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| Comparison of key provisions: *Mental Health and Wellbeing Act 2022* and the *Mental Health Act 2014* |
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Victoria’s Mental Health and Wellbeing Act 2022 commences on 1 September 2023. The new Act replaces the Mental Health Act 2014 and is a key recommendation of the Royal Commission into Victoria’s Mental Health System.

Comparison of key provisions table

| Key provisions in Mental Health and Wellbeing Act 2022 (MHWA) that are new or different from the Mental Health Act 2014 (MHA) | Key provisions in Mental Health and Wellbeing Act 2022 (MHWA) that are similar or comparable to the Mental Health Act 2014 (MHA) |
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| Chapter 1 – Preliminary - definitions, scope, objectives and principles |  |
| ‘Mental Health and Wellbeing Service Provider’ is defined more broadly to include a wider range of service providers than were regulated under the MHA. [s3]New requirements for the provision of ‘appropriate supports’ to assist a person to understand information, communicate and make decisions. All reasonable efforts must be made to provide supports any time the Act requires communication with a consumer or their family members, carers and supporters. [ss6&7]Strengthened and more comprehensive Mental Health and Wellbeing Principles with higher threshold for consideration. Mental Health and Wellbeing Providers must give proper consideration to the principles when making decisions and must make all reasonable efforts to comply with the principles when exercising a function under the Act. [ss15-29]New provision that information must not be disclosed if there is a risk that a person may be subject to family violence or other serious harm. [s31] | Meaning of ‘mental illness’ is comparable to the MHA with some updates to language and clarification that a person experiencing or having experienced psychological distress is not a reason to consider that the person has mental illness. [s4]Meaning of ‘treatment’ is comparable to the MHA. [s5] |
| Chapter 2 – Protection of rights |  |
| Advance statements of preference (formerly called advance statement) may include a broader range of preferences relating to treatment, care and support needs. Witnessing requirements have been eased. [Part 2.5]Nominated support person (formerly called nominated person) role is clarified as focussed on advocating for the views and preferences of the patient and supporting them to communicate and make their own decisions. Witnessing requirements have been eased. [Part 2.6]Increased obligation on designated mental health services to determine if a statement or nomination is in place, to make all reasonable efforts to give effect to an advance statement of preferences and/or to support a nominated support person. [ss32-34]A new opt out model of non-legal mental health advocacy is established. [Part 2.3] | Requirements to provide Statements of Rights are similar but with strengthened obligations to take all reasonable steps to ensure rights are understood and additional requirement to provide Statement of Rights to persons admitted to bed-based designated mental health services. [Part 2.2]Provisions related to the right to communicate are comparable to those of the MHA. [Part 2.4]Provisions related to second psychiatric opinions are comparable to those of the MHA [Part 2.7], however, with a new requirement that a patient is automatically provided with written reasons when recommendations of a second psychiatric opinion are not adopted. [s 74] |
| Chapter 3 – Treatment and interventions |  |
| New decision making principles for treatment and interventions that a person must give proper consideration to if making a decision or exercising a power under this Chapter or Chapter 4 (this includes in relation to treatment decisions, use of restrictive interventions and the use of compulsory assessment and treatment). [Part 3.1]New requirement for written reasons to be provided whenever a treatment preference outlined in an advance statement of preferences is overridden. [s90]Introduction of regulation of chemical restraint as a type of restrictive intervention. Chemical restraint is defined as 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. [Part 3.7] | Provisions related to the presumption of capacity and informed consent are comparable to those of the MHA. [Part 3.2]Provisions related to treatment, medical treatment and neurosurgery are comparable to those of the MHA. [Parts 3.3, 3.4 and 3.6]Provisions related to Electroconvulsive treatment (ECT) are comparable to those of the MHA, although with some drafting changes to clarify the provisions. [Part 3.5]Provisions related to the use of restrictive interventions are comparable [Part 3.7], however with the addition of:* obligation on providers to aim to reduce the use of restrictive interventions with the eventual aim of eliminating their use [s125]
* requirements to document alternatives tried or considered [s133]
* to review the use of restrictive interventions and to offer an opportunity for the person subject to these interventions an opportunity to participate in the review. [s138]

