

# Mental health advance statement

Practice guide



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Available at <http://www.health.vic.gov.au/mentalhealth/mhact2014/recovery/advance-statements.htm>

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# Terms and definitions

**Advance statement** – a document that records a person's treatment preferences in case they become unwell and require compulsory mental health treatment, and are unable to make or participate in treatment decisions.

**Assessment order** – an order made by a registered medical practitioner or mental health practitioner that enables a person to be compulsorily examined and assessed by an authorised psychiatrist to determine whether the criteria for a temporary treatment order applies to the person. Assessment orders can apply to a community or inpatient setting.

**Authorised psychiatrist** – a person appointed as an authorised psychiatrist for a designated mental health service under s. 150 of the *Mental Health Act 2014*.

**Authorised witness** – a registered medical practitioner, a mental health practitioner, or a person who may witness the signing of a statutory declaration under s. 107A of the *Evidence (Miscellaneous Provisions) Act 1958*.<sup>1</sup>

**Care** – the provision of ongoing support, assistance or personal care to another person.

**Carer** – a person, including a person under the age of 18 years, who provides care to another person with whom he or she is in a care relationship (but does not include a parent if person to whom care is provided is less than 16 years of age).

**Care relationship** – a person is in a care relationship if he or she provides another person, or receives from another person, care because one of the persons in the relationship has a disability, is older, has a mental illness or has an ongoing medical condition (including a terminal or chronic illness or dementia).

**Carer and/or family inclusive practice** – practice that includes identifying the carer, engaging with the carer, and involving and supporting carers by conducting an assessment of carer and family needs, knowledge of and referral to appropriate supports and services, and provision of information about advance statements and the caring role, mental illness and treatments<sup>2</sup> (VICSERV 2014).

**Compulsory patient** – a person subject to an assessment order, a court assessment order, a temporary treatment order or a treatment order.

**Designated mental health service** – a prescribed: public hospital; public health service; denominational hospital; privately operated hospital; private hospital (according to the *Health Services Act 1988*); or The Victorian Institute of Forensic Mental Health.

**Dignity of risk** – a term used to describe the right of individuals to take some risk in engaging in life experiences. It is an important concept because it places an emphasis on personal choice and self-determination – two concepts that are central to recovery. The Act includes mental health principles that must be considered when providing mental health services (see Appendix 5). One of the principles is that a person should be able to make decisions about assessment, treatment and recovery that involve a degree of risk. Services and individual workers have varying degrees of tolerance of risk. Accordingly, services should consider providing guidance, training and support to staff on how to reconcile flexibility and responsiveness to people's unique circumstances and preferences with appropriate risk management obligations.

**Mental health practitioner** – a registered psychologist, registered nurse, social worker or registered occupational therapist employed or engaged by a designated mental health service.

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<sup>1</sup> See Appendix 2 for the list of persons who may witness the signing of a statutory declaration

<sup>2</sup> Adapted from: VICSERV 2014, *Carer inclusion and involvement*, State Government of Victoria, Melbourne.

**Mental health service provider** – a designated mental health service, or a publicly funded mental health community support service.

**Mental health workforce** – the staff of Victorian public mental health service system, including specialist clinical mental health services and Community Mental Health Support Services.

**Nominated person** – a person nominated by a person with mental illness to receive information and support them while they are receiving compulsory mental health treatment.

**Patient** – includes a compulsory patient, a security patient or a forensic patient.

**Person** – anyone receiving mental treatment in a designated mental health service.

**Person-centred practice** – involves identifying and treating people as unique and responding to their holistic needs (rather than their diagnosis or treatment pathway).

**Recovery** – an overarching philosophy that encompasses notions of self-determination, self-management, personal growth, empowerment, choice and meaningful social engagement and thus is not only defined by clinical measures such as reduction or cessation of symptoms (Department of Health and Human Services 2011).

**Recovery-oriented practice** – a collaborative model of mental health practice where people with lived experience of mental illness and recovery are considered experts on their lives and experiences while mental health professionals are considered experts on available treatment services (Department of Health and Human Services 2011).

**Registered medical practitioner** – a person who is registered under the Health Practitioner Regulation National Law to practise in the medical profession (other than as a student).

**Registered nurse** – a person who is registered under the Health Practitioner Regulation National Law to practise in the nursing and midwifery profession as a nurse (other than as a midwife or as a student) and is in the registered nurses division of that profession.

**Registered occupational therapist** – a person who is registered under the Health Practitioner Regulation National Law to practise in the occupational therapy profession (other than as a student).

**Registered psychologist** – a person who is registered under the Health Practitioner Regulation National Law to practise in the psychology profession (other than as a student).

**Restrictive intervention** – seclusion or bodily restraint, including:

- **bodily restraint** – a form of physical or mechanical restraint that prevents a person having free movement of his or her limbs, but does not include the use of furniture (including beds with cot sides and chairs with tables fitted on their arms) that restricts the person's ability to get off the furniture
- **seclusion** – the sole confinement of a person to a room or any other enclosed space from which it is not within the control of the person confined to leave.

**Security patient** – a person who is detained in a designated mental health service and is subject to a court secure treatment order or a secure treatment order.

**Substitute decision making** – a process whereby another person or organisation is appointed to make financial, legal and/or personal decisions for a person who is unable to make decisions for him or herself (Office of the Public Advocate 2009).

**Supported decision making** – a model that enables and supports people to make decisions about their treatment and determine their individual path to recovery.

**Temporary treatment order** – an order that enables a person to be compulsorily treated for mental illness for up to 28 days.

**Treatment** – things done in the course of the exercise of professional skills to remedy the mental illness or to alleviate the symptoms and reduce the ill effects of the mental illness. Treatment includes electroconvulsive treatment and neurosurgery for mental illness.

**Treatment order** – an order that enables a person to be compulsorily treated for mental illness.

# Introduction

This guide has been developed to assist with the introduction, development and use of mental health advance statements (advance statements) within a supported decision-making framework under the *Mental Health Act 2014* (the Act).

Advance statements allow people to record their treatment preferences in case they become unwell and need compulsory mental health treatment. This also applies to people with mental illness who are not compulsory patients. Advance statements help to embed supported decision making by assisting people with mental illness to participate in decisions about their treatment while they are unwell. Advance statements are also relevant to any person accessing public or private mental health services. Their expressed preferences would be considered at a time when they are unwell.

## ***Mental Health Act 2014***

The Act involves significant changes to compulsory assessment and treatment of people living with mental illness. It seeks to ensure that people living with mental illness and subject to compulsory treatment are supported to make or participate in decisions about their mental health treatment.

The Act also recognises the important role of carers and the nominated person in supporting the recovery of people living with mental illness.

The four key reform objectives of the Act are to:

- establish a recovery-oriented framework and embed supported decision making
- minimise the use and duration of compulsory treatment
- increase safeguards to protect the rights and dignity of people with mental illness
- enhance oversight and encourage service improvement.

