Consolidated responses to ANMF queries

Question	Response
1. I work in resus at an ED. Will there be changes to physical restraints in emergency departments?	Unlike the *Mental Health 2014* (current) Act, the *Mental Health and Wellbeing Act 2022* (the Act), includes a definition of a 'mental health and wellbeing service'. A mental health and wellbeing service is a service performed for the primary purpose of: • improving or supporting a person's mental health and wellbeing; or • assessing, or providing treatment, care or support to, a person for mental illness or psychological distress; or • providing care or support to a person who is a family member, carer or supporter of a person with mental illness or psychological distress. Regulation of restrictive interventions applies whenever a person is receiving mental health and wellbeing services in a designated mental health service (including in the emergency department (ED) of a designated mental health service). This is regardless of whether or not they are on an order. However, recognising that the regulation of restrictive interventions in emergency departments for people who are not patients (i.e. subject to an order) will be a significant operational change, a regulation has been made by Governor in Council which means that until 31 March 2024, in emergency departments of designated mental health services, only 'patients' (i.e. people on orders under the Act) will be considered to be receiving a 'mental health and wellbeing service' under the Act. The effect of this is that (for that time period), in emergency departments of designated mental health services, restrictive interventions will only be regulated when used in relation to 'patients'.
2. Can ANMF collate a list of these links / resources and learning packages and send them to the attendees please	The department has a range of resources available which the ANMF is welcome to share with members. Useful links include: • MHWA home page: https://www.health.vic.gov.au/mental-health-and-wellbeing-act

	• MHWA Handbook: https://www.health.vic.gov.au/mental-health-and-wellbeing-act-handbook • Chief Psychiatrist's guidelines:https://www.health.vic.gov.au/chief-psychiatrist/chief-psychiatrist-guidelines • Video of MHW Act Sector briefing: Mental Health and Wellbeing Act 2022: Sector briefing - Zoom
3. Are PRN meds considered chemical restraint? When a client is admitted to a MH unit they often have PRN documented (even in an ED when waiting for a MH bed), which is really for the purpose of behaviour management. So can we still have PRN written up to use in an emergency or escalation?	PRN medications can still be written up. Whether or not they are considered chemical restraint (and therefore require authorisation, monitoring and reporting under the Act) will depend on the purpose for which the medication is being used. For the use of a medication to be chemical restraint it must be being given for the primary purpose of controlling a person's behaviour by restricting their freedom of movement. This does not include giving medication for the purpose of treatment or medical treatment. Chemical restraint (i.e. medication given for the primary purpose of controlling a person's behaviour by restricting their freedom of movement) can only be used to prevent imminent and serious harm to the person or another person; and must be authorised, monitored and reported in accordance with the Act. If medication is given for the purpose of treatment (i.e. to remedy or alleviate a person's mental illness or to alleviate the symptoms and reduce the ill effects of the person's mental illness – for example if it included medication to address sleeplessness caused by the person's illness which was causing them distress – it is not chemical restraint.
4. A consumer in ED waiting for a bed gets unhappy overnight and wants to leave. I give them meds to settle them and sleep. Is it chemical restraint?	The Act regulates the use of restrictive interventions, including chemical restraint in relation to people receiving mental health and wellbeing services in a designated mental health service. Whether or not the giving of medication is chemical restraint under the Act will depend on the purpose for which the medication was used. If it was used to alleviate the symptoms and ill effects of the consumer's illness then this would be treatment and therefore, not chemical restraint. However, if the primary purpose for giving the medication was to control the person's behaviour by restricting their freedom of movement, then this could be chemical restraint, and could only be used if the permitted reasons (i.e. to prevent imminent and serious harm to the person or another person) applied.

	It is unclear from this scenario if the person was distressed by the impacts of their illness which included sleeplessness, in which case the medication would be treatment.
5. Does only the treating psychiatrist need to provide written reasons for deviating from a person's advanced statement, or will nurses and allied health staff need to if appropriate? Will there be a form?	The requirement to provide written reasons only applies when an authorised psychiatrist (or delegate) makes a 'treatment decision' (under s89) for a person who does not have capacity to give, or does not give, informed consent to a treatment. A treatment decision that is not consistent with a treatment preference expressed in an advance statement of preference may only be made if the patient's preferred treatment is not clinically appropriate or is unable to be provided by the designated mental health services despite all reasonable efforts having been made. In these circumstances, the authorised psychiatrist must provide written reasons to the patient and their nominated support person within 10 business days. There has not been a form developed for this purpose and there is no required format under the Act. There is also an obligation on designated mental health services to ensure all reasonable steps are taken to give effect to a patient's advance statement of preferences. However, there is no requirement for written reasons for deviating from the broader range of matters that might be covered in an advance statement of preferences or not giving effect to preferences, except in the circumstances outlined above.
6. What is different in intensive care and where can I find that information?	The Act introduces regulation of chemical restraint as a restrictive intervention. Restrictive interventions (including chemical restraint) are regulated under the Act and must be reported to the Chief Psychiatrist when they are used in respect of a person *receiving mental health and wellbeing services* in a designated mental service. 'In a designated mental service means' in *a premises owned or operated by a DMHS*. That includes an ICU. For clarity, this does not need to be services received while the person is under an order. It is also a person who receives mental health and wellbeing services on a voluntary basis. If a person in ICU is receiving mental health and wellbeing services, then the use of medication for the primary purpose of controlling their behaviour by restricting their freedom of movement would constitute chemical restraint and the monitoring requirements