New regulation of chemical restraint as a type of restrictive intervention and introduction of new decision making principles. |
| Chapter 4 – Compulsory assessment and treatment |  |
| Maximum duration of a community treatment order reduced from 12 months to 6 months. [s193]A new requirement that an assessment order for a person must identify the designated mental health service that will be responsible for the person's assessment. [s148] | Compulsory assessment criteria and compulsory treatment criteria are unchanged from the MHA [ss142 & 143]Provisions for the making, variation and revocation and operation of assessment orders, court assessment orders, temporary treatment orders and treatment orders are comparable to those of the MHA, however, the decision-making principles for treatment and interventions must be given proper consideration in the application for and making of these orders [Parts 4.2, 4.3, 4.4, 4.5 and 4.6]The commencement of the new Act does not impact existing temporary treatment orders or treatment orders. These orders will continue to operate for the period of time specified on the order. |
| Chapter 5 – Taking into care and control, transport, transfer and search by authorised persons |  |
| New provisions are introduced to support establishment of a health led response to mental health crises, including:* new principles specific to mental health emergency response [s228-230]
* updated language to reflect a health led approach to mental health emergency
* expansion of powers to take a person into care and control to allow for the prescribing in regulations of additional classes of health professionals, such as registered paramedics employed by Ambulance Victoria
* new discretions to allow for transfer of care and control between authorised persons and release of a person from care and control in limited circumstances
* health professionals who can accept care and control at the designated mental health service or hospital are a registered medical practitioner, an authorised mental health practitioner or a registered nurse. [s239]
 | In other ways provisions relating to criteria for taking a person into care and control and authorised person powers to transport a person to or from a designated mental health service or other place are comparable to those of the MHA with the addition of Protective Services Officer operating in designated areas as Authorised Persons. |
| Chapter 6 – Administration |  |
| New provisions establishing:* Chief Officer for Mental Health and Wellbeing (reporting to the Secretary with role and functions similar to the Secretary) [Part 6.2]
* Regional Mental Health and Wellbeing Boards to provide advice to the Minister on the commission of mental health and wellbeing services in their regions [Part 6.4]
* State-wide and Regional Multiagency Panels to bring together service providers and support collaboration and accountability for those requiring ongoing intensive, treatment care and support from multiple services [Part 6.5]
* Mental Health Workforce Safety and Wellbeing Committee to provide advice to the department on the prevention of risks to health, safety and wellbeing of the workforce and approaches to monitoring and responding to these risks [Part 6.5A]
 | Role, functions and powers of the Health Secretary in relation to mental health and wellbeing services is re-established with some additional functions (for example, functions reflecting the new opt-out non-legal mental health advocacy service) and new obligation to give proper consideration to the mental health and wellbeing principles [Part 6.1]The role, functions and powers of the Chief Psychiatrist are comparable to that under the MHA [Part 6.3], however:* the Chief Psychiatrist’s jurisdiction is defined to include – designated mental health services; mental health and wellbeing service providers that provide mental health and wellbeing services in custodial settings; and any other prescribed entity or class of entity
* the new Act no longer provides for separate clinical practice audits by the Chief Psychiatrist. Instead, the clinical review power will have broader application, covering what would have been subject of a clinical practice audit under the MHA.

