Mental Health and Wellbeing Act 2022

Frequently Asked Questions

Protection of rights

Topic	Question	Response
Nominated support persons	How can services support Nominated Support Persons to perform their role and what documents do services need to provide to them?	The Act says that the designated mental health service (DMHS) must take all reasonable steps to support a nominated support person to perform their role. The Act does not define reasonable steps and the question of what constitutes reasonable steps will depend on the individual circumstances at the time but should be what a reasonable professional would have done in the same situation. The Act does provide examples of the sorts of steps a DMHS might take, including allowing a nominated support person to view relevant documents. While this may not always be possible in the particular circumstances or at a particular time, it would be expected that the service should have in place an approach to allow nominated support persons to view documents such as an advance statement of preferences or treatment plans if requested. This provision does not mean that a nominated support person has unfettered access to information about the person they are supporting. The nominated support person is entitled to certain information under the Act, including copies of orders and certain reports and decisions relating to treatment. They can access other information about treatment and care with consent of the person and services need to take all reasonable steps to support access.
Nominated Support Persons	What happens if a consumer is being harmed, or taken advantage of, by their nominated support person, for example in cases of known family violence?	The nominated support person's role is to advocate for the views and preferences of the patient and to support them. While the nominated support person plays an important role in advocating and supporting a patient, they do not have decision making power. The requirement to engage with a nominated support person does not overcome the requirement to engage with the patient themselves. As such, if a nominated person is using their role to coerce the patient, this is likely to become clear through discussions with the patient and nominated support person.

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		If it appears that the nominated support person is not carrying out their role in a way that aligns with the views and preferences of the patient, the authorised psychiatrist (or other person engaging with them) will be able to take this into account when determining how much weight to give the views of the nominated support person. Furthermore, if a service provider reasonably believes that there is a risk of family violence or other serious harm from sharing information with a nominated support person, information must not be shared.
Nominated Support Persons	Can a person under the age of 18 be nominated as a nominated support person?	There is no age limit regarding who can be a nominated support person. The nominated support person's role is to advocate for the views and preferences of the patient and to support them. They do not have decision making power. When making decisions under the Act, an authorised psychiatrist (or other person) must have regard to the views expressed by the nominated support person, to the extent that is reasonable in the circumstances. For example, it may be reasonable to give very strong weight to a nominated support person who is the 16 year old child of a patient and has a close supportive relationship with them and who is engaging closely with them regarding the particular decision. Less weight might be given to a nominated support person if they are struggling to understand the preferences of the patient or the decision that is being considered.
Advance Statements of Preferences	How will services know if a person has an Advanced Statement of Preferences?	The Act says that a DMHS must take all reasonable steps to find out if the person has an advance statement of preferences and whether it is in effect. In practice, reasonable steps may include: • checking their file to see if anything is on record. • asking the patient, their nominated support person or their family, carer or other supporter If a statement is located, reasonable steps would include asking the person if that is their most recent statement. If the person is not able to be asked at the time, it would be reasonable to ask them again when they are able to answer.

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Statements of Rights	Does the obligation to provide a Statement of Rights apply to patients in medical beds? Do services have to give consumers a Statement of Rights each time they come in to a service?	The statement of rights must be given to a person admitted to a bed-based service at a DMHS. It would only be required to be given a person receiving medical care if they were also receiving mental health and wellbeing services. A statement of rights must be given to a person receiving ECT whenever they provide informed consent to that treatment. If a person indicates they already have a statement of rights and have no further questions about it, it doesn't need to be given to them again.

Compulsory Treatment

Topic	Question	Response
Transitional Provisions	Community Treatment Orders will be a maximum duration of 6 months under the new Act, how will consumers on extended orders under the 2014 Act be transitioned to the new Act?	Orders made under the *Mental Health Act 2014* will continue in effect after commencement of the Act. The end date of a patient's order will not change. However, as is the case under the *Mental Health Act 2014*, orders are often ended by an authorised psychiatrist earlier than the duration of the order made by the Tribunal. *Subject to passage of the Mental Health and Wellbeing Amendment Bill 2023 – in circumstances where a community treatment order is varied to an inpatient treatment order and the order has a period of longer than 6 months, the Mental Health Tribunal will vary the period as the Tribunal considers appropriate so that it is not more than 6 months.*
Assessment Orders	If a GP deems that a consumer needs to be placed on an Assessment Order, would they contact The Local service, the Area Mental Health Service or Ambulance Victoria?	As a registered medical practitioner, a GP may make an assessment order in respect of a person if they have examined the person within the previous 24 hours and are satisfied the compulsory assessment criteria apply. On making an assessment order the GP must ensure an authorised psychiatrist for the responsible DMHS is notified of the order and provided a copy of the order.