	of the Act would apply. After the initial hour of continuous observation, the level of monitoring is to be determined clinically. Where sedation is used for the purpose of medical treatment this would not be considered chemical restraint.
7. Is there provision for sharing information with Ambulance Victoria without consent, as there can be considerable risk for ambulance crews attending?	Mental health and wellbeing service providers can share a person's health information with Ambulance Service Victoria without the person's consent for the purposes of (i) facilitating the provision of an emergency service to a person; or (ii) performing a function under the *Mental Health and Wellbeing Act 2022.*
8. Will there be a grace period from the Department of Health since paperwork and guidelines were not provided to AMHS before 01/09/2023? Could AMHS be at risk of legal action due to the slow rollout?	The department recognises that there is concern around the Act's commencement and, recognising this, it is timely to note another new feature in the legislation. The Act introduces, for the first time, immunity from personal liability for persons acting in good faith in compliance with the requirements of the Act. This means that practitioners acting in good faith and with a reasonable belief that they are acting in accordance with the Act, are not personally liable for any action. Nor will the relevant health service be liable. The department has worked closely with health service leaders, industry regulators and oversight bodies to understand potential points of liability and to emphasise the importance of taking an educative approach to change.
9. What support has been given to Act implementation leads (AIL)s? They have been given very delayed messages and information, and are finding out new information again in this meeting.	The department communicates primarily with AILs via email and a shared Microsoft Teams channel. At key points, the department has coordinated communications to and shared guidance materials with all AILs as the relevant key contacts in each designated service. This includes: • Orientation and planning sessions for AILs on 30–31 May 2023 • Provision of a comparison document between the 2014 and 2022 Acts on 1 June to form the basis of local presentations and to support local policy and guideline updates • Template readiness checklists and stakeholder mapping tools in June and July 2023 • Establishment of the AIL community of practice – meeting fortnightly from 14 June onwards to coordinate work and receive updates from the department and key external stakeholders • Provision of an early version of the (now published) MHWA handbook on 19 July

	• Development and publication of a Frequently Asked Questions document to respond to service question from AILs on 9 July • Provision of a DH-developed training package (slides, presenter notes and worksheets) on 8 August In line with the intent of having AILs employed by each service, rather than the department, AILs have been responsible for adapting and implementing readiness activities at each service based on the characteristics of those services. Additionally, through the community of practice, AILs have developed and shared their own training materials based on department guidance to support each other in delivering targeted implementation in services.
10. How are we distinguishing when medication is chemical restraint vs treatment? Meds may treat symptoms of psychosis but also be sedating so therefore could be argued as both. The line seems blurry.	For the use of a medication to be chemical restraint it must be being given for the *primary purpose* of controlling a person's behaviour by restricting their freedom of movement. This does not include giving medication for the purpose of treatment or medical treatment. If medication is given for the purpose of treatment (i.e. to remedy or alleviate a person's mental illness or to alleviate the symptoms and reduce the ill effects of the person's mental illness) it is not chemical restraint. It is recognised that treatments may have sedating effects. This does not mean they are chemical restraint, as long as the purpose for which they are given is treatment.
11. Inadequate staffing is one of the reasons why patients' mental health deteriorates – e.g. patients are denied their recovery plan due to insufficient staffing to facilitate. How will this issue be addressed?	The mental health and wellbeing workforce strategy released in 2021 brought with it additional government investment in new workers across disciplines, including significant increases in junior medical officer, registrar, nursing, allied health, and lived experience roles. Health services are encouraged to utilise the full scope of these resources to support this important work.
12. Is there a comparison document for the MHA 2014 vs the new MH&WA 2022 to show changes/differences?	Yes. This is available on the Department of Health website: https://www.health.vic.gov.au/mental-health-and-wellbeing-act#whats-different-in-the-new-mental-health-and-wellbeing-act
13. What are the implications for disability providers? What are the implications for disability providers if the primary disability is MH 'psychosocial'? Is this applicable to people under NDIS with mental health diagnosis? As a support worker,	This will depend on whether the provider meets the definition of a mental health and wellbeing service provider under the Act. This is not based on the diagnosis of the people being cared for by the organisation. Rather, to be a mental health and wellbeing service provider an entity must receive funding (either

how can we support them at their own home? How does this new Act affect us?	directly or indirectly) from the State for the primary purpose of providing mental health and wellbeing services.
	
