Mental health advance statement training

Facilitators manual

Department of Health & Human Services

Austin Health

Respecting Patient Choices Advance Care Planning

mind Supporting mental health recovery

State Government Victoria

Mental health advance statement training

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

Contents

About advance statements

An advance statement is a document that states a person's preferences for treatment if they become a patient.

The *Mental Health Act 2014* (the Act) sets out the requirements for making an advance statement, how advance statements are to be used, and the circumstances in which an advance statement may be overridden. It also sets out the requirements for clinicians to follow if an advance statement is overridden.

The Act makes significant changes to compulsory assessment and treatment of people living with mental illness. It seeks to ensure that people who access mental health services are supported to make or participate in decisions about their mental health treatment. The Act also recognises the important role of families and carers in supporting the recovery of people living with mental illness.

The Act establishes a legal framework that supports mental health services to embed recovery-oriented practice and supported decision making into service delivery, focusing on principles of self-determination, autonomy, shared responsibility and supported decision making.

About this manual

The mental health advance statement training package has been developed to improve both the knowledge and application of the use of advance statements in mental health services.

This training addresses the following competencies and knowledge in relation to advance statements:

- understanding the scope of the reforms in the Act, including advance statement roles and responsibilities
- definitions
- recovery-oriented practice
- supported decision making and risk
- person-centred practice
- cultural sensitivity – language, culture, age, service, gender
- communication and engagement skills.

This manual is a guide for facilitators who deliver mental health advance statement training to the Victorian public mental health workforce, including Mental Health Community Support Service (MHCSS) staff.

The statewide advance statement training consists of an online module (Module 1: *Advance statement essentials*) and two face-to-face modules (Modules 2 and 3).

The online and face-to-face modules will assist the workforce to introduce, develop and use advance statements within a recovery-oriented framework, while embedding supported decision-making principles in practice.

Advance statement training

Expectations of services

It is expected that services providing advance statement training will:

- ensure the integrity of the workshops by committing appropriate staff to their delivery
- provide practical support to enable relevant staff to attend the workshops
- maintain the integrity of the workshop content.

Expectations of facilitators

It is expected that facilitators using this manual are:

- experienced in working in the public mental health sector
- experienced and confident in delivering workshops
- knowledgeable about the provisions of the Act relating to advance statements
- in a position to facilitate workshops within their current workplace.

Role of consumers, carers and families

Facilitators may choose to involve consumers, carers and/or families for the purpose of sharing their lived experience in workshops to enhance learning.

Suggested roles include:

- experience of making and using advance statements in role-plays
- co-facilitation of training workshops
- discussing personal experiences of advance statements.

A video that shows consumers and clinicians talking about their experience of and hopes for advance statements is available at http://www.health.vic.gov.au/mentalhealth/mhact2014/recovery/advance-statements.htm

Expectations of workshop participants

It is expected that all participants of the facilitated workshops will:

- have completed the online learning Module 1 (*Advance statement essentials)* prior to attending a workshop. If this is not the case, the facilitator will need to use their own judgement to decide if the participant can undertake Modules 2 and 3
- work in mental health services where they are required to understand and apply the requirements of the Act relating to advance statements.

What the manual includes

The manual includes:

- an overview of the learning objectives for each module
- detailed workshop session plans for modules 2 and 3
- appendices with information and activity handouts
- a workshop evaluation template.

Note: This manual should be used in conjunction with the *Victorian mental health advance statement practice guide* (the guide).

Training overview

The training consists of three modules of 40–60 minutes each. Modules should be allocated 60 minutes to be of maximum benefit, particularly for less experienced members of the workforce, or those who will work more closely with consumers.

Modules

Module 1: *Advance statement essentials*

Module 1 covers basic concepts and gives an overview of the legislation and process. This module must be completed before the workshop. Participants will be given a certificate of completion that they must bring to the workshop.

Module 2: *Making an advance statement*

A workshop with role-plays, scenarios and small and large group discussions.

Module 3: *Using an advance statement*

A workshop with role-plays, scenarios and small and large group discussions.

Using scenarios

The workshops provide opportunities for experiential learning based on adult learning principles. Scenarios are used to illustrate practice guidance.

The basic principles of advance statements, such as knowledge and application of the legislation, and understanding of supported decision making are explored through role-play and discussion.

You may choose to send the scenarios to the workshop participants before the workshop, or present the scenarios in the workshop.

Adapt the scenarios for your group, and include, for instance:

- a brief summary
- key points, experiences or significant stages
- a completed advance statement to discuss (or homework between Modules 2 and 3).

The workforce consists of a wide variety of people with different roles and responsibilities. Similarly, the population of people accessing mental health services, their support networks, carers, families and other support people, varies considerably.

You should use a variety of scenarios, including:

- those in Appendix 1 of this manual
- scenarios you create, based on requests to explore particular scenarios, or knowledge of the need for exploration of certain scenarios in the workplace
- scenarios provided by the workshop participants before or during the workshop.

The scenarios in this manual have been designed to raise issues around the making and using of an advance statement. Several scenarios have been included with varying levels of complexity. These raise issues that for discussion. As you plan the workshops, choose scenarios relevant to your training participants.

Participants can also be asked to bring scenarios from their own practice, to be considered as part of the workshops.

You should:

- send the scenarios out before the workshop
- select a maximum of two scenarios per workshop (to limit discussion to pertinent issues for the group)
- use the same scenarios in both Module 2 and 3, so that there is continuity.

Facilitating role-plays

Setting up role-plays

Role-plays are central to the training as they are an effective way of making sense of the information presented in the online module, and practices involved in making and using advance statements. They consolidate the concepts into simulated practical experience and provide an opportunity to apply the theory in a safe environment.

Before the role-plays

Give clear instructions to participants, and to the observers. These include:

- time available for each conversation
- the role each person is playing
- the role of the observer, and the feedback process.

Feedback needs to be specific, relevant, achievable and given immediately. It is usually helpful to identify something positive as well as anything that could be done differently.

During the role-plays

The role-play is not a performance. It is possible for participants to put the role-play on hold, step outside it, and ask questions about the process or clarify the expectations of the task. To help answer questions, this guide includes a ‘Frequently asked questions’ section.

After the role-plays

It is important to give participants the opportunity to debrief and de-role from the experience. Some people may not feel the need to do so, but they should be given the opportunity. This should happen before the larger group reconvenes to discuss the experience and the learning that has arisen from it.

Key questions to ask include:

- Is there anything you need to say about the experience of being in this role play?
- Is there anything you need to do to leave the role behind?
- Can you tell me your name and what you had for breakfast this morning? (This line of questioning is used to bring a person back to their usual day-to-day role and life routines, without making too much of a fuss).

