocacy in the mental health system to be underpinned by intersectional, human rights-based and cultural safety approaches.

Question 5: Do you think the proposals meet the Royal Commission’s recommendations about supported decision-making?

The proposed provisions about supported decision-making in the Act seem to be a narrow interpretation of the Royal Commission recommendations, which only apply in relation to compulsory treatment. The Royal Commission’s commitment to supporting the autonomy of consumers and

people with lived experience and person-centred care would require a broader application of supported decision-making principles across the mental health system.

There is insufficient guidance in the Act as to how supported decision making practices and processes can be culturally relevant and safe for Victoria's multicultural community. Outlined in response to Question 6 below are our key recommendations for how this can be achieved.

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

Supported decision making requires a high level of health literacy and requires effective and culturally safe communication between consumers, their families and service providers. Amongst migrant and refugee communities there are varied levels of health literacy and English proficiency. The frames of reference through which mental health is experienced and understood by people from migrant and refugee backgrounds may be distinct from the Western legal or biomedical models, which are the basis for the proposed supported decision making model in the Act. It is therefore critical that the Act contains provisions for all communications and processes relating to supported decision making to be culturally safe and accessible to the diverse needs of our community. Supported decision making must utilise best practice models that take a rights-based and intersectional approach to empowering consumers while reducing the risk of coercion or forced consent.

ECCV welcomes the rights-based approach used in the proposed changes for written Statements of Rights, Advance Statements and second psychiatric reports. However, there is a risk that a consumer's rights will still be breached if they are unable to understand what is written in these statements.

In the current recommendations, the use of accessible formats is mentioned only with regards to the Statement of Rights. We propose that the Act includes provision for consumers to request all written records, and especially the three important records mentioned above, to be translated into a language of their choice as required. We would also recommend provision for these documents to be explained to consumers in plain English and/or the person's preferred language, as required.

Recommendation 4

That the Mental Health and Wellbeing Act specifies that consumers can request any written documents or records to be made available and explained in the consumer's preferred language.

ECCV also proposes that the description of nominated persons is expanded in the Act to reflect the wide range of supports that consumers from migrant and refugee backgrounds draw upon. Our findings and engagements with CALD communities suggest that people from migrant and refugee backgrounds will often seek mental health support from trusted individuals such as interpreters, faith leaders, community elders, complementary health practitioners and community health educators.

As it is the role of nominated persons to help represent the views and preferences of the person, including views and preferences set out in any advance statement made by the person, we recommend that nominated support persons should include non-mental health practitioners such as interpreters, faith leaders, community elders and complementary health practitioners. Asking if the consumer wants to use a nominated support person to support a request for a second psychiatric opinion should also be included in this section of the Act.

Recommendation 5

That the Mental Health and Wellbeing Act defines nominated persons broadly to include any person trusted by the consumer, which may include community elders, faith leaders or interpreters.

ECCV welcomes the decision to establish a Mental Health Improvement Unit within Safer Care Victoria to build the capacity of consumers, families, carers, supporters and the mental health workforce in supporting the autonomy of consumers using the mental health system. While the foundation of the Mental Health Improvement Unit is not legislated for in the Act, we note that the Mental Health Improvement Unit is recommended by the Royal Commission to work with mental health and wellbeing services to “increase consumer leadership and participation in all activities to reduce compulsory treatment” (Recommendation 55.4.a).

ECCV suggests that the Mental Health Improvement Unit must be required to play a key role in facilitating the cultural safety and responsiveness of the mental health workforce by working collaboratively with specialists in transcultural mental health and in culturally responsive practice. In particular, we propose that the Mental Health Improvement Unit works with Victorian Transcultural Mental Health and other specialists to deliver training for the mental health workforce in the following areas of cultural safety and cultural and gender responsiveness:

- Working with consumers in a culturally and gender safe manner
- Using and working alongside interpreters
- Working alongside complementary and community mental health practitioners
- Engaging with non-legal advocates
- Engaging and working with family members, carers and other supporters.

Information collection, use and information sharing

Question 7: Do you think the proposals meet the Royal Commission’s recommendations about information collection, use and sharing?

Volume 3 of the Royal Commission’s Final Report, “Promoting inclusion and addressing inequities,” highlights that there is a lack of consistent, high-quality data available relating to the prevalence of mental illness in culturally diverse communities. In response to this, **Recommendation 34(3)(a)** proposes that the Mental Health and Wellbeing Division of the Department of Health collects, analyses and reports on “data on the mental health and wellbeing of Victoria’s diverse communities for planning and funding purposes and to improve transparency in mental health and wellbeing outcomes for diverse communities.”