	If the disability provider is a mental health and wellbeing service provider, then the Act will apply.
	
	Obligations on mental health and wellbeing service providers include requirements to:
	
	• make all reasonable efforts to comply with the mental health and wellbeing principles when exercising a function under the Act
	• give proper consideration to the mental health and wellbeing principles when making a decision under the Act
	• provide safe, person-centred mental health and wellbeing services
	• foster continuous improvement in the quality and safety of the care and mental health and wellbeing services they provide
	• comply with specific provisions of the Act related to:
	  • the sharing of health information
	  • seeking informed consent before treatment is provided under the Act
	  • supporting consumers, family members, carers, guardians, nominated support people and complainants to understand information when the provider is required under the Act to communicate that information to any of these people.
	• establish procedures for receiving, managing and resolving complaints about the provision of mental health and wellbeing services.
	
	Mental health and wellbeing service providers will be within the scope of governance or oversight by the:
	
	• Mental Health and Wellbeing Commission
	• Mental Health and Wellbeing Chief Officer
	• Secretary of the Department of Health.
	
	Where a provider is a designated mental health service provider additional obligations will apply.

14. Is there anything being done to support services with the introduction of 'wellbeing' into their services?	Unlike the current Act, which primarily focused on clinical mental health service provision, the Act will regulate a broader scope of 'mental health and wellbeing service providers'. Mental Health Victoria has been working in partnership with the department to provide

	information (including through a 'road-show' of forums) to assist these newly regulated providers to understand their obligations and the Act. More information is available from https://www.mhvic.org.au/mental-health-and-wellbeing-act
15. Will there be any changes to sec.352 patients where they are returned to hospital by police?	The Act provides greater clarity on the powers of authorised persons (such as police and registered paramedics) to transport a person under the Act. This includes their ability to take an AWOL patient into their care and control to return them to hospital. A key change which may impact receiving services is the requirement that, where a person has transported to a designated mental health service or any other place specified under the Act (including the return of an AWOL patient), the person must be accepted by a registered medical practitioner, authorised mental health practitioner or registered nurse as soon as it is reasonably practicable and safe to do so. More information about the roles and responsibilities of authorised persons when using care and control powers is provided in the mental health crisis response and transport fact sheet.
16. Do the chemical restraint forms include mental health hospital in the home programs? Would they be under acute or community?	The Act regulates chemical restraint that is used in a designated mental health service. 'In a designated mental service means' in a premises owned or operated by a DMHS, therefore hospital in the home (HITH) programs are not provided in a designated mental health service. If a circumstance arose in the provision of HITH services that met the threshold of a serious and imminent risk of harm and necessitated the use of restraint, this would need to be used under a common law duty of care framework. It would be expected that in those circumstances an ambulance would be called, and consideration would need to be given to whether HITH remained an appropriate response.
17. If a patient on a medical ward becomes a danger to self/others on the ward and chemical restraint used, they would need to be specialed for 1hr and 15 min obs, is that correct?	Restrictive interventions (including chemical restraint) are regulated under the Act and must be reported to the Chief Psychiatrist when they are used in respect of a person *receiving mental health and wellbeing services* in a designated mental service. 'In a designated mental service means' in *a premises owned or operated by a DMHS*. That includes a medical ward. For clarity, this does not need to be services received while the person is under an order. It is also a person who receives mental health and wellbeing services on a voluntary basis.