Other elements of the Act that support recovery-oriented practice and supported decision making are:

- the presumption of capacity
- second psychiatric opinions
- nominated persons
- recognition of the role of carers.

In relation to advance statements, the Act:

- sets out the requirements for making an advance statement
- states when advance statements must be considered as part of decision making
- outlines the circumstances in which an advance statement may be overridden and
- sets out the requirements for clinicians in the event that an advance statement is overridden.

Advance statements are supported by the mental health principles outlined in the Act (see Appendix 3).

The Act is informed by the Victorian *Charter of Human Rights and Responsibilities Act 2006* and the United Nations (2006) Convention on the Rights of Persons with Disabilities.

# Recovery-oriented practice and supported decision making

Recovery-oriented practice acknowledges that people with mental illness are experts on their own lives and experiences.

The principles of recovery-oriented practice can be used when preparing advance statements, and advance statements are also a tool that can support clinicians to work in a recovery-oriented way.

When working with people to develop and use advance statements, consider whether your practice reflects the elements of recovery-oriented practice (Department of Health and Human Services 2011), particularly:

- actively promoting a culture of hope
- encouraging consumers' self-determination and self-management of mental health and wellbeing
- supporting people who access mental health services to define their goals, wishes and aspirations
- providing tailored, personalised, strengths-based care and support that is responsive to people's unique strengths, circumstances, needs and preferences (including cultural and spiritual beliefs and practices)
- practising with a holistic approach and open-mindedness that addresses a range of factors that impact on a person's wellbeing
- engaging, including, informing, valuing and supporting the roles of family, carers, nominated persons, support people and significant others
- encouraging and supporting people who access mental health services to utilise and enhance existing support networks
- acknowledging and challenging stigmatising attitudes
- engaging with people who access mental health services about their treatment preferences, both in making and using an advance statement
- continually improving knowledge of available treatments and services
- seeking to continually improve and evaluate practice.

Supported decision making was first developed as a set of principles to underpin the decision-making process for people with intellectual and communication disabilities. It is informed and guided by the *Charter of Human Rights and Responsibilities Act 2006*, the United Nations Convention on the Rights of Persons with Disabilities and the Convention on the Rights of the Child. It is the foundation of advance statement practice, particularly regarding the processes by which a person articulates decisions and treatment preferences within their advance statement.

The views and preferences of the person are paramount in supported decision making. The mental health workforce can use supported decision-making principles<sup>3</sup> to inform advance statement practice, which include:

- realising that people who access mental health services are capable of making decisions about most areas of their lives, and that it is the person who is the decision maker, not the mental health worker
- informing the person that they should receive whatever support is available to them in order to make decisions and encouraging them to draw on their own networks to help them make decisions
- exploring and recognising the potential importance of the carer and family role and carer and family inclusion
- enabling agreement by all involved to support the person in reaching and expressing their decisions
- helping the person understand the choices at hand by explaining the issues and providing information and explanations in plain language

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<sup>3</sup> Adapted from Roper and Weller 2013, and the Victorian Office of the Public Advocate 2009.

- understanding that capacity to make decisions can fluctuate, and is specific to each decision
- helping others to appreciate that a person who accesses mental health services is also a person with a history, interests and aims in life, and is someone capable of exercising their legal capacity
- communicating the person's decisions and preferences to others
- having and building awareness that capacity to make decisions can be learned, influenced, enhanced and suppressed
- informing the person and their support network that the person makes and retains control over (as far as is practicable) the decisions made and takes responsibility for them
- knowing that people have the right to take risks in their lives
- understanding that people do not always make good decisions but can learn from their mistakes and experience
- ensuring that support is independent of service delivery wherever possible
- knowing the difference between supported decision making and substituted decision making.

# Roles and responsibilities

People with mental illness, their families, carers and other support people, nominated persons, mental health services and members of the mental health workforce all have a role in developing and using advance statements.

People accessing mental health services are encouraged to:

- seek information about advance statements
- if they wish, develop their advance statement at a time when they understand what an advance statement is and the consequences of making one
- seek and use the support of others to make their advance statement
- keep a copy of their advance statement in a safe place
- consider providing a copy of their advance statement to their treating team so that the team is aware of the person's treatment preferences
- regularly review whether their advance statement accurately reflects their treatment preferences, and revoke their advance statement or make a new advance statement if necessary.

Mental health services are responsible for ensuring that:

- the mental health workforce is able to implement the advance statements, including engaging with carers, families and nominated persons where appropriate
- policies reflect an understanding of advance statements and supported decision making
- there is executive support for advance statements
- advance statements can be easily accessed within and between services
- quality control, monitoring and evaluation processes for advance statements are in place
- advance statements are promoted to people with mental illness, their carers and nominated persons.

The mental health workforce is responsible for:

- understanding their obligations under the Act in relation to advance statements
- providing information and support about making, using and revoking advance statements to people with mental illness, their carers, families, nominated person, and other support people
- engaging with carers, families and nominated persons where appropriate
- assisting people who access mental health services, where requested, to develop their advance statement (with the person's agreement)
- communicating the existence of the advance statement to other staff involved in the person's care
- assisting and encouraging people to copy and safely store their advance statement
- supporting timely access to advance statements
- ensuring that people are informed about how their advance statement informed decision making
- promoting the use of advance statements to the mental health workforce.

An authorised witness is responsible for:

- assessing whether they believe the person understands what an advance statement is and the consequences of making it
- stating that they believe the person understands what the advance statement is and the consequences of making it
- witnessing the person signing the advance statement
- signing the advance statement, and providing their signatory status and address.

## Engaging family, carers, nominated person and support people

Families, carers, nominated persons and other support people can be important partners in the development of an advance statement, if the person with mental illness consents to their involvement. Being involved in the development of an advance statement can assist carers and support people to better understand a person's treatment preferences. Support people may also be able to assist people to think about previous experiences to inform treatment preferences.

The potential contribution of a person's support network should be explored, acknowledged, encouraged, valued and supported by the mental health workforce.

# Who can make an advance statement

Any person may make an advance statement at any time provided they understand what an advance statement is and the consequences of making it. For example, a person can make an advance statement if they understand that an advance statement is a document that sets out their treatment preferences and that those preferences must be considered whenever a substitute treatment decision is made for the person if they become a compulsory patient. The person must complete the statement himself or herself; another person cannot complete it on their behalf.

While it is anticipated that people will usually make advance statements when they are relatively well, people may make an advance statement when they are unwell provided they meet the above requirements.

All people who access mental health services are encouraged to make an advance statement. Similarly, all members of the mental health workforce are encouraged to engage and include carers, families and nominated persons in the process of making an advance statement. The process of making an advance statement can be beneficial for all people who access mental health services in promoting discussion between a person and their family, carer or nominated person and treating team about the person's treatment preferences, goals, values and wishes.