Recommendation 49 also discusses the need for the monitoring and evaluation of mental health services from the perspectives of consumers, families, carers and supports. Addressing this recommendation within the information collection and sharing provisions in the Act would help to capture the lived experiences and outcomes of people from migrant and refugee communities using the mental health system.

Although the proposed content in the Act related to information collection and sharing may result in some improvements to mental health data and analysis for the general population, ECCV and the other multicultural and mental health organisations we consulted with feel that the proposed changes will not result in useful and culturally safe data being collected that will be relevant to the specific mental health needs of migrant and refugee communities.

Collecting, analysing, and reporting on data for migrant and refugee communities must be explicitly required in the Act, in accordance with **Recommendation 34** of the Royal Commission. Specific provisions for the establishment of culturally safe and responsive feedback mechanisms for consumers must also be established to promote greater accountability and transparency.

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

At the bare minimum, **Recommendation 34(3)(a)** from the Royal Commission’s Final Report needs to be included explicitly in the Act.

Furthermore, there are two crucial issues about information collection that need to be addressed in the new Act: the lack of consistency across culturally and linguistically diverse or “CALD” datasets collected from consumers, and the manner in which information is collected from consumers, with particular regard to how the need for collecting personal information is communicated in a culturally safe and responsive manner.

Currently there is no consistent approach in Australia for collecting migrant and refugee mental health data. This finding was borne out by recent research conducted by ECCV and VTMH in our joint paper “[Recommendations for a culturally responsive mental health system](#)” and the Federation of Ethnic Communities’ Councils of Australia (FECCA) issue paper, “If We Don’t Count It ... It Doesn’t Count!: Towards consistent national data collection and reporting on cultural, ethnic and linguistic data.”⁷

⁷ Federation of Ethnic Communities’ Councils of Australia, “If We Don’t Count It ... It Doesn’t Count!: Towards consistent national data collection and reporting on cultural, ethnic and linguistic data”, (2020); available at <https://fecca.org.au/if-we-dont-count-it-it-doesnt-count/>, last retrieved 27/7/21.

Collecting migrant and refugee service usage data is crucial for effective planning for culturally responsive mental health care. This enables services to understand the cultural diversity of populations in their catchment, the cultural diversity of users of their service and, by comparing these two data sets, to identify priority population groups that are missing out on mental health support. We recommend therefore that the Act includes a provision for mental health services to collect more consistent migrant and refugee service usage data, and to use this data in service planning and provision. Specific data sets that should be considered for collection include:

- Cultural background
- Country of birth
- Length of time in Australia
- Languages spoken
- Need for interpreter
- Religion
- Gender (including transgender status)

Recommendation 6

That the Mental Health and Wellbeing Act specifies that mental health services must collect data on the demographic profile of consumers with their consent. This should include data sets relevant to people from migrant and refugee backgrounds such as:

- Cultural background or ancestry
- Country of birth
- Length of time in Australia
- Languages spoken
- Need for interpreter
- Religion
- Gender (including transgender status)

Secondly, how the service collects this data from consumers, and the way questions are asked, must be safe and culturally responsive. People from migrant and refugee backgrounds often report feeling targeted or racially profiled when they are asked to identify their cultural background, ethnicity or religion. Some people from refugee and asylum seeker backgrounds might also have had traumatic experiences in their migration journey to Australia relating to their cultural identity or ethnicity, with the result that they are more reluctant to disclose such information.

We recommend therefore that the Act adds a provision that personal information collected from consumers should be “collected in a consistent and culturally safe way, using a variety of different platforms to ensure accessibility for all users of the mental health system.” Additionally, we recommend that the Act includes a provision stating that it is the responsibility of the mental health service to explain why and how personal information will be collected in a culturally safe way. Some ways to ensure this include:

- Giving the option to answer questions in the consumer’s language of choice when needed, via interpreters or translated materials;
- Explaining how the data will be used and shared – i.e. to plan for culturally responsive services, not for the purposes of cultural profiling;
- Disclosing personal information should be voluntary and confidential; this is particularly relevant for refugee and asylum seeker communities, especially those on precarious visas where data breaches could have detrimental impacts on their safety, or those in family violence situations;

- As not all people from migrant and refugee backgrounds have equitable access to digital devices or data, consumers should have the option to respond to questions via a choice of platforms including digital, paper, or with the support of interpreters.