	Assuming the person in this scenario is receiving mental health and wellbeing services, then the use of medication for the primary purpose of controlling their behaviour by restricting their freedom of movement would constitute chemical restraint and the monitoring requirements of the Act would apply. After the initial hour of continuous observation, the level of monitoring is to be determined clinically.
18. Where are we at with amendments removing ambulance paramedics from the provisions conferring powers to take a person into care and control?	Ambulance Victoria paramedics will remain authorised persons, just as they are under the current Act, and will have powers to take a person into care and control for the purpose of transport under the Act. Amendments have been made to the Act (the *Mental Health and Wellbeing Amendment Act 2023*, which was passed by Parliament on 1 August 2023). This includes amendment to allow Ambulance Victoria paramedics to be prescribed by regulations to take on a broader role responding to mental health crises in the community at a later date, rather than Ambulance paramedics taking on this new role from 1 September 2023. (The date for the making of regulations to give Ambulance Paramedics these powers is yet to be settled).
19. We need clarification on imminence of harm. Currently staff feel that patients need to assault staff/co-patients as evidence of imminence of harm?	It is not correct that an incident needs to have occurred before restrictive interventions can be authorised. Determination of imminent and serious harm is a clinical judgment and the person authorising the use of the restrictive interventions must be satisfied that there is a high probability that the person will (or within the near future will) seriously harm themselves or another person.
20. Is Acuphase IMI included as chemical restraint? Acuphase is slow acting and can be sedating hours afterwards.	The fact that a medication has sedating effects does not mean it is chemical restraint. Many treatments may have sedating effects. For the use of a medication to be chemical restraint it must be being given for the primary purpose of controlling a person's behaviour by restricting their freedom of movement. This does not include giving medication for the purpose of treatment or medical treatment. If medication is given for the purpose of treatment (i.e. to remedy or alleviate a person's mental illness or to alleviate the symptoms and reduce the ill effects of the person's mental illness) it is not chemical restraint.
21. Is there any new framework for delivery of assessment and care in the ED? I have developed	This is not something that is being addressed through implementation of the new Act and will be a matter for individual services.

one in my own ED as a wellbeing needs-based assessment but am wondering if there is anything across sites?	However, collaborative work will be undertaken over the next six months with emergency departments to clarify the framework and practices associated with the use of restrictive interventions to embed these changes.
22. Is there involvement from the LLEW in the delivery of the education for services? Is the LLEW involved in the development and delivery of the education you've spoken about?	Yes, Act Implementation Leads have worked closely with lived-experience leads to seek their input into training modules and seek their assistance in the delivery of presentations and e-learning modules. DH LLE representatives were also given the opportunity to input into training materials and resources. In addition, Act Implementation Leads and local Lived Experience Leads have discussed working collaboratively to work towards embedding the principles of into daily practice and to reflect this in training and other resources.
23. Employers are obligated to provide information to staff to be able to do their jobs safely, as per s21(2)(e), and services have been prosecuted by WorkSafe (i.e. the Alfred). How will consent impact this?	The Act continues to permit the sharing of health information without consent in specified circumstances including: • If the disclosure is reasonably necessary for the mental health and wellbeing service provider to perform functions or exercise powers under the Act or any other Act, or if the disclosure is permitted by certain Health Privacy Principles. • If the disclosure is reasonably required by another mental health and wellbeing service provider or a health service provider to provide health services to the person. • If the disclosure is made in general terms to family, a carer or supporter of the person and the disclosure is not contrary to the views and preferences expressed by the person that the health information must not be disclosed to family, a carer or supporter. This disclosure is subject to section 31 of the Act which limits the disclosure of health or personal information of a person if there may be a risk of family violence or other serious harm to that person by disclosure of that information. This limitation applies regardless of whether the person has consented to the disclosure of their personal or health information. • If the disclosure is made to a psychiatrist giving a second psychiatric opinion. The disclosure may include providing access to a consumer's clinical records or discussing a consumer's treatment with the psychiatrist giving the second psychiatric opinion.

	• If the disclosure is made in accordance with any guidelines issued by the Health Complaints Commissioner under the *Health Records Act 2001* (HR Act); and where the disclosure is reasonably necessary to lessen or prevent a serious threat to a person's life, health, safety or welfare, or a serious threat to public health, public safety or public welfare. The Act does not limit the sharing of information within a mental health and wellbeing service provider. The information-sharing provisions within the Act also do not override information sharing enabled in other Acts, including those which allow for information sharing without consent to assess and manage risk, for example under Part 5A of the *Family Violence Protection Act 2008*. These continue in accordance with current legislative arrangements.
24. What does a designated mental health service mean? Does it include ICU/ED?	The term designated mental health service (DMHS) refers to the entity, that is the hospital or health service that is prescribed in regulations. The Act applies to the provision of mental health and wellbeing services in the designated mental health service. 'In a designated mental service' means in a premises owned or operated by a DMHS. This means that regulation (including regulation of restrictive interventions) applies whenever a person is receiving mental health and wellbeing services in a premises owned or operated by a DMHS. This will include in an ICU or an ED of a DMHS. However, recognising that the regulation of restrictive interventions in emergency departments for people who are not patients (i.e. subject to an order) will be a significant operational change, a regulation has been made which will mean that until 31 March 2024, in emergency departments of designated mental health services, only 'patients' (i.e. people on orders under the Act) will be considered to be receiving a 'mental health and wellbeing service' under the Act. The effect of this is that (for that time period), in emergency departments of designated mental health services, restrictive interventions will only be regulated when used in relation to 'patients'.
25. If I work in ICU, and a client is waking up combative after surgery, and I use medication to control or settle them, is that chemical restraint?	It appears that in this circumstance the person is not receiving a mental health and wellbeing service. A mental health and wellbeing service is a service performed for the primary purpose of: • improving or supporting a person's mental health and wellbeing; or