# How to make an advance statement

An advance statement may be made at any time provided the person understands what an advance statement is and the consequences of making it. It is effective from the time it is made until it is revoked. An advance statement must:

- be in writing
- be signed and dated by the person making the advance statement
- be witnessed by an authorised witness
- include a statement signed by an authorised witness stating that –
- in their opinion, the person understands what an advance statement is and the consequences of making an advance statement
- the witness observed the person sign the advance statement
- the witness is an authorised witness.

An advance statement template has been developed (see Appendix 1). The template is a guide only. An advance statement will be valid if it meets the above requirements.

## Case example

You are a nurse and work in a community setting of a designated mental health service. You have been working with Colleen for some time and recently have been talking about whether she would like to make an advance statement. You assist Colleen to develop her advance statement, explain who may witness it and discuss distribution of copies to key support people to ensure key people and services have a copy to ensure that her treatment preferences are considered if Colleen needs compulsory mental health treatment and is unable to make or participate in decisions.

You help Colleen to think about her preferences by prompting her to think about what has worked or not worked for her in the past.

Colleen wants to take her advance statement away and get a different staff member to read it and sign it with her, as she wants to be sure she has sought other professional input.

You agree that this is a good idea. You remind her that if she wants the other staff member to witness the statement, they must be a registered medical practitioner, mental health practitioner or someone who is allowed to witness a statutory declaration. You also remind her that the witness will ask about her understanding of what an advance statement is and the consequences of making one, and will need to witness her sign it.

## Advance statement content

An advance statement sets out a person's treatment preferences and may include information about:

- treatment that has been more effective or less effective in the past
- the person's views and preferences about mental health treatment, including electroconvulsive treatment.

People who access mental health services should be supported to understand the difference between treatment preferences and other preferences. For example, treatment preferences might include preferred or non-preferred medications, modes and times of medication administration, sleep and rest patterns and preferences about electroconvulsive treatment (ECT).

## Case example

Natalie accesses your mental health service. Natalie is happy with her current medications and feels that she developed a very effective treatment plan with her previous treating team and would like to continue with this plan.

When you are supporting Natalie to make her advance statement, she indicates that she has been upset during previous inpatient admissions because the inpatient staff have changed her medications. She feels that this was not necessary and that her admissions were not related to her medications not working. She believes that making the changes to her medications meant that she stayed in the inpatient unit longer than necessary.

After Natalie has explored her options and the process of making an advance statement with you, she makes her advance statement with the support of her nominated person and family. The treatment preferences Natalie includes are that her medications not be changed if she is admitted as a compulsory patient in the future; that she does not want ECT as a first line of treatment if her medications are not seen to be helping; and that she is happy to take PRN medication (and lists preferred medications) during the admission to help with her acute symptoms.

## Additional information

People may wish to express a range of other preferences when thinking about what they would like to have happen when they become unwell. While the Act does not require preferences about non-treatment related matters to be considered, the person can express preferences that relate to personal or lifestyle considerations alongside their advance statement or in the 'additional information' section of their advance statement. This might include preferences about things that people feel impact positively on their mental health but are not strictly related to mental health treatment.

People may also record preferences regarding medical treatment in the 'additional information' section. This may include preferences regarding life support if they become seriously ill.

These preferences should also be documented and discussed in other planning and support documents that the person may have, such as the person's treatment or recovery plan. The difference between treatment preferences (which must be considered under the Act) and other preferences (which must be considered under the common law) should be made clear to the person.

## Case example

Natalie's two children enjoy visiting their aunt, which they do several times a week. Natalie would like to ensure that her children are still able to do this even if she is not able to go with them when she is an inpatient.

Natalie would like to write a preference alongside her advance statement that her mother takes her children to visit her sister if she is admitted for compulsory treatment. Natalie feels that knowing her preference will be considered will reduce her anxiety, which may reduce its impact on other symptoms. You remind Natalie that it is important that she talk to her mother and sister about this preference, so that they are aware of how important this is to Natalie when she is unwell. It is unlikely that the mental health service will be able to ensure that this occurs.

Natalie writes this information on the 'additional information' section of the advance statement.

## Supporting a person to make an advance statement

People making an advance statement may choose to prepare it and have it witnessed by a person who is not part of their treating team.

However, it is recommended that mental health practitioners encourage people and their nominated person, family or carer to engage with their treating team when making an advance statement.

Mental health practitioners can assist the person to think about what treatments they have found helpful or unhelpful in the past and help to inform conversations about available alternative treatments. It is appropriate for members of the mental health workforce to prompt the person to think about what treatments and preferences the person knows would benefit their recovery and are relatively sure would be available or accessible to them while they are a patient.

Being involved in developing an advance statement also has the benefit of assisting mental health practitioners to better understand a person's preferences and respond to these preferences if the person becomes unwell.

## Case example

Amanda is a 14 year old who has been diagnosed with anorexia nervosa and depression. She approaches you to help her write an advance statement. She would like to prepare one before she is discharged. She is thinking about including a treatment preference that she only has certain types of antidepressants, as she knows that there are some that can cause weight gain and does not want them.

Amanda also wants to include in her advance statement that she wants her best friend to look after her cat when she is an inpatient, as she is worried that her parents do not look after it properly and one day it will run away.

You explain to Amanda that she needs to organise her preferences into those that are about mental health treatment and those that are personal preferences. You provide her with time to discuss why she has particular preferences and encourage her to include this information in her advance statement. You offer to assist her to discuss the advance statement with her parents and support people.

This discussion with Amanda about her advance statement provides you with an opportunity to explore the possibility of including her family, nominated person and any other support people in the process of making her advance statement. You also discuss her rights under the Act and her responsibilities in relation to making an advance statement.

## What to do with a completed advance statement

- Offer assistance to people in communicating and storing their completed advance statement.
- Print a minimum of three copies of the person's advance statement – a copy for the person, the person's medical records and the person's carer/nominated person (if the person wishes these people to have a copy).
- Scan the completed copy into the person's electronic patient record.
- Document the advance statement completion in the Client Management Interface (CMI) and the person's recovery plan or equivalent.

## Witnessing advance statements

An advance statement must be witnessed by an authorised witness, which includes a registered medical practitioner, a mental health practitioner, or a person who is authorised to witness statutory declarations (see Appendix 2).

As noted above, there are a number of benefits to the person's treating team being involved in the development of the advance statement, and any of the above-listed people may witness the advance statement.

The authorised witness has no role in assessing whether or not the preferences within the statement are appropriate or inappropriate. The authorised witness's role is to confirm that the person making the advance statement understands what an advance statement is and the consequences of making the statement and that they have witnessed the person signing the advance statement.

The person making the advance statement must remember to sign the statement under the observation of the authorised witness.