Recommendation 7

That the Mental Health and Wellbeing Act specifies that consumers' data must be collected in a consistent and culturally safe way. This must include an explanation of why personal information will be collected, and how it will be used.

There are risks involved in personal mental health information sharing that need to be addressed in the Act. Many people do not want to have their personal health information accessible to the many people who work in a health service. This kind of information can be used in a range of ways that may not always benefit the person or be in their best interests, and people may rightfully have legitimate concerns about their information being accessed and used in ways they did not intend. Consequently, we recommend that the Act includes safeguards and guarantees of transparency relating to information sharing practices, some of which might include:

- Building in significant security into any new ICT system
- Building in security clearance levels to prevent information being accessed
- Requiring court orders for agencies such as child protection or police to access records, and
- Monitoring of records accessed through court orders or by people who are not treating clinicians.

Recommendation 8

That the Mental Health and Wellbeing Act includes specific requirements for data security and protection of consumers' personal and health information, including requirements for court orders for agencies (including Victoria Police or the Department of Families, Fairness and Housing) to access mental health records.

Finally, we recommend that all consumer feedback and evaluation mechanisms and processes are developed in a culturally safe and accessible manner. Feedback and evaluation data should therefore be collected, analysed, reported on and shared using the same guidelines outlined above.

Treatment, care and support

Question 9: Do you think the proposals meet the Royal Commission's recommendations about reducing the use and negative impacts of compulsory assessment and treatment?

ECCV welcomes the recommendations for the new Act to reduce the use and negative impacts of compulsory treatment. The expectations that compulsory treatment is to be used only as a last resort and that such treatment should be provided with the least possible restrictions on people's rights is broadly in alignment with **Recommendations 42(2)(e)** and **42(2)(f)** of the Royal Commission's Final Report.

We support the provision that the Act will contain clear and specific principles relating to compulsory treatment that will require decision makers to consider the impact of compulsory treatment on the person receiving it, with special regard for people who may have experienced trauma. With the right input from people with lived experience from migrant and refugee backgrounds and from multicultural mental health specialists, there is potential to make these principles culturally responsive to meet the needs of our diverse community.

To give effect to these principles, ECCV proposes that the Act must contain strong accountability requirements for progressing the elimination of seclusion and restraint, and regulation of compulsory treatment. This must include requirements for clinicians to ensure that consumers understand information, have access to independent, culturally responsive supports.

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

In line with many of our other recommendations, we propose that the development of the principles and practices around the compulsory treatment reforms must necessarily be co-produced with consumers and mental health specialists from migrant and refugee backgrounds. Otherwise, as we have noted elsewhere, there is a risk that the perspectives and needs of people from migrant and refugee backgrounds will be overlooked in the process of reform.

An area of particular concern regarding compulsory treatment and assessment is that consumers from migrant and refugee backgrounds have support to understand what the treatment or assessment entails, and why it is compulsory. The new Act must include a provision for consumers to use interpreters at any time as needed, and to have access to relevant translated materials.

The new Act should require that other treatment and non-treatment supports which could be reasonably provided to a person to reduce the risk of distress or harm, such as talking therapies, peer support, specialist trauma services, respite services or referral to other services to such as housing, be considered first, and that compulsory treatment and assessment are only pursued after all other options have been exhausted. Clinicians making compulsory treatment orders would need to demonstrate that they have explored other options before resorting to compulsory treatment, and that this decision need to be communicated to and understood by the consumer. All such treatments considered would also necessarily have to be subjected to a rigorous trauma-informed assessment to ensure that the consumer does not experience secondary mental health harm or trauma as a result of the treatment.

Recommendation 9

That the Mental Health and Wellbeing Act specifies that clinicians making compulsory assessment or treatment decisions must explore a broad range of treatment and non-treatment supports, and that clinicians pursue compulsory assessment or treatment only if they can demonstrate that all other options have been exhausted.

The role of non-legal advocates or nominated support persons should also be formally included in this section of the Act. Consumers from migrant and refugee backgrounds must have the option for support from people from their communities who they trust and who can help the consumer represent their needs to the mental health workforce involved.

Recommendation 10

That the Mental Health and Wellbeing Act specifies that:

- non-legal advocates and support persons must be notified if compulsory assessment or treatment are to be used
- any specific needs or considerations raised by the support person and/or advocate on behalf of the person are recorded and addressed by clinicians who are administering the assessment or treatment.