	• assessing, or providing treatment, care or support to a person for mental illness or psychological distress; or • providing care or support to a person who is a family member, carer or supporter of a person with mental illness or psychological distress. In this scenario it appears that the person is in ICU for a purpose related to surgery. As the person is not a person receiving a mental health and wellbeing service, the use of medication to control them is not regulated under the Act. If the medication is required, it would be provided outside of regulation of the Act on the basis of Duty of Care under common law and in accordance with the SCV guideline.
26. If I work in ICU and treat an intentional OD and they wake up and want to leave, are they considered a MH client as they took an OD, and thus am I chemically restraining them?	It appears that in this circumstance the person is not receiving mental health and wellbeing services and the primary purpose of their ICU admission is to address the physical effects of the overdose. If this assumption is correct, the use of medication would not be regulated as chemical restraint under the Act. However, if in this scenario, the person has been referred for assessment by the mental health liaison team (for example: pending their waking) they would be receiving mental health and wellbeing services. In that case, if the primary purpose for administering the medication was to detain the person to facilitate this assessment that would be chemical restraint. Chemical restraint could only be used if the threshold for any restrictive intervention is met (ie. if the nurse concludes that there is a risk of imminent and serious harm). Wanting to leave hospital in its own right doesn't meet that threshold. It would be about what they are articulating they intend to do when they leave that may mean a reasonable belief can be formed).
27. Sec 351 (or new equivalent) arrives in ED, unknown to MH, obviously drug affected, has not had MH Ax or involvement. I'm an ED nurse and offer oral meds to settle client. Is this chemical restraint?	The equivalent section of the new Act is s232. Under the Act, regulation (including regulation of restrictive interventions) applies whenever a person is receiving mental health and wellbeing services in a premises owned or operated by a DMHS. This will include in an ED of a DMHS. Although the person in this scenario is yet to be assessed, they have been brought to the ED under the Act for the purpose of being examined under the Act. Therefore, they will be considered to be receiving mental health and wellbeing services. This means that if

	medication is given for the primary purpose of controlling their behaviour by restricting their freedom of movement, it will be regulated as chemical restraint. As such, the requirements of the Act in relation to the permitted use of restrictive interventions (i.e. must be to prevent imminent and serious harm to the person or another person), authorisation, monitoring and reporting will need to be complied with. However, recognising that the regulation of restrictive interventions in emergency departments for people who are not patients (i.e. subject to an order) will be a significant operational change, a regulation has been made which will mean that until 31 March 2024, in emergency departments of designated mental health services, only 'patients' (i.e. people on orders under the Act) will be considered to be receiving a 'mental health and wellbeing service' under the Act. The effect of this is that (for that time period), in emergency departments of designated mental health services, restrictive interventions will only be regulated when used in relation to 'patients'.
28. When am I a person receiving treatment in a designated mental health service on a voluntary basis?	The term designated mental health service (DMHS) refers to the entity, that is the hospital or health service that is prescribed in regulations. The Act applies to the provision of mental health and wellbeing services in a designated mental health service. 'In a designated mental service' means in a premises owned or operated by a DMHS. Some requirements, such as one of the requirements to provide a statement of rights, apply to a person receiving mental health and wellbeing services who is admitted to a bed-based service at a designated mental health service. This means the person must be receiving mental health and wellbeing services (i.e. a service performed for the primary purpose of improving or supporting a person's mental health and wellbeing; or assessing, or providing treatment, care or support to a person for mental illness or psychological distress; or providing care and support to a person who is a family member, carer or supporter of a person with mental illness or psychological distress) for the obligation to apply. It is important to note that receiving a mental health and wellbeing service is different to receiving *treatment. Treatment* for mental illness means professional skill is used to (a) remedy or alleviate the person's mental illness; or (b) to alleviate the symptoms and reduce the ill effects of the person's mental illness.
29. Part A of form, chemical restraint must be authorised by an authorised psychiatrist or	A nurse practitioner can only authorise chemical restraint if the authorised psychiatrist or delegate is not reasonably available. A nurse who is not a nurse practitioner cannot authorise