# Override procedures and notifications

There may be times when an authorised psychiatrist may make a treatment decision that is not consistent with the patient's treatment preferences.

The authorised psychiatrist must be satisfied that the treatment specified in the advance statement is not clinically appropriate or is not a treatment ordinarily provided by the designated mental health service.

If the authorised psychiatrist makes a decision that is not consistent with the preferences specified in a patient's advance statement, they must tell the person, explain their reasons and advise the person that they can request written reasons for the decision.

It is important that the reasons for overriding an advance statement are clearly documented in the patient's clinical record in the event that the person asks for written reasons.

If requested, the authorised psychiatrist must provide written reasons within 10 business days after the request has been made.

If a person is not satisfied with the response provided by the authorised psychiatrist, the person may make a complaint.

People who access mental health services should be advised of complaint processes, such as making a complaint to the local mental health service complaints officer or management of the mental health service, and the process of making a complaint to the Mental Health Complaints Commissioner.

If a patient is not satisfied with the written response provided by the authorised psychiatrist, the patient may make a complaint.

Mental health services have a responsibility to provide patients with information about their rights, which include making complaints about mental health service providers. Complaints can be made to the local mental health service or management of the mental health service, or to the Mental Health Complaints Commissioner. Information about making a complaint to the Mental Health Complaints Commissioner is contained in the statements of rights that support the Act. The statements of rights available at <http://www.health.vic.gov.au/mentalhealth/mhact2014/safeguards/statement-of-rights.htm>

## Case example

Josh has written an advance statement. He has indicated in his advance statement that he will take oral psychotropic medications, but finds needles scary and painful and does not want intramuscular injections. Josh has also indicated in his advance statement that being isolated from other people helps him calm down when he is agitated and psychotic. Josh has made his mother his nominated person, enabling her to be more involved in decision making when he is unwell.

One month after Josh made his advance statement you receive a phone call from Josh's mother, saying that he has been admitted to the inpatient unit. She was not told at the time and she is upset, as Josh received an intramuscular injection when in the emergency department. Josh told his mother that he was held down, stripped of his pants and given an injection in his buttocks, which he found embarrassing. Josh was told he was given the injection because he was being violent but he does not recall hurting anyone, although he did feel confused and upset by being surrounded by so many people in the emergency department and then in the inpatient unit.

Josh's mother goes on to say that once Josh was in the unit he was placed into seclusion away from others and he reports feeling very alone and upset by being treated this way. You explain the difference between isolation (a voluntary action at the request of the consumer or suggested by the mental health clinician) and seclusion (a restrictive intervention). You discuss circumstances when the preferences within an advance statement can be overridden, what steps she and Josh can take to find out why it was overridden, as well as options for making a new advance statement and the option of registering a complaint.

Two weeks later Josh decides to make a complaint to the Mental Health Complaints Commissioner because he and his mother are not satisfied with the reasons the authorised psychiatrist gave for overriding his treatment preferences.

# Revoking an advance statement

A revocation is a statement declaring that the previous advance statement is revoked. This statement must be made by the person who made the advance statement, and must:

- be in writing and state that the advance statement is revoked
- be signed and dated by the person revoking the advance statement
- be witnessed by an authorised witness
- include a statement signed by an authorised witness stating that –
  - in their opinion, the person understands what an advance statement is and the consequences of revoking it
  - the witness observed the person revoking the advance statement
  - the witness is an authorised witness.

A revocation will be valid if it meets the above requirements. A template to revoke an advance statement is available (see Appendix 1).

Making a new advance statement automatically revokes any earlier advance statements made by that person.

## What to do with an revocation

Suggestions for members of the mental health workforce:

- Offer assistance to people in revoking their advance statement.
- Print a minimum of three copies of the revocation of the advance statement – for the person, the person's medical records, and for the person's carer/nominated person (if the person wishes).
- Place a copy of the revocation into the person's clinical record, including any electronic patient record.
- Document the revocation in the Client Management Interface (CMI) and the person's recovery plan or equivalent.

If a person has made a new advance statement it is important to ensure this is documented and the new advance statement is stored and communicated as per the recommended process in the section on 'What to do with a completed advance statement'.

# Amending or changing an advance statement

An advance statement must not be amended. An amended advance statement is void. If a person wishes to change or amend any part of their advance statement they must make a new advance statement.

## Case example

Patricia has had two admissions since she developed her advance statement. During the second admission, which closely followed the first, her preference not to have ECT was overridden. The Mental Health Tribunal found that Antoinette did not have capacity and granted the authorised psychiatrist's application for Antoinette to have ECT even though she did not agree.

She improved quickly following the first three ECT treatments and since returning home she has discussed her treatment preferences with her family. She has decided to write a new advance statement in which she will now express her preference to have the same ECT treatment she had during her last admission because, despite the side effects, she recognises that it helped her get better and she has since been able to remain out of hospital and return to her regular lifestyle.

Antoinette correctly revokes her advance statement and has the revocation witnessed. She then writes a new advance statement which her GP witnesses. Antoinette, her family and her GP make sure her revocation and new advance statement are witnessed, copied and communicated to all services involved in her care.

# Advance statement reviews

There is no requirement under the Act for an advance statement to be reviewed. However, it is recommended that the person who made the advance statement and the nominated person, family and/or carer consider whether the treatment preferences expressed in the advance statement remain current.

If a person's treatment preferences have changed, they must make a new advance statement. If a person prepares a new advance statement, they should make relevant people including their treating team, nominated person, family and/or carer aware of the new advance statement. It is recommended that an advance statement be reviewed:

- as part of the discharge planning process
- after each episode of illness (as this may be a good time to evaluate whether the person found the advance statement useful)
- after any changes in diagnosis, or with major life or health changes
- after changes to treatment availability and/or service provision
- if the person, their nominated person or family or carer requests a review
- at least every one to two years.

# Balancing risk

Risk tolerance and recovery-oriented practice go hand-in-hand given that recovery-oriented practice involves person-centred approaches such as consumer choice, agency and self-management. An advance statement provides an opportunity to ensure the person is supported to participate in decisions about treatment.

At times, tensions may arise between the principles of duty of care and supported decision making.

At times this tension may present challenging decisions where risk must be balanced or weighed against benefit. These situations will have to be worked through on a case by case basis with the person and their support people. For example, a person's treatment preferences may involve a choice of medication that has fewer side-effects, but may be seen as less effective.

The person's treatment preferences must be considered as part of decision making and followed unless they are not clinically appropriate or not ordinarily provided by the mental health service.

# Working with diversity

There is diversity both in the people who might want to make an advance statement, and those who may be involved in supporting them. Support for particular groups or populations must be tailored to accommodate, for example, the different needs and perspectives of people from culturally and linguistically diverse (CALD) populations; Aboriginal and Torres Strait Islander people; refugees; people with literacy challenges; the aging and aged populations; and/or young people.