If someone appears to be, or says they are, unsettled or traumatised by the experience of the role-play or scenario information, please refer to the protocols and supports available for debriefing at your service.

Resources

Resources include:

- the practice guide
- this facilitators manual
- handouts from the appendices of the manual
- the Mental Health Act 2014

Module 1 states that participants should bring their own copies of the practice guide with them to the workshops, but it is a good idea to have spare copies with you.

Handouts

- Appendix 1: Scenarios
- Appendix 2: Advance statement practice checklist
- Appendix 3: Relevant excerpts from the Act
- Appendix 4: Example of an advance statement template (or the advance statement template developed by your service)

Handout for the end of the workshop

- Appendix 5: Workshop evaluation forms

Optional handouts

- Appendix 6: Possible workshop activities

Content overview

Module 1: Advance statement essentials

This online module **must** be completed by all participants before the workshop modules. It covers the basic legal, philosophical and practical concepts that form the foundation for the experiential learning of the subsequent modules.

The online module is the most efficient way to reach the Victorian mental health workforce and provide information prior to the workshops. Some educators may wish to use Module 1 as the basis for group learning and discussion. In this case, the facilitator will guide a member or members of the group to log into the online module and the group can then complete the module together.

Module 2: Making an advance statement

Module 2 includes:

- introductions as 'ice-breaker' activity
- reflection exercises to recap Module 1
- role-plays of scenarios with two or three people, each playing:
  - a mental health practitioner
  - the person making an advance statement or a carer, family member, nominated person or support person/s
  - role play observer (if in groups of three) using the 'Advance statement practice checklist' (Appendix 2)
  - small and large group reflection on the experience, paying particular attention to supported decision-making principles.

Note: Given the time limit of workshops, conducting role-plays in groups of two maximises the opportunity of the participants to play an active role. The role played by the second person should be varied so that the person playing the role of the mental health practitioner can practise discussing advance statements with a consumer, a carer, a family member, a nominated person, or a support person.

Module 3: Using an advance statement

Module 3 includes:

- role-plays of scenarios, with two or three people, each playing:
  - a mental health practitioner or authorised psychiatrist
  - the person with an advance statement or a carer, family member, nominated person, support person
  - role-play observer (if in groups of three) using the 'Advance statement practice checklist' (Appendix 2)
- small and large group reflection on the experience, paying particular attention to recovery-oriented practice and principles
  - conclusion and evaluation.

Note: Given the time limit of workshops, conducting role-plays in groups of two maximises the opportunity of the participants to play an active role. The role played by the second person should be varied so that the person playing the role of the mental health practitioner can practise discussing advance statements with a consumer, a carer, a family member, a nominated person, or a support person.

Lesson plan: Module 2

Making an advance statement

Learning objectives

Through experiential learning and role-plays, workshop participants will:

- apply knowledge and skills regarding provisions in the Act relevant to advance statements
- support a person to make an advance statement, with the inclusion of carers, family, nominated person and other supports, if appropriate
- describe the various roles of people involved with making advance statements
- demonstrate reflective practice regarding supported decision making and dignity of risk.

Content

Workshop content includes:

- reflections from Module 1 (online)
- introductions – participants introduce themselves
- role-play activities.

Themes

Key themes include:

- supported decision making
- dignity of risk.

Overview of session (40–60 minutes)

Module 2 activity	Time	Suggested resources
Welcome • Ice-breaker – reflections from Module 1. This could be a brief five-minute activity where participants pair up and tell each other the two main points they discovered from the reflection exercises in Module 1 • Introductions – each participant introduces themselves to the larger group • Ground rules, such as eating/drinking in the room, respecting others' experiences and comments, confidentiality of the discussion content, no cross-talking, what to do if feeling overwhelmed • Overview of the session • Check participants have brought the practice guide, and hand out copies if someone has forgotten theirs	15 mins	• Possible activities, including copy of reflection exercises from Module 1: Appendix 6 • The practice guide (for those without one)

Scenario role-play • Two to three people in each group focus on making an advance statement, playing roles of the person, the mental health practitioner and an observer (in a group of three) • Instructions to small groups: – Select or have a scenario to use – The roles discuss preferences and attempt to complete the template – The observer uses the practice checklist to guide observations Each role-play should run for a maximum of 10 minutes (before participants fatigue or become distracted), followed by two to three minutes of feedback and debriefing. Participants should then swap roles for a further 10 minutes with two to three minutes debriefing. In total this will take 25–30 minutes.		• Scenario/s (Appendix 1) • Advance statement practice checklist (Appendix 2) • Excerpts from the Act (Appendix 3) • Advance statement template (Appendix 4), or template developed by your service • See 'Facilitating role-plays' section of this manual for guidance on how to facilitate role-plays
Debriefing/discussion/reflection in small groups • Instruct the small groups to reflect on: – how it felt playing each role, including observer – any issues/queries the experience raised – positive outcomes – questions the group would like answered. You should visit the small groups to assist with any queries, prompt the group to use the practice guide and FAQ section for guidance, and provide information and general role-play direction if required.		• The practice guide • FAQs
Large group discussion • Answer, or provide guidance as to where participants might find the answers to, any questions raised • Experiences and reflections of the role-plays – for example, how did it feel? How could the experience be improved? • Pay particular attention to supported decision-making principles and practice	10 mins	• FAQs • The practice guide • Principles underpinning supported decision making (see below)

Supported decision-making principles

The following principles underpin supported decision making (Roper and Weller 2013):

- People are capable of making decisions about most areas of their lives.
- Everyone has a will and can communicate their will and preferences. These preferences can be built into valid decisions.
- The person should receive whatever support is available to receive in order to make decisions.
- Competency can be learned, influenced, enhanced and suppressed.
- The person makes and retains control over the decisions made and takes responsibility for them.
- People have the right to take risks in their lives.
- People do not always make good decisions but can learn from their mistakes and experience.
- The person is encouraged/enabled to draw on their own networks to help them make decisions (relational).

Lesson plan: Module 3

Using an advance statement

Learning objectives

Workshop participants will:

- demonstrate the application of knowledge and skills regarding the provisions in the Act relevant to advance statements
- experience how to support a person who has an advance statement, including carers, family, nominated person and other supports
- describe the various roles of people involved with the use of advance statements
- demonstrate the application of key concepts relevant to using advance statements, such as:
  - supporting the person who has made the advance statement
  - supporting the workforce to understand and use advance statements
  - applying relevant principles including recovery-oriented practice, supported decision-making principles and the dignity of risk to the experience of using an advance statement.

Content

Workshop content includes:

- using an advance statement
- role-play activities based on scenarios
- training conclusion.