delegate, or if they are not available a registered medical practitioner or NP. Can this be clarified? Can a nurse on the ward/ED give the meds, but must speak to the authorised person first? Or after the fact? Can't imagine this in an emergency situation…	chemical restraint. However, they can give medication that is considered chemical restraint to a person, if this has been authorised by someone permitted under the Act (the authorised psychiatrist or delegate, registered medical practitioner or nurse practitioner). A person who is authorising chemical restraint does not need to complete the form before the medication is administered. However, it must be completed as soon as practicable after the use of the restraint.
30. I work on a general medical ward and have received no education from my health service – what impact will the new act have on MH patients admitted?	Assuming the general medical ward is part of a designated mental health service, then the use of restrictive interventions may be regulated under the Act. Restrictive interventions (including chemical restraint) are regulated under the Act and must be reported to the Chief Psychiatrist when they are used in respect of a person *receiving mental health and wellbeing services* in a designated mental service. 'In a designated mental service means' in *a premises owned or operated by a DMHS*. That includes a medical ward. For clarity, this does not need to be services received while the person is under an order. It is also a person who receives mental health and wellbeing services on a voluntary basis. It will also be important to be aware of the new mental health and wellbeing principles of the Act that will apply whenever a person is receiving mental health and wellbeing services.
31. How does the new Act look in residential aged care facilities?	The Act applies to mental health and wellbeing service providers. To be a provider an entity receives funding from the State for the primary purpose of providing mental health and wellbeing services. Therefore, if the facility is a residential aged care facility fully funded and regulated by the Commonwealth, the Act will not apply. However, if it is a specialist aged persons mental health service or if it is a facility that has funded aged person mental health beds then the Act will apply to the mental health and wellbeing services provided.
32. Per the new MHWA page 210 part 5.5 – searching of a person is not permitted once they're admitted. What does this mean for persons returning from leave, returning from AWOL or clinically indicted?	Section 247 of the *Mental Health and Wellbeing Act 2022* creates a power for an authorised person to search a person who is under their care and control as a result of a mental health crisis (Part 5.2) or to facilitate transportation (Part 5.3). This provision has a limited scope and is not designed to be applied beyond these circumstances.

	Sub-section 247(4) is intended to clarify that authorised persons are only empowered to conduct searches under the Act if the individual to be searched is about to be transported, either as part of a mental health crisis response or other compulsory transport under the Act. Neither the *Mental Health Act 2014* nor the *Mental Health and Wellbeing Act 2022* explicitly authorise searches outside of emergency response or transport scenarios. However, there may emerge situations where searches become necessary to fulfill the healthcare facility's duty of care towards people receiving services. Should a contact search be carried out based on this duty of care, it's essential that a lawful rationale supports it. An example of a lawful basis for a contact search could involve reference legislation such as: • Part 3 of the *Occupational Health and Safety Act 2004* • Section 463B of the *Crimes Act 1958* • Section 462A of the *Crimes Act 1958*
33. I'm from a mental health telephone triage service. If we are contacted by an IMHA or other non-legal advocate, what are our options to clarify their identity – eg. can they send us an email?	IMHA works closely with designated mental health services to ensure they have the full names of any advocates working with consumers at that service. For clinicians working outside of these settings, IMHA can be contacted if there is a need to confirm an advocate's identity. Contact us | Independent Mental Health Advocacy (imha.vic.gov.au)
34. General medical wards – dementia and sundowning patients – do the new chemical restraint laws impact giving these patients the nocte +/- PRN Risperdone or Olanzapine?	If the person is receiving mental health and wellbeing services in a designated mental health service, and the primary purpose of the medication being given is to control the person's behaviour by restricting their freedom of movement (and the medication is not treatment) then this may be chemical restraint. If that is the case, the medication may only be used to prevent serious and imminent harm to the person or another person and the requirements of the Act regarding authorisation, monitoring and reporting will apply.
35. I've added myself to the DoH Bulletin, however haven't been sent anything yet. And also having difficulty accessing past presentations/information…	A daily consolidation of news and updates is being provided to Act Implementation Leads, Clinical and Ops Directors each day. AILs have been asked to ensure this information is circulated broadly through services and made accessible to all relevant staff.
36. Is murrenda RACs (part of Eastern Health and next door to Wantirna Health) listed as a psycho geriatric? There are residents with mental health orders.	As the unit is part of a designated mental health service, obligations of the Act that apply to designated mental health services will be relevant. This will include, for example, obligations related to the authorisation, monitoring and reporting of restrictive interventions when they are used in respect of a person *receiving mental health and wellbeing services.* For clarity,