Question 11: Do you think the proposals meet the Royal Commission’s recommendations about reducing the use and negative impacts of seclusion and restraint, and regulation of chemical restraint?

ECCV agrees that the proposals for the new Act meet the Royal Commission’s recommendations for reducing the use and impact of seclusion and restraints, albeit with some significant reservations. The proposals are also aligned with the Royal Commission’s recognition of the need to build and sustain a trauma-informed approach across the new mental health system, as described in Volume 2 of the Royal Commission’s Final Report, “Collaboration to support good mental health and wellbeing.”⁸

While we welcome the Act’s commitment to phasing out seclusion and restraint practices that have proven to have strong negative impacts on the mental health outcomes of consumers, in line with other mental health advocacy organisations, we urge that seclusion and restraint are phased out sooner than the 10-year timeframe currently proposed.

This will be especially important to prevent secondary mental health harms for people from refugee and asylum seeker backgrounds who have experienced torture or other traumatic events during their migration journey to Australia, and for whom seclusion and restraint may constitute a triggering experience.⁹

Phasing out seclusion and restraint sooner than the current 10-year timeframe will reduce untold amounts of unnecessary human suffering and trauma. If the decision has already been made to discontinue seclusion and restraint, then we see no reason to delay the process to end these practices. Moreover, in line with the position taken by Foundation House in their submission to the Act, we propose that it would be consistent with the Royal Commission’s findings to incorporate a general principle in the Act about the need to ensure that services are provided in a manner that is responsive to experiences of trauma, not limited to compulsory treatment, seclusion or restraint.

To support progress towards this end, the Mental Health and Wellbeing Act needs to include accountability mechanisms for the Victorian Government to demonstrate progress towards ending

⁸ State of Victoria, Royal Commission into Victoria’s Mental Health System, Final Report, “Volume 2: Collaboration to support good mental health and wellbeing,” Parl Paper No. 202, Session 2018–21 (document 3 of 6); available at https://finalreport.rcvmhs.vic.gov.au/wp-content/uploads/2021/02/RCVMHS_FinalReport_Vol2_Accessible.pdf, last retrieved 27/7/21.

⁹ Foundation House, *Australian Refugee Health Practice Guide: Primary care for people from refugee backgrounds – ‘Management of psychological effects of torture or other traumatic events,’* website resource, 2021, available at: <https://refugeehealthguide.org.au/psychological-effects-of-torture-trauma/>

restrictive interventions. The Chief Officer for Mental Health and Wellbeing should be required to report annually to the Victorian Parliament on the progress towards achieving the Royal Commission's 74 Recommendations. As part of this reporting, the Chief Officer should be required to prepare a plan to end restrictive interventions that includes progress milestones, in collaboration with people with lived experience.

Recommendation 11

The Chief Officer for Mental Health and Wellbeing is required to report annually on progress towards ending the use of seclusion and restraint to the Victorian Parliament.

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

In the event more time is needed to phase out seclusion and restraint, then ECCV proposes that more explicit provisions are made in the new Act to monitor these practices to ensure that they are only used as last resorts and, if and when they are used, they are subject to rigorous assessment to minimise any secondary harms, including harm arising from lack of cultural safety.

We recommend that the Act strengthens **Recommendation 53** from the Royal Commission with regards to the Mental Health and Wellbeing Commission's oversight of seclusion and restraint practices. In particular, we propose that the Act includes a provision for the office of a Chief Practitioner to be established within the Commission, which will be responsible for monitoring the elimination of restrictive interventions. The Chief Practitioner's office would need to reflect certain cultural competency standards or criteria, such as monitoring the use of interpreters and non-legal advocates in restrictive interventions, and promoting culturally responsive supported decision-making. In this capacity the Chief Practitioner would be supported by the Commissioner for Migrant and Refugee Communities' Mental Health and the Migrant and Refugee Mental Health Reference Group, whose proposed roles are detailed in response to Question 14.

The oversight provided by these offices would therefore ensure that the protocols and practices for seclusion and restraint be subject to co-review processes with consumers from migrant and refugee backgrounds who have had lived experience of seclusion and restraint.

Recommendation 12

That the Mental Health and Wellbeing Act includes a provision to establish a Chief Practitioner for monitoring the use of restrictive interventions, promoting alternative and less invasive approaches, and promoting the rights of people who are subjected to restrictive interventions.

The mental health workforce engaged in seclusion and restraint practices will require capacity building to become more culturally responsive to the needs of consumers from migrant and refugee backgrounds. A provision for cultural safety training or the inclusion of cultural safety content in existing training should be included in the Act.