Themes

Key themes include:

- recovery-oriented practice
- supported decision making
- dignity of risk.

Overview of session (40–60 minutes)

Module 3 activity	Time	Suggested resources
Welcome back If this workshop session continues straight on from Module 2 workshop session: • Overview of the session and expectations (role-play and discussion regarding advance statements and supported decision-making principles) If there has been a period of time between modules, also cover: • Ground rules (eating/drinking in the room, respecting others' experiences and comments, confidentiality of the discussion content, no cross-talking, what to do if feeling overwhelmed) • Ice-breaker activity (Module 2 reflection in pairs), or have group give examples of experiences with making or using advance statements between modules	5 mins (if returning straight away) 10 mins (if group returning after a period of absence)	• Check that all participants have the practice guide • Possible activities: Appendix 6

Module 3 activity	Time	Suggested resources
Scenario role-play • Two to three people in each group focus on using an advance statement. Roles include, person/patient/carer, mental health practitioner and an observer • Instructions to small groups: – Select or have a scenario to use – The roles discuss the person's existing advance statement and preferences and whether they have been followed or not – The observer uses the practice checklist to guide observations Each role-play should run for a maximum of 10 minutes (before participants fatigue or become distracted), followed by two to three minutes of feedback and debriefing. Participants should then swap roles for a further 10 minutes with two to three minutes debriefing. In total this will take 25–30 minutes.	25–30 mins	• The advance statement that was written in Module 2 • Scenario/s (Appendix 1) • Advance statement practice checklist (Appendix 2) • Excerpts from the Act (Appendix 3) • See 'Facilitating role-plays' section of this manual for guidance on how to facilitate role-plays
Discussion/reflection in small group • Instruct the small groups to reflect on: – how it felt playing each role, including observer – any issues/queries the experience raised – positive outcomes – questions the group would like answered. Visit the small groups to assist with any queries, prompt group to use the practice guide and FAQ section for guidance, and provide information and general role play direction if required.		• The practice guide • FAQs
Large group discussion • Answer, or provide guidance as to where participants might find the answers to, any questions raised • Experiences and reflections of the role-plays – with particular attention to supported decision-making principles and practice	10 minutes	• The practice guide • FAQs
Workshop conclusion • Thank the group for their participation • Summarise lessons learned, and check on learning objectives for all modules • Ask participants to evaluate the workshop	5 mins	Workshop evaluation form (Appendix 5)

Recovery-oriented practice principles

The aim of a recovery-oriented approach to mental health service delivery is to support people to build and maintain a (self-defined and self-determined) meaningful and satisfying life and personal identity, regardless of whether or not there are ongoing symptoms of mental illness.

A recovery-oriented approach moves away from a primarily biomedical view of mental illness to a holistic approach to wellbeing that builds on individual strengths.

The term 'recovery-oriented practice' describes this approach to mental healthcare, which encompasses principles of self-determination and personalised care.

Recovery-oriented practice emphasises hope, social inclusion, community participation, personal goal setting and self-management.

Typically, literature on recovery-oriented practice promotes a coaching or partnership relationship between people accessing mental health services and mental health professionals, whereby people with lived experience 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).

The *Framework for recovery-oriented practice* (Department of Health and Human Services 2011) lists a number of domains (see below). It may be useful for participants to reflect on how they have demonstrated responsiveness to these domains in assisting people to make and use an advance statement.

- 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

Content not covered in the training

Facilitators could consider including/discussing service specific issues that relate to using an advance statement, such as:

- how to access documents, for example when in emergency departments, eCATT, rural areas
- storage of documents
- monitoring of document uptake, overrides and complaints
- liaising with external services
- barriers regarding access to and communication about the documents.

Frequently asked questions

The training will elicit different responses and queries from different audiences. Use the following questions and answers as a guide. You can also use the practice guide and the excerpts from the Act.

1. Who can help write an advance statement?

Anyone can help a person to write an advance statement. For the document to be effective for the purposes of the Act, it must be witnessed by an authorised witness.

2. Who can be an authorised witness?

An authorised witness is 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* (see 'Appendix 2: List of persons who may witness statutory declarations' in the practice guide).

A mental health practitioner is defined as a registered psychologist, registered nurse, social worker or registered occupational therapist employed or engaged by a designated mental health service.

A registered psychologist means a person who is registered under the Health Practitioner Regulation National Law to practise in the psychology profession.

A registered nurse means 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.

A registered occupational therapist means a person who is registered under the Health Practitioner Regulation National Law to practise in the occupational therapy profession.

A designated mental health service means a prescribed: public hospital; public health service; denominational hospital; privately-operated hospital; private hospital; or the Victorian Institute of Forensic Mental Health.

3. Can a private mental health practitioner (such as a private psychiatrist or psychologist) act as an authorised witness?

A private psychiatrist can act as an authorised witness, as they are a registered medical practitioner. Other private practitioners can only witness advance statements if they are a registered medical practitioner, a mental health practitioner (see above), or a person who can sign a statutory declaration.

4. Can someone witness an advance statement if they helped a person to make it?

Yes, provided they meet the criteria for being an authorised witness.

5. Are bodily restraint and seclusion 'treatments' under the Act?

No. Bodily restraint (physical and mechanical restraint) and seclusion are restrictive interventions and are not treatments.

Bodily restraint means 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 means 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.

6. Can non-treatment preferences be included?

Preferences that do not relate to treatment are also important to acknowledge. These can be documented in an advance statement, as 'additional information', or in a separate document containing information the consumer feels would be useful to the treating team while he/she is a patient.

There is no requirement under the Act for non-treatment preferences to be followed. Treating teams, however, should acknowledge non-treatment preferences and consider why these are important to the person and how they may be met. The team can also talk to the person about what else might help them to feel safe or to assist recovery.

7. Can an advance statement be amended if the amendment is witnessed?

An advance statement must not be amended. Instead, if a person wants to change his or her preferences expressed in their advance statement, they must make a new advance statement.

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

8. Can personal preferences be amended?

An advance statement must not be amended.

For this reason, it is recommended that people prepare a document outlining their personal preferences as a separate document that sits alongside their advance statement in their clinical record, but that can be updated with greater ease (s. 22).

9. Can a new advance statement be written without revoking the existing one?

Making an advance statement automatically revokes any earlier advance statement made by that person.

10. How can you ensure that the advance statement is a true expression of a person's treatment preferences?

An advance statement is designed to assist a person to express their own treatment preferences.

If you have concerns that a person is being coerced to express a treatment preference, you can them that making an advance statement is entirely their choice and they do not have to make one or express particular preferences if they don't want to.

The authorised witness has a responsibility to confirm that the person making the advance statement is able to understand what an advance statement is and the consequences of making one.