Mental health services also have distinct perspectives, for example community mental health support service requirements for support and information about advance statements differ from acute and community care services or emergency services (including police, ambulance and emergency departments).

## Diversity – people making and using advance statements

An advance statement must be developed with cultural sensitivity.

This begins with a conversation with the person, and if they wish, their family members and/or carer/s, nominated person and others.

Family and carer involvement and its importance may vary across cultural and ethnic groups. While family and carer involvement is always encouraged, there needs to be sensitivity to issues such as stigma, gender and past experience with authority. For example:

- Aboriginal and Torres Strait Islander people may have a lack of trust in the mental health service system due to past experiences. It may be useful to engage with Aboriginal or Torres Strait Islander people through Aboriginal health workers, who may be best positioned to provide information, education and training.
- Aged persons present comorbidity challenges and complicated recovery processes. There are differences between advance statements and advance care directives, medical enduring power of attorney, and the interplay between mental health and medical treatments under the Act.
- If a person has literacy difficulties, it is important to provide support and practical management of the advance statement, for instance by having the document dictated to a scribe and including a statement to the effect that the document has been dictated and scribed with the consumer's consent, signed and dated by the consumer, with the witness in attendance.
- Members of the mental health workforce must possess cultural awareness and sensitivity when working with people from culturally and linguistically diverse backgrounds. This involves seeking information from a range of sources, and including and engaging carers, families, support people, nominated persons and interpreters (if required) in the practice of developing and using advance statements.

### Case example

Antoinette does not speak English as she speaks and understands Italian. She has had episodes of depression that have required her to become a compulsory patient in the past.

Her daughter (who speaks and understands English) has accompanied her to an appointment to ask if you could explain what an advance statement is, and the benefits of her mother having one. Based on discussions she has had with Antoinette, her daughter asks you to explain the pros and cons of ECT and antidepressants.

Antoinette's daughter decides that she now has enough information to help her mother write an advance statement with their family GP, who also speaks and understands Italian.

You discuss the steps for making and communicating an advance statement, including that if the mother initially writes it in Italian (with the assistance of her daughter and GP) then it must be translated into

English with confirmation that it has been translated correctly. This confirmation or certification should be done by an independent translator and both the Italian and English included in the same advance statement and signed and witnessed.

## **Diversity – mental health service providers**

Different service providers' roles and responsibilities will fluctuate across disciplines and/or services. Based on information gathered during statewide mental health advance statement consultations in 2014, the following are some of the examples of the diversity of needs among service providers:

- General practitioners primarily need to understand the requirements for developing and witnessing an advance statement.
- Police, ambulance and emergency department staff are primarily concerned with how to access the advance statement after hours and when people are in crisis.
- Mental health practitioners must understand their responsibilities with regard to the development and use of advance statements.
- Authorised psychiatrists must understand their responsibilities with regard to the use of advance statements, together with information about least-restrictive practices (as they apply to each patient) and decisions to override a person's advance statement.
- Members of the mental health community support workforce must understand how to encourage and support people with mental illness who wish to make an advance statement, as well as any family, carer, nominated person and other support peoples they wish to involve in the development of advance statements.

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# Appendix 1: Example of a mental health advance statement template

Note: This template is a guide only.

Advance statement of \_\_\_\_\_ (insert name and date of birth)

Insert barcode here	<b>My advance statement</b>	
	<b>Name</b>	
	<b>Date of birth</b>	
	<b>Address</b>	
	<b>Primary mental health worker / support worker</b>	
	<b>Psychiatrist</b>	
	<b>GP</b>	
	<b>GP's address</b>	
	<b>Health team/s you are involved with</b>	
	<b>Family members, carers, peer worker/s, and/or support people involved in your recovery</b>	
<p><b>Suggestions for person making this advance statement</b></p> <p>Send or give a copy of your advance statement to your mental health worker and anyone else involved in your care in order that your statement may be placed in your healthcare records or a safe place.</p> <p>If you realise you do not want to use this advance statement any more you can revoke your advance statement in writing (you could use the 'advance statement revocation' template below), make sure it is witnessed by an authorised witness and let key people involved in your care and recovery know that you have revoked your advance statement.</p> <p>Alternatively, you can make a new advance statement and let key people know about your new statement. Making a new advance statement automatically revokes any previous advance statement.</p>		

Date:        /        /

(Please attach additional sheets if necessary)

<b>If I become unwell and/or I am placed on a compulsory treatment order:</b>	
<b>My treatment preferences are:</b>	
<b>The reasons for these preferences:</b> [Optional]	
<b>I would like you to contact: Who is my ... (relationship to you, e.g. mother, carer, nominated person etc.)</b> [Optional]	
<b>Signature:</b> _____ <b>Date:</b> /     /	

<p><b>Advance statement witness declaration</b></p> <p>In my opinion, the person making this advance statement understands what an advance statement is and the consequences of making the statement and I have observed the above named person signing the advance statement.</p>
<p><b>Witness name:</b></p>
<p><b>Witness status as a signatory:</b></p>
<p><b>Witness address:</b></p>
<p>Those who can act as a witness are: a registered medical practitioner; a mental health practitioner; or a person who may witness the signing of a statutory declaration under s. 107A of the <i>Evidence (Miscellaneous Provisions) Act 1958</i>.</p>
<p>Witness signature:</p> <p>_____</p> <p>Date:                                /        /</p>
<p><b>Suggestions for person making this advance statement</b></p> <p>If you want to, you could ask your mental health worker to:</p> <ul style="list-style-type: none"> <li>• assist you in drawing up your advance statement</li> <li>• print a minimum of three copies – for you, your records and your carer/nominated person (if you want)</li> <li>• ensure a completed copy is placed into your clinical record, if you have one</li> <li>• document your advance statement completion in their electronic alert system, your CMI, and your recovery plan (or equivalent, e.g. ISP etc.).</li> </ul>

## Additional information [optional]

You can add and/or attach additional statements to your advance statement, including additional information you would like your treating team to know, such as personal or non-treatment preferences, including what has helped and what has not helped in the past etc.

I understand that the following are not treatment preference/s, but I would like people to know this/these things about me if I become too unwell to communicate them.