Provisions related to the appointment of Authorised Psychiatrists and delegation of Authorised Psychiatrist powers are comparable to those of the MHA. [Part 6.6] |
| Chapter 7 – Mental Health Tribunal |  |
| The Mental Health Tribunal will have a new statutory function to hear and determine applications for intensive monitored supervision orders. [s332] [See also chapter 12] | The provisions establishing and governing the procedures and operations of the Mental Health Tribunal are comparable to those of the MHA [Chapter 7] with minor changes to allow for single member divisions for unopposed adjournment hearings and leave to withdraw proceedings applications. [s360] |
| Chapter 8 – Community Visitors and the Community Visitors Mental Health Board |  |
|  | The provisions regarding the appointment and operations of Community Visitors and the Community Visitors Mental Health Board are comparable to those of the MHA. |
| Chapter 9 – Mental Health and Wellbeing Commission |  |
| The Mental Health and Wellbeing Commission is established with multiple Commissioners including those in designated lived experience roles. The jurisdiction of the Mental Health and Wellbeing Commission extends to all mental health and wellbeing service providers. [Chapter 9]Commission to play a key role in system wide oversight of quality and safety and monitoring achievement of Royal Commission’s key goals.An ‘own motion’ investigation power is introduced for the Commission. | The complaints handling role of the Mental Health Complaints Commissioner under the MHA will be taken over by the new Commission with some changes to:* allow complaints from families, carers and supporters in relation to their experiences in those roles
* more closely align processes and powers with those available to the Health Complaints Commissioners under the Health Complaints Act 2016
* explicitly allow for complaints about a failure to comply with obligations in relation to principles.
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| Chapter 10 – Security Patients |  |
| New obligation to provide statements of rights to security patients. | In other respects, provisions regarding Security Patients are comparable to those of the MHA. |
| Chapter 11 – Forensic Patients |  |
| New obligation to provide statements of rights to forensic patients. | In other respects, provisions regarding Forensic Patients are comparable to those of the MHA. |
| Chapter 12 – Intensive monitored supervision |  |
| Intensive monitored supervision orders are introduced as a new response for adult patients of Forensicare (security, forensic or treatment patients) with highly complex needs who pose an ongoing unacceptable risk of seriously endangering the safety of another person. These orders are an alternative to long term seclusion for a very small group of these Forensicare patients. Intensive Monitored Supervision orders are made by the Mental Health Tribunal for a maximum of 28 days (renewable). These orders will allow for a person to be detained within a supervision unit and limit their contact with others. |  |
| Chapter 13 – Interstate application of mental health provisions |  |
|  | Provisions regarding Interstate application of mental health provisions are comparable to those of the MHA. |
| Chapter 14 – Victorian Institute of Forensic Mental Health (Forensicare) |  |
|  | Provisions regarding the Victorian Institute of Forensic Mental Health (Forensicare) are comparable to those of the MHA, with a minor change to Board composition (to require representation of a person with lived experience as a carer on the Board) and new powers for the Secretary to issue Directions to Forensicare. |
| Chapter 15 – Victorian Collaborative Centre |  |
|  | The Act repeals the Victorian Collaborative Centre for Mental Health and Wellbeing Act 2021 and remakes comparable provisions establishing the Collaborative Centre. |
| Chapter 16 – Youth Mental Health and Wellbeing Victoria |  |
| Youth Mental Health and Wellbeing Victoria (YMHWV) is established as a new entity which will: * provide system leadership and provide strategic advice, giving agency to the voices of young people with lived experience in response to a crisis in youth mental health; and
* enable a flexible model of delivery and oversight for integrated mental health and wellbeing services for young people by declared operators in specific areas.
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| Chapter 17 – General  |  |
| New provisions in relation to information sharing are introduced, including to:* introduce new principles to clarify the purpose and expectations in relation to information sharing
* reflect the new service system by allowing information sharing with specified emergency service providers in an emergency
* specify who can access information from the current electronic health information system and the scope of such access
* enable a consumer to contribute a statement on their health information where a request to correct information has been made under the Freedom of Information Act 1982 or the relevant Health Privacy Principle and the provider has refused to make the correction
* to oblige mental health and wellbeing service providers to share information with family, carers or supporters at defined points of care (such as admission or discharge) when a consumer has consented to this disclosure.

A requirement for a review of the Act to be undertaken after the first 5 years of operation. | In other respects, provisions regarding the collection, use and disclosure of information are comparable to those of the MHA.Provisions regarding the powers for the Chief Psychiatrist to issue Codes of Practice are comparable to those of the MHA.Provisions regarding the mental health and wellbeing surcharge are remade. |

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