An advance statement details the treatment preferences of the person who becomes a patient under the legislation. The final decision about treatment to be enacted in any particular situation is the responsibility of the authorised psychiatrist.

11. Is it necessary to use a template?

No. The only requirements are that 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 will be valid if it meets these requirements.

12. Can a nominated person witness an advance statement?

Yes, provided they meet the criteria for an authorised witness.

13. Is it necessary to include reasons for preferences?

It is not necessary to include reasons. However, including reasons will help clinicians who make a treatment decision for a person to make decisions that better align with a person's preferences.

The Act requires the authorised psychiatrist to take into account the person's views and preferences about treatment of his or her mental illness and the person's reasons for those views and preferences, so it is useful to have these documented.

14. Is there a preferred length for an advance statement? Can an advance statement be too long?

There is no limit on the length of an advance statement. However, the more clear and concise the advance statement is, the easier it will be read and understand, particularly in crisis or acute situations.

An advance statement is not a substitute for documents such as wellness recovery action plans and individual service plans that consider a person's holistic needs and goals.

15. What happens with patients from interstate?

If a person from interstate has an advance statement that meets the requirements of the Act, then that advance statement is valid.

16. Can someone who has never had an admission to hospital make an advance statement?

Yes.

17. Can an advance statement be overridden?

If the authorised psychiatrist is satisfied that the preferred treatment specified by the patient in the advance statement is not clinically appropriate; or is not a treatment ordinarily provided by the designated mental health service, then the preferences expressed in the advance statement can be overridden.

The authorised psychiatrist must inform the person about the decision, including the reasons for the decision and advise the patient that he or she has a right to request written reasons for the decision. The authorised psychiatrist must provide written reasons for his or her decision within 10 business days after receiving a request.

18. What should I do if someone specifies a treatment preference that I know the service can't deliver, or is highly likely to be overridden?

It is important to provide people with honest feedback about whether their expressed preferences are likely to be able to be followed. You may want to talk to the person about whether, in your view, their preferences are likely to be clinically appropriate or whether the treatment is not ordinarily provided by the designated mental health service. If a person expresses a preference for a restrictive intervention to be used, you should talk to the person about the difference between treatment and restrictive interventions.

You could prompt the person to think about the reasons for their preferences, and to consider if there is another way they could achieve their desired outcome.

It is important to remember you can and should provide advice to the person, but the person may still choose to make their advance statement in the way that they prefer. A person who expresses preferences related to restrictive interventions should be informed that these do not constitute treatment and are only used to ensure the safety of the person or of others.

19. What if someone who is receiving compulsory mental health treatment, and lacks capacity or refuses to provide informed consent to treatment, states they have an advance statement, but a written copy cannot be found?

The treatment preferences in an advance statement can only be considered by an authorised psychiatrist if they can be accessed. However, if a patient is able to communicate their treatment preferences, then the authorised psychiatrist must consider these preferences when making a treatment decision.

20. What legal rights does a person with an advance statement have?

A person with an advance statement has the right to state their treatment preferences in their advance statement and have their advance statement taken into account. If their advance statement is overridden, they have the right to request written reasons.

They will also have all the other rights patients have under the Act. Statements of rights are available at: www.health.vic.gov.au/mentalhealth/mhact2014/safeguards/statement-of-rights.htm

21. Where should an advance statement be kept?

An advance statement needs to be kept in a location where it can be easily communicated to, or accessed by, the treating psychiatrist. It may be scanned and kept in a person's electronic files. The person with an advance statement and their nominated person should also have a copy.

The person with an advance statement should explore all possibilities with their support networks, and make sure that all key people are informed of where the copies of the advance statement are kept.

22. Does a person likely to be admitted to hospital have to make an advance statement?

Making an advance statement is voluntary. No-one is obliged to make an advance statement.

23. Can medical treatment preferences be written on a mental health advance statement?

No. Treatment is defined in the Act and does not include medical treatment. However a person can also complete an advance care plan, which is the medical equivalent of an advance statement, where they can express their medical treatment preferences, to be considered in the event that they become too unwell physically to communicate their wishes, for example, if they become unconscious, or have a brain injury or stroke.

24. Can a nominated person ensure that an advance statement is considered?

A nominated person may bring an advance statement to the attention of the treating team. They may also use the advance statement as a guide to represent the person's preferences when talking to the treating team. The authorised psychiatrist must consider the views of the nominated person as well as the views and preferences expressed by the person, including in the advance statement, when making a treatment decision for a person.

25. What is dignity of risk?

The mental health principles in the Act state that a person should be able to make decisions about assessment, treatment and recovery that involve a degree of risk. Dignity of risk means respecting each individual's autonomy and self-determination (or dignity) to make choices for him or herself. The concept

means that all adults have the right to make their own choices about their health and care, even if healthcare professionals believe these choices endanger the person's health or longevity.[1]

26. Can an advance statement be written in a language other than English?

An authorised psychiatrist needs to be able to read and understand an advance statement for it to be effective. However, a person could write an advance statement in their preferred language and have the advance statement translated. Therefore, even if it is originally written by the person in their preferred language, it would need to be translated so it can be correctly witnessed and referred to.

27. Is it possible to make a video or recording of treatment preferences?

An advance statement must be in writing. A person can receive assistance to prepare a written advance statement.

28. What can be included in 'additional information'?

Preferences other than treatment can be included in an additional section. This may include whether a person wants to be left alone, and requests regarding visitors, confidentiality of information, access to social media, issues regarding the care of dependants and so on. It is titled 'Additional information' in the attached template, but could be titled any way that the person or service prefers.

29. If someone revokes their advance statement, do they have to make a new one?

No.

30. Is the override of advance statements being monitored?

At this stage there is no monitoring system around the state, but services are encouraged to keep records of the activities around advance statements.

31. Can people who do not have capacity make an advance statement?

The Act does not stipulate that a person must have capacity in order to be able to make an advance statement. The Act prescribes a lower test, which is that the person must be able to understand what an advance statement is and the consequences of making one.

32. What is the procedure if, for example, an insurance company or private health insurer makes an enquiry as to whether a person has an advance statement?

An advance statement is subject to the same privacy protections as any other mental health related health information.

[1] Disability Practice Institute 2014, 'Dignity of risk', <www.disabilitypracticeinstitute.com/services/%E2%80%9Cdignity-of-risk%E2%80%9D/>.

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Appendix 1: Scenarios

Scenario 1: Tom

Tom is 24 years old and accesses your community mental health support service. You are working with Tom toward his recovery goals. You and Tom have been discussing the development of his advance statement. Tom was recently admitted to hospital as a compulsory patient and did not have an advance statement at the time of his recent hospital admission

Tom is not able to identify a nominated person, carer or family member he wishes to be involved in his recovery. However, Tom tells you that he has a good friend he met the last time he was in hospital. He states he wants to bring his friend in to his next appointment to help him add more treatment preferences to his advance statement. He states he is thinking about making his new friend his nominated person.