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		If the order is an inpatient order the GP must also arrange for the patient to be transported to the responsible DMHS as soon as practicable. Transport arrangements should be appropriate to the person and their circumstances and should use the least restrictive transport option possible. General practitioners should talk to the local mental health service about what form of transport is appropriate in the circumstances. If a Community Assessment Order is made the registered medical practitioner should arrange with the relevant designated mental health service for the person to be assessed in the community.

Opt out non-legal mental health advocacy

Topic	Question	Response
Advocates	With the new opt-out non-legal advocacy system staff may need to spend more time assisting advocates to perform their role.	A Designated Mental Health Service must give all reasonable assistance to a mental health advocate for the purpose of enabling them to perform and carry out their functions and duties The Act does not define reasonable assistance and the question of what constitutes reasonable steps will depend on the individual circumstances at the time. An advocate will only be able to access personal and health information under the instruction of the relevant consumer. It is anticipated that advocates will have a regular presence within services. It will be important that services work together with advocates to determine how this will work in each circumstance.
Advocates	Who will be the non-legal advocacy provider and what training will advocates have?	Victoria Legal Aid (VLA) has been appointed provider of the non-legal mental health advocacy service. This means VLA can expand on its current well-regarded service – the Independent Mental Health Advocacy Service (IMHA).
Advocates	What policies and procedures will be in place to support non-legal advocates to undertake their role?	Work is underway to develop protocols to support the operation of the non-legal mental health advocacy service. This work is being informed by a Steering Committee comprising the advocacy provider (VLA), mental health and wellbeing service provider representatives, consumers and family/carer representatives. These protocols will be published when available.

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Notifications	How will non-legal advocates be notified at particular notification points? What are the safeguards to ensure advocates are notified?	Work is underway to develop protocols (as required under the Act) regarding the processes for making notifications. Wherever possible these notifications will be automated through CMI. Further information will be made available as soon as possible.
Support for staff	Will the opt out non-legal advocacy service provider support staff at services?	The role of the non-legal advocate is to provide non-legal assistance to consumers in understanding their treatment and exercising their rights under the Act, based on instructions they receive from the consumer.

Treatment and interventions

Topic	Question	Response
Examination under the Act	When can a person be examined remotely and how will this work in practice?	Section 8 of the Act provides that whenever a person is required under the Act to be examined, this examination must be in person if this is practicable. If not practicable the examination may be conducted remotely. Whether in person examination is practicable will depend on the particular circumstances. The Chief Psychiatrist will provide guidelines to support decision makers in determining what is practicable in the circumstances. It is expected that in-person examination will be the norm but remote examination may be appropriate, for example, if no authorised psychiatrist is available in a remote area, to ensure that the person is not detained without examination longer than necessary.
Capacity/informed consent	What do the terms capacity and informed consent mean?	The Act provides detail about when a person gives informed consent. A person gives informed consent if they – • have capacity to give informed consent • have been given adequate information to enable them to make an informed decision (see below) • have been given a reasonable opportunity to decide whether or not to consent • have given consent freely without undue pressure or coercion

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		• have not withdrawn consent or indicated any intention to withdraw consent. A person has capacity to give informed consent if they are able to – • understand the information given to them about the decision – a person should be supported to understand the information • remember the information – a person need only be able to remember information necessary to make the decision, a general recollection is sufficient • use or weigh the information – a person must be able to assess the information and understand the impact of making (or not making a decision); and • communicate their decision – this can be through speech, gesture or any other means. These provisions are not substantively changed from the *Mental Health Act 2014*
Chemical restraint	When is sedation considered chemical restraint? When is administering an anti-psychotic drug considered treatment and when would it be considered chemical restraint? If a patient poses a risk to themselves or others when can they be given medication to control their behaviour? How will the regulation of chemical restraint work in Emergency Departments? What is the difference between medical treatment and chemical restraint? Have there been considerations made regarding the monitoring of chemical restraint practices as defined in the Act?	The Act regulates the use of chemical restraint for the first time in Victoria. This means chemical restraint can only be used on a person to prevent imminent and serious harm to that person or another person. The Act defines chemical restraint to mean the giving of a drug to a person for the primary purpose of controlling the person's behaviour by restricting their freedom of movement but does not include the giving of a drug to a person for the purpose of treatment or medical treatment. The definition of chemical restraint excludes treatment (for mental illness) and medical treatment because sedation may be a legitimate purpose of treatment or a side effect of it. The Office of the Chief Psychiatrist is undertaking a comprehensive body of work to support the monitoring and regulation of chemical restraint, including the production of a new clinical guideline. There will be relevant consultations to inform the work, including with services. A specific form is being developed to record usage of chemical restraint in services.