	this does not need to be services received while the person is under an order. It is also a person who receives mental health and wellbeing services on a voluntary basis.
37. Are there guidelines on what monitoring requirements there will be for chemical restraint? And what exactly will be considered a chemical restraint with differing legal status/presentations/symptom?	For the use of a medication to be chemical restraint it must be being given for the *primary purpose* of controlling a person's behaviour by restricting their freedom of movement. This does not include giving medication for the purpose of treatment or medical treatment. If medication is given for the purpose of treatment (i.e. to remedy or alleviate a person's mental illness or to alleviate the symptoms and reduce the ill effects of the person's mental illness) or for medical treatment, it is not chemical restraint. Restrictive interventions (including chemical restraint) are regulated under the Act and must be reported to the Chief Psychiatrist when they are used in respect of a person *receiving mental health and wellbeing services* in a designated mental service. 'In a designated mental service' means in *a premises owned or operated by a designated mental health service*. For clarity, this does not need to be services received while the person is under an order. It is also a person who receives mental health and wellbeing services on a voluntary basis. However, recognising that the regulation of restrictive interventions in emergency departments for people who are not patients (ie subject to an order) will be a significant operational change, a regulation has been made by Governor in Council which means that until 31 March 2024, in emergency departments of designated mental health services, only 'patients' (i.e. people on orders under the Act) will be considered to be receiving a 'mental health and wellbeing service' under the Act. The effect of this is that (for that time period), in emergency departments of designated mental health services, restrictive interventions will only be regulated when used in relation to 'patients'. The monitoring requirements are stipulated in the Act for chemical restraint (a minimum of one hour) but after that point they are based on clinical grounds having regard to the condition of the person.
38. In a situation where clients are attending ED for a compulsory treatment (depot), will this new Act provide them more choice to receive treatment at a location of their choice rather than ED?	The broader mental health and wellbeing system reforms are intended, in line with the principles of the Act, to allow for people to access services at locations that better meet their diverse needs and preferences. Although the commencement of the Act may not have any immediate impact on the treatment location options available to people, implementation of the Royal Commission's broad suite of recommendations will achieve this.

39. I still didn't understand what is the change made to mechanical restraints? Or chemical restraints? In simple words please.	Restrictive interventions (including seclusion, physical restraint, mechanical restraint and chemical restraint (see below)) are regulated under the Act and must be reported to the Chief Psychiatrist when they are used in respect of a person *receiving mental health and wellbeing services* in a designated mental service. 'In a designated mental service' means in *a premises owned or operated by a designated mental health service*. For clarity, this does not need to be services received while the person is under an order. It is also a person who receives mental health and wellbeing services on a voluntary basis. <u>However</u>, recognising that the regulation of restrictive interventions in emergency departments for people who are not patients (ie subject to an order) will be a significant operational change, a regulation has been made by Governor in Council which means that until 31 March 2024, in emergency departments of designated mental health services, only 'patients' (i.e. people on orders under the Act) will be considered to be receiving a 'mental health and wellbeing service' under the Act. The effect of this is that (for that time period), in emergency departments of designated mental health services, restrictive interventions will only be regulated when used in relation to 'patients'. The Act introduces regulation of chemical restraint for the first time. The use of a medication will be chemical restraint if it is given for the *primary purpose* of controlling a person's behaviour by restricting their freedom of movement. This does not include giving medication for the purpose of treatment or medical treatment. If medication is given for the purpose of treatment (i.e. to remedy or alleviate a person's mental illness or to alleviate the symptoms and reduce the ill effects of the person's mental illness) or for medical treatment, it is not chemical restraint. The Act does not ban the use of chemical restraint within designated mental health services, rather it requires that its use be authorised, monitored and reported in accordance with the Act, in the same way that the use of other restrictive interventions (seclusion, physical restraint and mechanical restraint) are.
40. I think there is a lot of confusion around medication administration in aged care – e.g., for medication alleviating psychiatric symptoms,	For the use of a medication to be chemical restraint it must be being given for the primary purpose of controlling a person's behaviour by restricting their freedom of movement. This does not include giving medication for the purpose of treatment or medical treatment.