Tom and attends church every Sunday. Tom states that he becomes very anxious and worries that something very bad will happen to him and/or his family if he cannot go to church on a Sunday. Tom wants to add 'attending church on Sundays' to his treatment preferences.

When you are supporting Tom to develop his advance statement, he states he has been claustrophobic since he was a child and that he felt acutely distressed during his recent hospital admission when he was experiencing an acute episode of psychosis and was secluded for a period of time. He states that, while he is not opposed to having intramuscular injections of psychotropic medications, he would like to document a treatment preference for mechanical restraint, rather than seclusion, in his advance statement.

A week later Tom has completed, signed and dated his advance statement. During a phone conversation with him, he tells you he is going to have his advance statement witnessed by his chosen authorised witness tomorrow. You alert Tom to the valid process around signing and witnessing the document.

After informing Tom about who can witness his advance statement, Tom tells you that the authorised witness Tom has chosen is his uncle, who is a minister of religion authorised to celebrate marriages.

Two weeks later

Tom tells you he has made a change to his treatment preferences in the copy of the advance statement he has at home. You alert him to the process for amending and revoking advance statements.

For Module 3

Admitted

Tom has now been admitted to an acute public mental health service under a temporary treatment order. You are his allocated mental health practitioner on the evening after he was admitted. Tom tells you he is feeling unhappy that his advance statement preference for mechanical restraint was not respected, and he was secluded again while experiencing acute psychosis last night.

You are aware that he was given an intramuscular injection in the emergency department, was secluded for two hours when he arrived in the unit because he had been medicated and was still violent and threatening the staff and other patients on the unit, and that no staff had access to his advance statement at the time (his uncle brought in a copy of his statement this morning).

Scenario 2: Bruce

Bruce is 51 years old and has had contact with mental health services on and off for 20 years.

Bruce has been on a community treatment order for the past 10 months. He was placed on the community treatment order after a long period of not adhering to his oral medications, which was associated with an increase in his symptoms. Bruce currently receives a four-weekly depot psychotropic injection.

Bruce will occasionally bring his wife with him to appointments. They disagree about whether Bruce needs to be on the community treatment order. His wife is concerned that Bruce is harder to live with when he is not taking his medication consistently, and does not want to have to deal with this again.

Bruce and his wife have two children, aged 19 and 22. While Bruce's wife is involved in appointments, and he is happy for her to be in contact with the treating team, he would like his 19-year-old daughter to be his nominated person.

When you are supporting Bruce to develop his advance statement, he describes that he does not like getting the depot medication and would prefer to be back taking the oral medication. He also reports that medications make him less creative, and this takes the edge off his musical ability, as he really enjoys playing the guitar in a band with friends.

Bruce would also like to write down a treatment preference regarding ECT. This is a treatment that the treating team have never discussed with Bruce, but he has heard that it 'fries your brain' and wants to write down a preference that he does not want ECT, as he worries that this would also take the edge off his musical ability.

You help Bruce to write an advance statement, but he does not wish to sign it until he speaks with his daughter. You advise Bruce of the procedures for signing and witnessing the advance statement to make it valid. You encourage and support him to discuss his advance statement with his daughter as his nominated person.

Two weeks later

At your next appointment Bruce asks you to be the authorised witness that signs his advance statement, as he trusts you more than the other members of his treating team. He has also brought his daughter along to the appointment and would like to appoint her as nominated person.

For Module 3

Two months later

Bruce's CTO is reviewed and his treatment preferences are taken into consideration. He is switched onto oral medication. He asks that you do not advise the other members of his treating team or his wife of this change. He is happy for his nominated person to know.

Another two months later

Bruce attends for an appointment and his wife has come along. His wife is upset as she has just learned that Bruce is no longer receiving the depot medication, and is worried that he is inconsistent with the oral medication and is starting to 'go downhill' again.

Scenario 3: Natalie

Natalie is 35 years old. She has been seeing you for only two months after moving into the area.

Natalie has been admitted to an acute public mental health service on three previous occasions. She takes oral psychotropic medications and enjoys long periods of wellness. Her inpatient admissions have occurred at periods when she has been highly stressed, which have significantly increased the symptoms of her mental illness.

Natalie is a single mother with two young children. Her own mother is very supportive, and helps to care for the two children when Natalie needs her to. Natalie is happy for the treatment team to be in contact with her mother, but does not feel it necessary to make her nominated person.

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 develop 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 feels that making all these changes to her medications meant that she stayed in the inpatient unit longer than necessary, which was hard for her children to deal with.

She would like to write a treatment preference that, if she is admitted again in the future, that her medications not be changed. She is happy to take PRN medication during the admission to help with her acute symptoms.

Natalie also describes that she easily gets overwhelmed by the number of unfamiliar faces in an inpatient unit, and would like to write a preference that she has the same contact nurse throughout the admission. She would also like to write a treatment preference that she does not receive any psychotherapy while an inpatient, as she feels too overwhelmed to make use of this option.

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 in her advance statement that her mother takes her children for these visits if she is admitted, as she feels anxiety about this could make her symptoms worse.

Natalie indicates that she plans to take her written advance statement home to discuss with her mother, and will then ask her to act as the witness. You advise Natalie about the appropriate people who can act as a witness.

One month later

Natalie tells you that she is feeling very stressed as she has been having lots of arguments with her sister and they are currently not talking. She would like to amend her advance statement to remove the preference for her children to visit their aunt. You talk her through how to amend her advance statement.

For Module 3

Another month later

Natalie is admitted to an acute public mental health service where the treating team have decided to change her antidepressant medication. Natalie is refusing to take the new medication, telling staff that she doesn't have to take it because her 'advance statement says so'. You discuss with Natalie the circumstances in which a preference in an advance statement may be overridden, and what her options are.

Scenario 4: Antoinette

Antoinette is a 62-year-old woman of Italian background who is admitted to your inpatient service occasionally, and has been admitted again recently as a compulsory patient.

Antoinette suffers from severe and recurring bouts of major depression. She also suffers bouts of debilitating anxiety. She is increasingly reluctant/fearful to leave her home.

A few nights ago she was found wandering the street in the early hours of the morning, just after midnight, in her nightgown, with no sense of where she was, who she was, or why she was out at night.

Antoinette does not see a mental health practitioner regularly, but sees a GP regularly, and only if he visits her at home. Her GP speaks English and Italian. She migrated from Italy when she was a child, and has struggled to learn English.