In line with our recommendation for Question 4 regarding the use of interpreters, we recommend that consumers undergoing seclusion or restraint must be able to have access to interpreters and translated information at any point throughout the process as needed.

One of the current recommendations is that clinicians would be required to "document the alternative treatments and supports that were tried or considered and the reasons why they were found unsuitable." In line with our response for Question 6, we propose that this could be broadened to include consultations with community and complementary mental health supports and practitioners, such as faith leaders or elders.

Recommendation 13

That the Mental Health and Wellbeing Act specifies that clinicians are required to engage professionally trained interpreters and provide written material translated into the person's preferred language when the person, or their nominated advocate, carer, and/or support person identify that this is required, or if this is recommended by another clinician or service provider.

Recommendation 14

That the Mental Health and Wellbeing Act specifies that clinicians are required to identify cultural and community-based support options relevant to the person and seek to engage these supports before using seclusion and/or restraint.

Governance and oversight

Question 13: Do you think the proposals meet the Royal Commission's recommendations about governance and oversight?

The provisions relating to governance and oversight would benefit from incorporating a number of the Royal Commission's recommendations to better give effect to the intent and direction set out by the Royal Commission. The multiple and interlocking levels of the new governance system are overly complex and will result in an extra burden on consumers when navigating the mental health system.

For instance, **Recommendation 6** addresses improving access through better health promotion activities and cross-referrals. The section on governance bodies and processes to be specified in the Act should specifically address collaboration and coordination between services with regards to health promotion, collaboration, referrals, and other activities that require coordination.

In 2020 ECCV conducted community consultations for a project about improving cultural responsiveness in primary health services (including mental health services) commissioned by the North Western Melbourne Primary Health Network in 2019-20. ECCV found that people from migrant and refugee backgrounds often encounter systemic barriers to accessing and navigating the mental health system. These include a requirement of high English-language health literacy skills and complex referral pathways. People from migrant and refugee backgrounds are also likely to engage with mental health services through more diverse and complex pathways due to stigma and diverse help-seeking approaches.

These barriers are major factors that result in people from migrant and refugee backgrounds either not receiving the level of support they require, or in deciding not to use the mental health system at all.

When the new governance structure is implemented, there is a risk that the resulting changes to access and referrals will disproportionately and unfairly impact consumers from migrant and refugee backgrounds. Establishing differing and overlapping regulatory arrangements, funding arrangements, funding periods, eligibility requirements and access mechanisms will increase the potential gaps which will further exclude people from migrant and refugee backgrounds. This type of complexity and fragmentation results in significant barriers and disadvantage for people from migrant and refugee backgrounds who may be excluded due to financial barriers, visa status, lack of availability of interpreters, limitations of service scope or catchment, and other constraints.

Neither the mental health system nor the multicultural sector is sufficiently resourced for the workload of coordinating and navigating this complexity in existing service systems. The referral pathways, partnerships and coordination required to ensure culturally responsive access pathways need to be addressed in the Act.

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

It is absolutely crucial that the governance bodies outlined in the new Act – the Mental Health and Wellbeing Commission, the Regional Mental Health and Wellbeing Boards and the Statewide and Regional Multiagency Panels – include membership reflecting the cultural and gender diversity of the community, including representation of people with lived experience.

The Royal Commission report found that there is inadequate system level support and accountability in the mental health system. Currently, the system lacks an overarching framework to address diversity, access, and equity across the service delivery landscape. While there is broad commitment to improving this in response to the Royal Commission's recommendations, this is not captured in the proposed provisions in the Act.

ECCV recommends strengthening **Recommendations 4 and 44** from the Royal Commission (which legislated for the establishment of Regional Mental Health and Wellbeing Boards and the Mental Health and Wellbeing Commission respectively) by making a number of specific recommendations towards these ends:

- That the Act makes explicit provision for the membership of these bodies to be gender culturally equitable and diverse
- That specific targets are set for cultural and gender diversity among the membership of these bodies
- That the Mental Health and Wellbeing Commission includes a Commissioner for Migrant and Refugee Communities' Mental Health, with specific oversight powers relating to culturally safe practices and the monitoring of restrictive practices and compulsory treatment.

These proposed mechanisms will enhance the capacity of the mental health system to be culturally responsive by integrating equity and inclusion across levels of governance of the mental health system.