My personal preference/s and the reasons for my personal preference/s is/are as follows:



## Appendix 2: List of persons who may witness statutory declarations

Under s. 107A of the *Evidence (Miscellaneous Provisions) Act 1958* any of the following persons may witness the signing of a statutory declaration:

- a justice of the peace or a bail justice
- a public notary
- an Australian lawyer (within the meaning of the *Legal Profession Act 2004*)<sup>4</sup>
- a clerk to an Australian lawyer<sup>5</sup>
- the prothonotary or a deputy prothonotary of the Supreme Court, the registrar or a deputy registrar of the County Court, the principal registrar of the Magistrates' Court or a registrar or deputy registrar of the Magistrates' Court
- the registrar of probates or an assistant registrar of probates
- the associate to a judge of the Supreme Court or of the County Court
- the associate of an Associate Judge of the Supreme Court or of an associate judge of the County Court
- a person registered as a patent attorney under Chapter 20 of the *Patents Act 1990* of the Commonwealth
- a member of the police force
- the sheriff or a deputy sheriff
- a member or former member of either House of the Parliament of Victoria
- a member or former member of either House of the Parliament of the Commonwealth
- a councillor of a municipality
- a senior officer of a council as defined in the *Local Government Act 1989*
- a person registered under the Health Practitioner Regulation National Law to practise in the medical profession (other than as a student)
- a person registered under the Health Practitioner Regulation National Law –
  - to practise in the dental profession as a dentist (other than as a student)
  - in the dentists division of that profession
- a veterinary practitioner
- a person registered under the Health Practitioner Regulation National Law to practise in the pharmacy profession (other than as a student)
- a principal in the teaching service
- the manager of an authorised deposit-taking institution
- a member of the Institute of Chartered Accountants in Australia or the Australian Society of Accountants or the Institute of Public Accountants
- the secretary of a building society
- a minister of religion authorised to celebrate marriages
- a Victorian Inspectorate Officer within the meaning of the *Victorian Inspectorate Act 2011*
- a person employed under Part 3 of the Public Administration Act 2004 with a classification that is prescribed as a classification to which this section applies or who holds office in a statutory authority with such a classification

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<sup>4</sup> May only act as an authorised witness for a person's advance statement if they are not acting on behalf of the person in any legal proceedings pertaining to the advance statement.

<sup>5</sup> May only act as an authorised witness for a person's advance statement if they are not acting on behalf of the person in any legal proceedings pertaining to the advance statement.

- an IBAC Officer within the meaning of the Independent Broad-based Anti-corruption Commission Act 2011
- a fellow of the Institute of Legal Executives (Victoria).

# Appendix 3: Excerpts from the Act

## Section 71: When a patient does not give consent to treatment

- (3) The authorised psychiatrist may make a treatment decision for the patient if the authorised psychiatrist is satisfied that there is no less restrictive way for the patient to be treated other than the treatment proposed by the authorised psychiatrist.
- (4) In determining whether there is no less restrictive way for the patient to be treated, the authorised psychiatrist must have regard, to the extent that is reasonable in the circumstances, to all of the following—
  - (a) the patient's views and preferences about treatment of his or her mental illness and any beneficial alternative treatments that are reasonably available and the reasons for those views and preferences, including any recovery outcomes that the patient would like to achieve;
  - (b) the views and preferences of the patient expressed in his or her Advance statement;
  - (c) the views of the patient's nominated person;
  - (d) the views of a guardian of the patient;
  - (e) the views of a carer, if the authorised psychiatrist is satisfied that the treatment decision will directly affect the carer and the care relationship;
  - (f) the views of a parent of the patient, if the patient is under the age of 16 years;
  - (g) the views of the Secretary to the Department of Human Services, if the person is the subject of a custody to Secretary order or a guardianship to Secretary order;
  - (h) the likely consequences for the patient if the proposed treatment is not performed;
  - (i) any second psychiatric opinion that has been given to the authorised psychiatrist.

## Part 3 – Protection of rights

### Section 6 What is treatment?

For the purposes of this Act—

- (a) a person receives *treatment* for mental illness if things are done to the person in the course of the exercise of professional skills—
  - (i) to remedy the mental illness; or
  - (ii) to alleviate the symptoms and reduce the ill effects of the mental illness; and
- (b) *treatment* includes electroconvulsive treatment and neurosurgery for mental illness.

### Section 19 What is an Advance statement?

An Advance statement is a document that sets out a person's preferences in relation to treatment in the event that the person becomes a patient.

### Section 20 Making an Advance statement

- (1) An Advance statement may be made at any time and must—
  - (a) be in writing; and
  - (b) be signed and dated by the person making the Advance statement; and

- (c) be witnessed by an authorised witness; and
  - (d) include a statement signed by the authorised witness stating that—
    - (i) in the opinion of the witness, the person making the Advance statement understands what an Advance statement is and the consequences of making the statement; and
    - (ii) the witness observed the person making the Advance statement sign the statement; and
    - (iii) the witness is an authorised witness.
- (2) An Advance statement is effective from the time it is made until it is revoked.

## **Section 21 Revoking an Advance statement**

- (1) An Advance statement is revoked if the person who made the Advance statement—
- (a) makes a new Advance statement under section 20; or
  - (b) revokes the Advance statement in accordance with subsection (2).
- (2) A revocation of an Advance statement under this section must—
- (a) be in writing and state that the Advance statement made under section 20 is revoked; and
  - (b) be signed and dated by the person who made the revocation; and
  - (c) be witnessed by an authorised witness; and
  - (d) include a statement signed by the authorised witness stating that—
    - (i) in the opinion of the witness, the person revoking the Advance statement understands the consequences of revoking the Advance statement; and
    - (ii) the witness observed the person revoking the Advance statement sign the revocation; and
    - (iii) the witness is an authorised witness.

## **Section 22 Advance statement must not be amended**

- (1) An Advance statement must not be amended.
- (2) A person who changes his or her mind about the preferences he or she expressed regarding treatment in an Advance statement and who wishes to record new preferences must make a new Advance statement under section 20.

## **Under Part 4 – Compulsory Patients**

### **Section 46 Authorised psychiatrist may make Temporary Treatment Order**

- (2) In determining whether the treatment criteria apply to the person, the authorised psychiatrist—
- (a) must, to the extent that is reasonable in the circumstances, have regard to all of the following—
    - (i) the person's views and preferences about treatment of his or her mental illness and the reasons for those views and preferences, including any recovery outcomes that the person would like to achieve;

- (ii) **the views and preferences of the person expressed in his or her Advance statement;**<sup>6</sup>
  - (iii) the views of the person's nominated person;
  - (iv) the views of a guardian of the person;
  - (v) the views of a carer of the person, if the authorised psychiatrist is satisfied that making a Temporary Treatment Order will directly affect the carer and the care relationship;
  - (vi) the views of a parent of the person, if the person is under the age of 16 years;
  - (vii) the views of the Secretary to the Department of Human Services, if the person is the subject of a custody to Secretary order or a guardianship to Secretary order; and
- (b) may consider other information communicated to the authorised psychiatrist by persons other than the person who was examined.

## Section 48 Community or Inpatient Temporary Treatment Order?

- (2) For the purposes of making a determination under subsection (1), the authorised psychiatrist must, to the extent that is reasonable in the circumstances, have regard to all of the following—
- (a) the person's views and preferences about treatment of his or her mental illness and the reasons for those views and preferences, including any recovery outcomes that the person would like to achieve;
  - (b) **the views and preferences of the person expressed in his or her Advance statement;**
- (3) The authorised psychiatrist may only make a person subject to an Inpatient Temporary Treatment Order if the authorised psychiatrist is satisfied that treatment of the person cannot occur within the community.