there is no change? Would be good to get the hierarchy checklist.	If medication is given for the purpose of treatment (i.e. to remedy or alleviate a person's mental illness or to alleviate the symptoms and reduce the ill effects of the person's mental illness) it is not chemical restraint.
41. When will you offer the education on mechanical and chemical restraints? Please look at including other clinical areas/wards, e.g. ICU departments.	Guidelines and additional information will be issued by the Chief Psychiatrist addressing these matters. These will be available on the Chief Psychiatrist's webpage: https://www.health.vic.gov.au/chief-psychiatrist. Safer Care Victoria has a role in this too and they have guidance available on their website: Acute behavioural disturbance | Safer Care Victoria The OCP and SCV will need to work conjointly on this education of the wider workforce.
42. What are the main considerations for community mental health clinicians when the MHWA is implemented?	There are a range of ways in which the new Act is applicable to community-based organisations. For example, if the community-based organisation is a mental health and wellbeing provider (i.e. they receive funding from the State for the primary purpose of providing mental health and wellbeing services) they will need to: • make all reasonable efforts to comply with the new mental health and wellbeing principles • comply with provisions in the Act regarding the sharing of health information • understand that consumers can make complaints about the provider to the new Mental Health and Wellbeing Commission. Mental health clinicians operating in the community who are registered medical practitioners or authorised mental health practitioners will need to note new requirements about making assessment order. This includes: • the requirement to specify the responsible designated mental health service on the order (there is a new form MHWA101 which can be used) • the need to give proper consideration to the decision-making principles for treatment and interventions when making the assessment order. Authorised mental health practitioners include persons employed by a designated mental health service as a registered psychologist, registered nurse, social worker or registered occupational therapist.

43. Would there be changes in private inpatient mental health settings having only voluntary patients?	Private inpatient units will not be in scope of the new Act unless they receive funding from the State for the primary purpose of providing mental health and wellbeing services (i.e. if they are considered a mental health and wellbeing service provider). Similar to the current legislation, where private inpatient units are providing electroconvulsive treatment (ECT), the requirements of the Act must be complied with. This includes seeking informed consent, providing a statements of rights regarding ECT and applying to the Mental Health Tribunal for authority to perform ECT where the consumer is a young person, or in relation to adult consumers who do not have capacity to consent, but have an instructional directive or medical treatment decision maker who is consenting.
44. Is the regulation for chemical restraints only for patients who have been sectioned and made compulsory for treatment? We have patients with dementia and delirium on our unit who receive chemical restraint.	Restrictive interventions, including chemical restraint, is regulated by the Act when used in relation to persons receiving mental health and wellbeing services in designated mental health services. The regulation of restrictive interventions applies regardless of whether the person is receiving voluntary or compulsory treatment. There is an exception to this for a time limited period, in relation to the use of restrictive interventions in emergency departments of designated mental health services. Until 31 March 2024, in emergency departments of designated mental health services, only 'patients' (i.e. people on orders under the Act) will be considered to be receiving a 'mental health and wellbeing service' under the Act. The effect of this is that (for that time period), in emergency departments of designated mental health services, restrictive interventions will only be regulated when used in relation to 'patients'.
45. What are the changes mentioned to Section 351? What are the ED-specific changes?	The new *Mental Health and Wellbeing Act 2022* introduces a new framework for responding to mental health crises and for providing transport under the Act. Most of these changes impact the roles and responsibilities of authorised persons like police and registered paramedics employed by Ambulance Victoria, and do not directly impact service providers, including emergency departments. Under the new Act, section 351 is now section 232 and punitive terminology like, 'apprehension' and 'custody' will be replaced with 'care and control' to reflect a more health-led approach. These care and control powers will replace the current '351 apprehensions' and are also used where compulsory transport is required under the Act. For example, when providing interfacility transfers.

	The Act also introduces new principles to apply specifically to authorised persons. These principles support the vision of the Royal Commission by requiring that any responses or transport by authorised persons are health led, or where this is not reasonably practicable, informed by the advice of health professionals wherever it is reasonably practicable in the circumstances. Any use of power by an authorised person must also be done in the least restrictive way possible wherever it is reasonably practicable in the circumstances. The only change directly impacting service providers (including emergency departments) is a new requirement that, where a person has been transported to a designated mental health service (or other place specified under the Act) under care and control of an authorised person, the person must be accepted by a registered medical practitioner, authorised mental health practitioner or registered nurse as soon as it is reasonably practicable and safe to do so. More information about the roles and responsibilities of authorised persons when using care and control powers is provided in the Mental health crisis response and transport fact sheet.
46. Where can we find the e-learning modules?	The e-learns will be available and accessible to any interested provider, public or private, via the Liberate Learning website and through the mental health learning platform (MHPOD): https://www.mhpod.gov.au/ More information is available from https://www.mhvic.org.au/mental-health-and-wellbeing-act