Recommendation 15

That the Mental Health and Wellbeing Act includes specific requirements for the Mental Health and Wellbeing Commission, the Regional Mental Health and Wellbeing Boards and the Statewide and Regional Multiagency Panels to reflect the diversity of the Victorian community by including targets for the cultural and linguistic diversity of membership of these bodies.

Recommendation 16

That the Mental Health and Wellbeing Act includes a provision to establish a Commissioner for Migrant and Refugee Communities' Mental Health with specific oversight powers relating to culturally safe practices.

In addition to the membership of the key governance bodies, we also propose including a Migrant and Refugee Mental Health Reference group in the new governance structure specified in the Act. The responsibilities of the Migrant and Refugee Reference Group would be to:

- Advise and inform the other governance bodies on matters relating the mental health needs of consumers from migrant and refugee backgrounds
- Assess the cultural safety of policies, practices and programs in the mental health system including restrictive practices and compulsory treatment
- Make recommendations to the Chief Officer for Mental Health and Wellbeing as needed.

The Migrant and Refugee Mental Health Reference Group should consist of:

- Representative bodies for migrant and refugee communities, including ECCV
- Specialists in migrant and refugee mental health including community advocates, clinicians and service providers
- Specialists with expertise across a range of issues including gender, disability, and needs of LGBTIQ+ communities
- Consumers from migrant and refugee backgrounds who have lived experience of using the mental health system.

Recommendation 17

That the Mental Health and Wellbeing Act establishes a Migrant and Refugee Reference Group to support the proposed Commissioner for Migrant and Refugee Communities' Mental Health, which will:

- Advise and inform the other governance bodies on matters relating the mental health needs of consumers from migrant and refugee backgrounds
- Assess and advise upon the cultural safety of policies, practices and programs in the mental health system
- Make recommendations to the Chief Officer for Mental Health and Wellbeing as needed.

Recommendation 18

That the Mental Health and Wellbeing Act specifies that membership of the Migrant and Refugee Mental Health Reference Group must comprise:

- Representative bodies for migrant and refugee communities, including ECCV
- Specialists in migrant and refugee mental health including community advocates, clinicians and service providers
- Specialists with expertise across a range of issues such as gender, disability, and the needs of LGBTIQ+ communities
- Consumers from migrant and refugee backgrounds who have lived experience of using the mental health system.

To complement these provisions, ECCV also recommends that the standalone legislation establishing the Collaborative Centre for Mental Health and Wellbeing (which is not covered by the Mental Health and Wellbeing Act) includes a stronger provision for including people from diverse cultural and linguistic backgrounds who have lived experience using the mental health system, and multicultural and ethno-specific community organisations in its mission brief. This is to ensure that the collaborative work done at the Centre includes co-production with migrant and refugee communities so that the work of the Centre is fit for the purpose of meeting the needs of all Victorians with respect to mental health equity and diverse mental health needs.

Recommendation 19

That legislation establishing the Collaborative Centre for Mental Health and Wellbeing includes a provision requiring the Centre to work with people from diverse cultural and linguistic backgrounds who have lived experience using the mental health system, and multicultural and ethno-specific community organisations.

In order to implement the mental health reforms required in the current environment, Victoria needs independent agencies with appropriate expertise in clinical practice, cultural responsiveness, intersectional approaches, community partnerships and system governance. The multicultural mental health sector at present lacks sufficient resourcing to engage in the governance of the new mental health system in the ways outlined above. The Act must contain provisions for support and funding from the Victorian Government to develop the multicultural mental health sector and make it an integral part of the new governance structures and processes.

We propose that the Act enables the office of the Commissioner for Migrant and Refugee Communities' Mental Health (proposed above) to play a key role in mental health reform, including oversight for the integration of lived experience into service design and delivery, the development of the Workforce Capability Framework and performance measures, mental health policy and more broadly to participate in the development and implementation of a Diversity, Equity and Inclusion Framework. To undertake this work, sufficient funding must be allocated for the proposed Commissioner for Migrant and Refugee Communities' Mental Health, so that it can deepen and extend its work with communities, including multicultural peak agencies, ethno-specific community organisations, networks and groups.

Recommendation 20

That the Mental Health and Wellbeing Act includes a provision for the Minister and the Victorian Government to allocate resources to agencies specialising in working with people from migrant and refugee backgrounds to:

- Develop and deliver culturally and gender responsive mental health and wellbeing programs and services
- Support and strengthen capacity of people from migrant and refugee backgrounds with lived experience of mental health conditions to participate in mental health system governance, co-design and co-production.