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	If so, what are they? Have practice guidelines been considered?	
Elimination of seclusion and restraint	Does the Act ban the use of seclusion and restraint? What is the department's planned approach to the elimination of seclusion and restraint?	The Royal Commission recommended the Victorian Government work towards eliminating seclusion and restraint in mental health and wellbeing service delivery within the next 10 years. The Act does not prohibit the use of restrictive interventions but does reflect in the objectives the ultimate aim of elimination and provides for the setting of targets towards this goal. Additionally, the Act establishes decision-making principles for treatment and interventions including that restrictive interventions have no inherent therapeutic benefit and can cause significant harm and should only be used unless the harm that will be prevented is likely to be greater than the harm caused. The government recognises the complexity of this issue—the imperative to ensure safety for all, and the new system resourcing requirements to provide the right workforce levels and built environments to support the objective. To support the 10-year elimination goal, the Act establishes the Chief Officer for Mental Health and Wellbeing that will develop targets and a strategy which aims to reduce and ultimately eliminate the use of seclusion and restraint. The strategy will guide future actions towards the elimination of seclusion and restraint. It will build on the significant work underway to reduce restrictive interventions and improve the quality and safety of mental health and wellbeing service delivery across Victoria. Further information on this initiative can be found in https://www.health.vic.gov.au/mental-health-wellbeing-reform/developing-a-strategy-towards-elimination-of-seclusion-and-restraint

Implementation of the Act

Topic	Question	Response
Forms	Will there be new forms and what will the transition process be?	Work is underway to update the current forms to be compliant with new Act, these updated forms are expected to be ready by late July.

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		Work to redesign the forms will occur over the next year, this will give services adequate time to test the new forms before they go live.
Staffing and resources	Has there been consideration of ongoing funding for services to provide targeted support to clinical staff, to prevent statutory breaches and maintain legal compliance?	The 2022-23 Budget provided transitional support to ensure that the mental health and wellbeing sector is supported during the transition to the new legislation, and aware of their obligations under the new Act. Implementation support to services is focused on establishing and supporting the Act Implementation Leads and their Community of Practice and will include Learning and Development and Communications and a Helpdesk provided by the department.
Staffing and resources	What additional resources have been provided to support transition? What supports and tools are available to these potential lead practitioners in mental health services?	Yes, there are Mental Health and Wellbeing Act Implementation Leads funded for each of the 21 designated health services. A series of resources, FAQs, forums and webinars will assist the sector to understand the reforms and transition to the new legislation. An e-learning training course will be developed that covers the foundations of the new Act and support workers to understand and apply the new requirements of the Act. A help desk is currently being mapped for queries from services. Data will be collected for monitoring and evaluation that will assist in identifying the common questions and hotspots where queries occur. This will provide a more informed approach to support the transition to the Act. These activities will be supported by regular, clear, consistent communication and strengthened engagement between the department and the sector to assist in the implementation of the Act.
Continuous information as the Act evolves	How does the department intend to communicate principle and practice changes to services and provide ongoing support to services during these stages of change?	The Act Implementation Leads are part of a coordinated strategy to support sector implementation of the Act. The Act Implementation Leads will have a range of responsibilities to locally implement the Act within the designated health services. They will lead the development of service level plans in conjunction with the department's Sector Implementation Team who will coordinate and support their Community of Practice. Where there are changes to regulations, protocols or other Act-related information, information will be shared via websites, media releases and engagement activities with the support of sector partners and stakeholders.

Topic	Question	Response
		The Sector Implementation team will lead the Embedded Practitioner/ Act Implementation Lead deployments, helpdesk launch and the roll out of e-learning modules.