When discussing her recovery goals, she expects to be an active and happy grandmother. She has five children and six grandchildren, and wants to be able to help her children care for their children, but feels as though her life is worthless as she struggles to get out of the house and doesn't see her friends. She feels that she has failed in her social obligations, and friends have also stopped visiting. She identifies feelings of shame.

Antoinette states that her GP has suggested ECT may be a possibility for her in the future, and that she should also consider therapy in addition to her current antidepressant. Her GP informed her about advance statements but said he doesn't know enough about them to help her write one.

Antoinette was married at the age of 18 to Carlo. He is supportive, but spends increasing amounts of time outside the family home. There is no-one in the nominated person role. Her husband says he does not understand enough and the doctors should make the decisions.

Antoinette would like to write an advance statement, as her GP thinks it would be beneficial. When you discuss this with her further, she cannot identify clear treatment preferences, instead asking you what would be best for her. She states that her mother-in-law has recently been placed in a nursing home, and is worried that her family may try to do that to her as well. She does not want to have to leave her home.

Two days later

Antoinette's daughter has come to visit and has asked you to explain what an advance statement is, and the benefits of her mother writing one. Based on discussions with Antoinette, her daughter asks you to outline the pros and cons of ECT, antidepressants and therapy.

Her daughter decides that she now has enough information to help her mother write an advance statement with the GP. You discuss with Antoinette and her daughter the steps for writing and communicating an advance statement.

For Module 3

Two months later

Antoinette's daughter calls the service concerned that her mother was started on a course of ECT after her recent admission, despite having discussed with the GP that she did not want ECT.

When you look through the hospital records, there is a copy of an advance statement signed by the GP and Antoinette's daughter, but not Antoinette herself.

Discuss with Antoinette's daughter what may have happened in this situation.

Scenario 5: Josh

Josh is a 19-year-old person who accesses your mental health service.

He has episodes of psychosis associated with drug use, and can be violent under the influence of some substances, particularly methamphetamines which he uses approximately once per month. He also uses cannabis ‘every few days’ and drinks alcohol on weekends. He is aware that methamphetamines in particular have contributed to problems he is having with his mental health and with the police.

You have been working with Josh to identify his recovery goals during his last three appointments. He identifies that he would like to return to school to finish year 12 so he can go to university, and would also like to get his driver’s licence. But he does not think these are a real possibility because of his drug use, and does not feel able to abstain. He would also like to improve his relationships with his parents and sister, as life at home can be stressful sometimes, but he is not sure how to achieve this. You suggest that Josh asks his family to come to an appointment with him to discuss this further.

One week later

Josh attends an appointment with his mother, who is very supportive and concerned about her son. She says Josh’s angry outbursts at home can be difficult for the family, and that his father can be very angry, and has hit Josh in the past in an attempt to control him.

She has been actively involved in trying to understand what might help Josh, including medications. She has expressed considerable frustration about Josh’s situation and does not think he gets adequate care, especially when he is in hospital. She is very worried that Josh could be harmed when he is psychotic and becomes involved in violent incidents with police and security guards. She thinks this could be avoided if people got to know Josh and how to respond to him when he is acutely unwell.

You discuss advance statements with Josh and his mother. They are not certain that it will help, and feel that no-one will pay attention to their wishes, as this has been a pattern in the past.

After further discussion, they agree to write an advance statement to see if it will make any difference.

Josh states he will take oral psychotropic medications, but finds needles painful and does not want intramuscular injections. Josh also knows that being isolated from other people helps him calm down when he is agitated and psychotic. Josh and his mother would also like her to become his nominated person, so she can be more involved in decision making when he is unwell.

For Module 3

One month later

You receive a phone call from Josh’s mother, saying that Josh has been admitted to the inpatient unit. She is upset, as Josh received an intramuscular injection when at the emergency department, and has described being held down, stripped of his pants and given an injection in his buttocks, which he found very embarrassing.

He was told it was 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 ward. Once on the ward he was placed into seclusion away from others, and he reports feeling very alone and upset because of this.

You discuss with Josh’s mother the options for finding out more about the advance statement override, as well as options for amending the advance statement based on this recent experience.

Scenario 6: Colleen

Colleen is a 42-year-old woman who lives alone. She has been a long-time user of your service and is well known to staff. Each year she typically has an inpatient admission and is cared for by the CAT team for a period of time.

Colleen describes frustration with the treatment and care that she receives and feels that people do not listen to her. She is especially frustrated by the contact she has with so many different clinicians when she is being cared for by the CAT team, and that staff often think she is not taking her medications. You discuss with Colleen how an advance statement may help with some of her concerns.

Colleen has very few family supports and few friends. She finds the period of time after any inpatient admission difficult, as there is no one to look after her house for her, and she has to try and 'put the pieces back together again'. Her primary treatment preference is that she be treated at home and keep any hospital stays to a minimum.

She also finds the CAT home visits intrusive and stressful. She would like to arrange a set location, like a local café, for them to meet with her, rather than her 'nosey neighbours' always seeing them drop by. She also gets frustrated that the CAT team are always trying to give her medications, and that more often it would help for them to sit and talk with her instead.

If she does need an inpatient admission, she would also like the staff there to consider her preference for talking rather than medication. She also wants the hospital to pay her phone bill when she is an inpatient as she gets frustrated when she runs out of credit to make calls.

You help Colleen to write her advance statement and discuss whom she should give copies to. She decides to write it with you, but wants to take it away and get a different staff member to read it and sign it with her, in case you have made some bad suggestions.

For Module 3

One week later

Colleen advises you that she had a 24-hour crisis admission during the week. She describes being very stressed and upset on the night she was admitted, and that the staff refused to give her enough medication to help her feel better.

She thinks that you gave her bad advice when writing her advance statement to put down a preference for talking rather than medication, and thinks this is to blame for making her evening so horrible. She didn't want to talk to anyone while admitted, as no one was making any sense. She also tells you that the staff refused to give her money to put more credit on her phone, and that it was not written anywhere on her file about this being a decision that was agreed upon.

With further discussion with Colleen, you learn that she did not get the advance statement witnessed or provide it to the people/services you discussed. You review with Colleen the requirements for a valid advance statement and whether she wants to add/change anything based on her recent experience.

Scenario 7: Amanda

Amanda is 14 years old, with a history of anorexia nervosa and depression who has been admitted to your acute mental health service.

In the past year she has been admitted three times due to severe depressive symptoms and low BMI. She has had long admissions each time due to ongoing medical issues and the need for her to gain a certain amount of weight before being well enough for discharge.