## Section 55 Making a Treatment Order

- (1) After conducting a hearing under section 53, 54, 58 or 60, the Tribunal must—
- (a) make a Treatment Order in respect of a person if the Tribunal is satisfied that the treatment criteria apply to the person and determine—
    - (i) the duration of the Order; and
    - (ii) whether the Order is—
      - (A) a Community Treatment Order; or
      - (B) an Inpatient Treatment Order; or
  - (b) revoke the Order to which the person is currently subject if the Tribunal is not satisfied that the treatment criteria apply to the person.
- (2) For the purposes of making an Order under subsection (1)(a), the Tribunal must, to the extent that is reasonable in the circumstances, have regard to all of the following—
- (a) the person's views and preferences about treatment of his or her mental illness and the reasons for those views and preferences, including any recovery outcomes that the person would like to achieve;
  - (b) **the views and preferences of the person expressed in his or her Advance statement;**

<sup>6</sup> Bold text has been added to indicate where the Act makes reference to advance statements.

- (3) The Tribunal may only make a person subject to an Inpatient Treatment Order if the Tribunal is satisfied that treatment of the person cannot occur within the community.

### **Section 64 Leave of absence with approval**

- (3) In determining whether to grant a leave of absence to a person, to grant a leave of absence subject to conditions or to vary its conditions or duration under this section, the authorised psychiatrist must, to the extent that is reasonable in the circumstances, have regard to all of the following—
- (a) the person's views and preferences about the leave of absence and the reasons for those views and preferences, including the recovery outcomes that the person would like to achieve;
  - (b) the views and preferences of the person expressed in his or her Advance statement;**

### **Section 65 Another designated mental health service to provide assessment or treatment—variation by authorised psychiatrist or as directed by chief psychiatrist**

- (4) In determining whether under this section to vary, or direct the variation of, an Order to which this section applies, an authorised psychiatrist or chief psychiatrist (as the case may be) must, to the extent that is reasonable in the circumstances, have regard to all of the following—
- (a) the person's views and preferences about the proposed variation and the reasons for those views and preferences, including the recovery outcomes that the person would like to achieve;
  - (b) the views and preferences of the person expressed in his or her Advance statement;**

## **Under Part 5 – Treatment**

### **Section 71 When a patient does not give consent to treatment**

- (3) The authorised psychiatrist may make a treatment decision for the patient if the authorised psychiatrist is satisfied that there is no less restrictive way for the patient to be treated other than the treatment proposed by the authorised psychiatrist.
- (4) In determining whether there is no less restrictive way for the patient to be treated, the authorised psychiatrist must have regard, to the extent that is reasonable in the circumstances, to all of the following—
- (a) the patient's views and preferences about treatment of his or her mental illness and any beneficial alternative treatments that are reasonably available and the reasons for those views and preferences, including any recovery outcomes that the patient would like to achieve;
  - (b) the views and preferences of the patient expressed in his or her Advance statement;**
  - (h) the likely consequences for the patient if the proposed treatment is not performed;
  - (i) any second psychiatric opinion that has been given to the authorised psychiatrist.

### **Section 73 Circumstances in which patient's preferences in Advance statement may be overridden**

- (1) An authorised psychiatrist may make a treatment decision under section 71(3) for a patient that is not in accordance with that patient's Advance statement if the authorised psychiatrist is satisfied that the preferred treatment specified by the patient in the Advance statement—
  - (a) is not clinically appropriate; or
  - (b) is not a treatment ordinarily provided by the designated mental health service.
- (2) If an authorised psychiatrist overrides a patient's preferred treatment in accordance with this section, the authorised psychiatrist must—
  - (a) inform the patient of the decision and include the reasons for the decision; and
  - (b) advise the patient that he or she has a right to request written reasons for the decision.
- (3) An authorised psychiatrist must provide written reasons for his or her decision under this section within 10 business days after receiving a request made under subsection (2)(b).

### **Section 82 Powers of a psychiatrist giving a second psychiatric opinion**

For the purposes of exercising his or her functions under this Division, a psychiatrist giving a second psychiatric opinion—

- (a) may examine the entitled patient; and
- (b) may access any health information that is held by the designated mental health service that is treating the entitled patient and is relevant to the treatment of the entitled patient; and
- (c) may consult the authorised psychiatrist and any other staff of the designated mental health service about the treatment of the entitled patient; and
- (d) in deciding whether to recommend any changes to the treatment and the nature of those changes—
  - (i) must have regard to the following—
    - (A) the entitled patient's views and preferences about treatment and any beneficial alternative treatments that are reasonably available and the reasons for these views and preferences, including any recovery outcomes that the entitled patient would like to achieve;
    - (B) **the views and preferences of the entitled patient expressed in his or her Advance statement...**

### **Section 88 Review by chief psychiatrist**

- (3) In deciding whether to recommend any changes to the treatment and the nature of those changes, the chief psychiatrist must, to the extent that is reasonable in the circumstances, have regard to the following—
  - (a) the entitled patient's views and preferences about treatment of his or her mental illness and any beneficial alternative treatments that are reasonably available and the reasons for those views and preferences, including any recovery outcomes that the entitled patient would like to achieve;
  - (b) **the views and preferences of the entitled patient expressed in his or her Advance statement**

## **Section 93 Application to Tribunal to perform electroconvulsive treatment on a patient who is not a young person**

- (1) An authorised psychiatrist may make an application to the Tribunal to perform a course of electroconvulsive treatment on a patient who is not a young person if—
  - (a) the patient does not have the capacity to give informed consent to the performance of a course of electroconvulsive treatment on himself or herself; and
  - (b) the authorised psychiatrist is satisfied in the circumstances that there is no less restrictive way for the patient to be treated.
- (2) In determining under subsection (1)(b) whether there is no less restrictive way for a patient to be treated, the authorised psychiatrist must, to the extent that is reasonable in the circumstances, have regard to all of the following—
  - (a) the views and preferences of the patient in relation to electroconvulsive treatment and any beneficial alternative treatments that are reasonably available and the reasons for those views or preferences, including any recovery outcomes the patient would like to achieve;
  - (b) the views and preferences of the patient expressed in his or her Advance statement...**

## **Under Part 11 – Security patients**

### **Section 281 Grant of leave of absence**

- (4) In determining whether to grant a leave of absence to a security patient, to grant a leave of absence subject to conditions or to vary its conditions or duration, the authorised psychiatrist must, to the extent that is reasonable in the circumstances, have regard to all of the following—
  - (a) the security patient's views and preferences about the leave and the reasons for those views and preferences, including the recovery outcomes that the security patient would like to achieve;
  - (b) the views and preferences of the security patient expressed in his or her Advance statement...**