As Amanda's contact nurse, you observe that she shows high levels of paranoia on the inpatient unit, talking only to a few select staff and patients. One patient she has become comfortable with tells her about her own advance statement, and Amanda asks you for more information about what they are. She says that she would maybe like to write one, as she doesn't feel like her own views are always listened to, and is suspicious of her mother's intentions at times. She is also worried that staff on the inpatient unit are trying to make her fat and are constantly watching her. You discuss with Amanda some information about advance statements.

Four days later

Amanda's mother takes you aside after she has been in to visit Amanda and tells you that she does not want her to write an advance statement. Her mother describes that Amanda often shows high levels of paranoia and suspiciousness when she is unwell, especially towards her mother. She does not think that Amanda understands what things will actually help her get better, and that it is best that her family decide for her. She is concerned that writing an advance statement will only support Amanda's suspicious behaviour rather than help her to get better.

One week later

Amanda is a couple of days away from being discharged from the inpatient unit, and she approaches you to help her write an advance statement. She would like to write one before she is discharged, as she is worried that her mother will interfere and stop her from writing one with her outpatient clinician.

She would like to write a 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. She also does not want to be prescribed any Seroquel or Olanzapine, as she has been prescribed these before and understands that these medications are prescribed to 'crazy people', and she is not crazy.

She states that if she is ever an inpatient again, she does not want to be under observation while on the ward and does not want to have to sit out in the open and be watched while eating her food. She would like 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.

For Module 3

Three months later

Amanda has been re-admitted to your inpatient unit under a temporary treatment order. She is placed on bed rest and constant observations as she is severely underweight and suicidal.

You learn that she has made an advance statement and appointed a nominated person after the last admission.

Her advance statement states that she does not want Seroquel or Olanzapine, does not want bed rest as a treatment, and does not want to be observed while eating. She also wants her cat to be looked after by her nominated person, and for her nominated person to be informed of everything that happens while she is an inpatient, and to have unlimited visiting hours.

Her nominated person is her 15-year-old best friend.

She is commenced on Seroquel, constant observations and bed rest as a treatment regime.

You are her nurse for the shift. She is angry and states you cannot make her do anything because her advance statement ‘forbids you to follow through with the treatment plan as it is’.

Appendix 2: Advance statement practice checklist

Process	Yes	No	NA
Did you engage the person and their support network, including carer, family, nominated person, and any other supports identified by the person?			
Did you make an effort to help the person understand the definition and limits of the advance statement?			
Did you inform the person about the possibilities regarding the format (that is, the person could complete an advance statement in any format, as long as it contains the essential elements as per the *Mental Health Act 2014*)*?*			
Did you assist the person to cover the relevant content sections of the advance statement?			
Did you give, or refer the person to, relevant, current and objective information about treatment preferences and/or alternative treatment preferences?			
Did you ask about all relevant information, including additional information the person may wish to include?			
Did you elicit reasons behind the person's decisions or preferences about treatments?			
Did you allow the person to direct the process of completing the advance statement as much as possible, for example not telling the person what to write in the advance statement, but instead eliciting the person's own preferences, and/or if the person was initially vague regarding symptoms, behaviours, or feelings, did you query until the person provided specific examples?			
Did you give encouragement after the person provided a preference?			
Did you make an effort to help the person understand the definition and limits of the authorised witness requirements?			
Did you assist the person to obtain a valid witness signature according to specifications in the *Mental Health Act 2014*?			
Was the advance statement document effectively witnessed and signed (including signatory status and address of witness)?			
Was appropriate advice and assistance given to the person with regards to storage and safekeeping of the document?			
Was the advance statement document copied and filed in the person's health records and/or electronic record?			
Was an advance statement alert entered into the person's health record, CMI and/or electronic record?			

Supported decision-making practice[2]/principle	Yes	No	NA
Did you demonstrate the understanding 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?			
Did you demonstrate the understanding that people do not always make good decisions but can learn from their mistakes and experience, for example, did you demonstrate a belief that people have the right to take risks in their lives?			

[2] Adapted from Roper and Weller 2013, and the Victorian Office of the Public Advocate 2009.

Supported decision-making practice[2]/principle	Yes	No	NA
Did you inform the person that they should receive whatever support is available to them and encourage the person to draw on their own support people/networks to help them make decisions about preferences?			
Did you explore and recognise the potential importance of the carer and family and/or other support roles,[3] and carer, family and/or other support inclusion? Did you enable agreement by all involved to support the person in reaching and expressing their decisions?			
Did you help the person and their support person/s to understand the choices at hand by explaining the issues and providing or referring them to, information and explanations in plain language?			
Did you demonstrate an understanding that capacity to make decisions can fluctuate, and is decision-specific?			
Did you demonstrate awareness that capacity to make decisions can be learned, influenced, enhanced and suppressed?			
Did you help 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?			
Did you communicate the person's decisions and preferences to others (for example, relevant other support people, services)?			
Did you inform the person and their support network that the person makes and retains control over the preferences stated (as far as is practicable) and takes responsibility for them?			
Did you ensure that support is independent of service delivery wherever possible? (for example, explore all possible supports in the person's community)			
Did you demonstrate that you know the difference between supported decision making and substituted decision making?			

[3] Including nominated person, if the person has a nominated person.

Recovery-oriented practice[4]/principle	Yes	No	NA
Did you actively promote a culture of hope?			
Did you encourage the consumers' self-determination and self-management of their mental health and wellbeing?			
Did you support the person to define their goals, wishes and aspirations?			
Did you provide tailored, personalised, strengths-based care and support that is responsive to the person's unique strengths, circumstances, needs and preferences (including cultural and spiritual beliefs and practices)?			
Did you demonstrate a holistic approach and a degree of open-mindedness that addresses a range of factors that impact on the person's wellbeing?			
Were you engaging, including informing, valuing and supporting the roles of family, carers, nominated persons, support people and significant other supports?			
Did you encourage and support the person to utilise and enhance existing support networks?			
Did you demonstrate the acknowledgement and challenging of any apparent stigmatising attitudes by any persons involved?			
Did you engage with the person about their treatment preferences, both in making and using an advance statement (for example, discussing the potential risks involved, and/or informing the person about revocation, override processes et cetera)			
Did you demonstrate willingness to continually improve your knowledge of available treatments and services?			
Did you demonstrate willingness to continue to improve and evaluate your practice?			

Further comments/feedback:

[4] From Department of Health and Human Services 2011, *Framework for recovery-oriented practice*.

Appendix 3: Relevant excerpts/sections from the Act[5]

Under Part 1 – Preliminary, Section 3, Definitions

Authorised psychiatrist means a person appointed as an authorised psychiatrist for a designated mental health service under section 150.

Authorised witness means –

a) a registered medical practitioner; or

b) a mental health practitioner; or

c) a person who may witness the signing of a statutory declaration under section 107A of the *Evidence (Miscellaneous Provisions) Act* 1958.