### **Section 287 Matters to take into account**

In determining whether to grant monitored leave under section 285 or whether to vary its conditions or duration under section 286, the Secretary to the Department of Justice must—

- (a) to the extent that is reasonable in the circumstances, have regard to all of the following—
  - (i) the security patient's views and preferences about the leave and the reasons for those views and preferences, including the recovery outcomes that the patient would like to achieve;
  - (ii) the views and preferences of the security patient expressed in his or her Advance statement ...**

### **Section 291 Authorised psychiatrist may direct security patient to be taken to another designated mental health service**

- (2) In determining whether the security patient is to be taken to another designated mental health service, the authorised psychiatrist must, to the extent that is reasonable in the circumstances, have regard to all of the following—
  - (a) the security patient's views and preferences about receiving treatment at another designated mental health service and the reasons for those views and preferences, including the recovery outcomes the security patient would like to achieve;

- (b) **the views or preferences expressed by the security patient in his or her Advance statement...**

## Under Part 12 – Forensic patients

### Section 307 Authorised psychiatrist may direct taking forensic patient to another designated mental health service

- (3) In determining whether taking a forensic patient to another designated mental health service is necessary for the forensic patient's treatment, the authorised psychiatrist must, to the extent that is reasonable in the circumstances, have regard to all of the following—
  - (a) the forensic patient's views and preferences and the reasons for those views and preferences, including any recovery outcomes the patient would like to achieve;
  - (b) **the views or preferences expressed by the forensic patient in his or her Advance statement**

## Under Part 13 – Interstate Application of Mental Health Provisions

Section 321 Transfer of responsibility for treatment of person to interstate mental health facility—without person's consent

- (3) In determining an application made under subsection (1), the Tribunal must, to the extent that reasonable in the circumstances, have regard to—
  - (a) the person's views and preferences about the proposed transfer and the reasons for those views and preferences, including the recovery outcomes that the person would like to achieve; and
  - (b) **the person's views and preferences expressed in his or her Advance statement...**

### Section 323 Taking person to interstate mental health facility—without person's consent

- (3) In determining an application made under subsection (1), the Tribunal must, to the extent that reasonable in the circumstances, have regard to—
  - (a) the person's views and preferences about being taken to an interstate mental health facility and the reasons for those views and preferences, including the recovery outcomes that the person would like to achieve; and
  - (b) **the person's views and preferences expressed in his or her Advance statement...**

## Under Part 15 – General

### Section 346 Disclosure of health information

- (1) The following must not disclose health information about a consumer—
  - (a) the mental health service provider;
  - (b) any member of staff or former member of staff of the mental health service provider;
  - (c) any person who is or was a contractor of the mental health service provider;

- (d) any volunteer or former volunteer at the mental health service provider;
- (e) any member of the board or former member of the board of the mental health service provider.

Penalty: 60 penalty units.

(2) Subsection (1) does not apply in the following circumstances—

- ... (h) the person to whom the health information relates is a patient and—
  - (i) the disclosure is reasonably required by a carer of the patient to determine the nature and scope of the care to be provided to the patient and to make the necessary arrangements in preparation for that role or to provide care to the patient; and
  - (ii) **regard has been had to the patient's views and preferences, including those expressed in any Advance statement that the patient may have prepared...**

## Appendix 4: Mental health principles

- Persons receiving mental health services should be provided assessment and treatment in the least restrictive way possible with voluntary assessment and treatment preferred.
- Persons receiving mental health services should be provided those services with the aim of bringing about the best possible therapeutic outcomes and promoting recovery and full participation in community life.
- Persons receiving mental health services should be involved in all decisions about their assessment, treatment and recovery and be supported to make, or participate in, those decisions, and their views and preferences should be respected.
- Persons receiving mental health services should be allowed to make decisions about their assessment, treatment and recovery that involve a degree of risk.
- Persons receiving mental health services should have their rights, dignity and autonomy respected and promoted.
- Persons receiving mental health services should have their medical and other health needs, including any alcohol and other drug problems, recognised and responded to.
- Persons receiving mental health services should have their individual needs (whether as to culture, language, communication, age, disability, religion, gender, sexuality or other matters) recognised and responded to.
- Aboriginal persons receiving mental health services should have their distinct culture and identity recognised and responded to.
- Children and young persons receiving mental health services should have their best interests recognised and promoted as a primary consideration, including receiving services separately from adults, whenever this is possible.
- Children, young persons and other dependents of persons receiving mental health services should have their needs, wellbeing and safety recognised and protected.
- Carers (including children) for persons receiving mental health services should be involved in decisions about assessment, treatment and recovery, whenever this is possible.
- Carers (including children) for persons receiving mental health services should have their role recognised, respected and supported.
- A mental health service provider must have regard to the mental health principles in the provision of mental health services.
- A person must have regard to the mental health principles in performing any duty or function or exercising any power under or in accordance with this Act.

# Appendix 5: Framework for recovery-oriented practice

## Domains of recovery-oriented practice

The following domains inform the provision of recovery-oriented care under the Victorian *Framework for recovery-oriented practice* (Department of Health and Human Services 2011, p. 6):

- promoting a culture of hope
- promoting autonomy and self-determination
- collaborative partnerships and meaningful engagement
- focus on strengths
- holistic and personalised care
- family, carers, support people and significant others
- community participation and citizenship
- responsiveness to diversity
- reflection and learning.

## Appendix 6: Useful resources

In addition to documents found in the reference section of this guide, the following documents may be of some assistance in practice.

Department of Health and Human Services 2014, Mental Health Act 2014 *handbook: advance statements*, <http://www.health.vic.gov.au/mentalhealth/mhact2014/recovery/advance-statements.htm>

Department of Health and Human Services 2014, Mental Health Act 2014 *information sheet: Victoria's new Mental Health Act starts on 1 July 2014* – information for consumers, [http://docs.health.vic.gov.au/docs/doc/10108987B6D34267CA257C830014FE9C/\\$FILE/Consumer%20pamphlet%20A4%20version%2009.04.14.pdf](http://docs.health.vic.gov.au/docs/doc/10108987B6D34267CA257C830014FE9C/$FILE/Consumer%20pamphlet%20A4%20version%2009.04.14.pdf)

Department of Health and Human Services 2014, Mental Health Act 2014 *quick guide: how does the Mental Health Act assist clinicians?*, [http://docs.health.vic.gov.au/docs/doc/D53D66919AA454C2CA257C830014996F/\\$FILE/Quick%20guide%20-%20How%20does%20the%20Mental%20Health%20Act%20assist%20clinicians.pdf](http://docs.health.vic.gov.au/docs/doc/D53D66919AA454C2CA257C830014996F/$FILE/Quick%20guide%20-%20How%20does%20the%20Mental%20Health%20Act%20assist%20clinicians.pdf)