Compulsory patient means a person who is subject to –

an Assessment Order; or

a) a Court Assessment Order; or

b) a Temporary Treatment Order; or

c) a Treatment Order.

Consumer means a person who –

a) has received mental health services from a mental health service provider; or

b) is receiving mental health services from a mental health service provider; or

c) was assessed by an authorised psychiatrist and was not provided with treatment; or

d) sought or is seeking mental health services from a mental health service provider and was or is not provided with mental health services.

Mental health practitioner means a person who is employed or engaged by a designated mental health service and is a –

a) registered psychologist; or

b) registered nurse; or

c) social worker; or

d) registered occupational therapist.

Mental health service provider means –

a) a designated mental health service; or

b) a publicly funded mental health community support service.

Patient means –

a) a compulsory patient; or

b) a security patient; or

c) a forensic patient.

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[5] *Mental Health Act 2014*, available from: http://www.legislation.vic.gov.au/domino/Web_Notes/LDMS/PubPDocs.nsf/ee665e366dcb6cb0ca256da400837f6b/D5F4227EEA352E41CA257C8300112BD7/$FILE/571160bs1.pdf

Restrictive intervention means seclusion or bodily restraint.

Bodily restraint means 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 means 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.

A **registered psychologist** means a person who is registered under the Health Practitioner Regulation National Law to practise in the psychology profession.

A **registered nurse** means 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.

A **registered occupational therapist** means a person who is registered under the Health Practitioner Regulation National Law to practise in the occupational therapy profession.

A **designated mental health service** means a prescribed: public hospital; public health service; denominational hospital; privately-operated hospital; private hospital; or the Victorian Institute of Forensic Mental Health.

When does an advance statement have to be considered?

An advance statement must be considered whenever a treatment decision is made for a patient.

The Act also lists specific points where an advance statement must be considered, including when:

- the authorised psychiatrist or the Mental Health Tribunal determines whether the treatment criteria apply to the person for the purposes of making a compulsory treatment order
- the authorised psychiatrist or the Mental Health Tribunal determines the setting of a compulsory treatment order
- the authorised psychiatrist determines whether to grant a leave of absence to a compulsory patient
- the authorised psychiatrist or chief psychiatrist varies or directs a variation of a compulsory order
- the authorised psychiatrist determines the least restrictive treatment for a patient for whom a treatment decision is being made
- the authorised psychiatrist determines the least restrictive treatment for a patient for the purposes of making an application to the Mental Health Tribunal to perform electroconvulsive treatment
- the authorised psychiatrist or a psychiatrist determines the least restrictive treatment for a young person for the purposes of making an application to the Mental Health Tribunal to perform electroconvulsive treatment
- a second psychiatric opinion psychiatrist or the chief psychiatrist decides whether to recommend changes to a person’s treatment when providing a second psychiatric opinion report
- the authorised psychiatrist determines whether to grant leave of absence, grant a leave of absence subject to conditions or vary a leave of absence to a security patient
- the Secretary to the Department of Justice determines whether to grant monitored leave to a security patient
- the authorised psychiatrist directs a security or forensic patient to be taken to another designated mental health service
- the Mental Health Tribunal determines an application for an interstate transfer of treatment order
- disclosing information about a patient to a carer of the patient to enable the carer to provide care or prepare for their caring role.

An advance statement may also be considered at any time during a person’s treatment to assist discussions and decision making. For example, a person voluntarily receiving mental health services

may have an advance statement and this could be a good point from which to start discussions with the person about the treatment they would prefer.

Appendix 4: 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	**My advance statement**	
	Name	
	Date of birth	
	Address	
	Primary mental health worker / support worker	
	Psychiatrist	
	GP	
	GP's address	
	Health team/s you are involved with	
	Family members, carers, peer worker/s, and/or support people involved in your recovery	
	Suggestions for person making this advance statement 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. 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. 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.	

Date: / /

(Please attach additional sheets if necessary)

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

Advance statement witness declaration 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.
Witness name:
Witness status as a signatory:
Witness address:
Those who can act as a witness are: (a) a registered medical practitioner; or (b) a mental health practitioner; or (c) a person who may witness the signing of a statutory declaration under section 107A of the *Evidence (Miscellaneous Provisions) Act 1958*
Witness signature: _____ **Date**: / /
Suggestions for person making this advance statement If you want to, you could ask your mental health worker to: • assist you in drawing up your advance statement • print a minimum of three copies - for you, your records and your carer/nominated person (if you want) • ensure a completed copy is placed into your clinical record, if you have one • document your advance statement completion in their electronic alert system, your CMI, and your recovery plan (or equivalent, such as ISP et cetera).

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, and so on.

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:

Advance statement revocation

Revocation of the advance statement of _____(insert name and date of birth)

If you realise you do not want to use this advance statement any more, or want to write a new advance statement, you must fill in a revocation statement, make sure it is witnessed by an authorised witness and let all persons involved in your care and recovery know that you have revoked this advance statement and/or that you have made a new statement.

I, _____ (name) wish that my advance statement, completed on _____ (date), be revoked, as it is no longer an expression of my wishes in times of mental ill health.

Signature:

_____ date: / /

Send or give a copy of this revocation 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.

Revocation of advance statement witness declaration

I have witnessed the stated person revoking this advance statement and I am satisfied he understands the consequences of revoking the advance statement and have observed the person signing this revocation.

Authorised witness name:

Professional title:

Address:

Witness signature:

_____

Date: / /

Suggestions for person revoking this advance statement

If you want to, you could ask your mental health worker to:

- assist you in revoking your advance statement by helping you make your revocation statement (if you want)
- print a minimum of three copies – for you, your records and your carer/nominated person (if you want)
- ensure a completed copy is placed into your clinical record, if you have one
- document your advance statement revocation in their electronic alert system, CMI, and your recovery plan (or equivalent, for example, ISP et cetera).

Appendix 5: Workshop evaluation form

Mental health advance statement workshop evaluation

Training location:

Training date:

- **In relation to the content for each module of the workshop described below:**

Module 1: Advance statement essentials (online)

(Tick your response to each item)		Strongly disagree	Disagree	Agree	Strongly agree
	The module was easy to understand				
	The module has improved my knowledge				
	The module has improved my confidence				

Module 2: Making an advance statement

(Tick your response to each item)		Strongly disagree	Disagree	Agree	Strongly agree
	The module was easy to understand				
	The module has improved my knowledge				
	The module has improved my confidence				

Module 3 *Using an advance statement*

(Tick your response to each item)		Strongly disagree	Disagree	Agree	Strongly agree
	The module was easy to understand				
	The module has improved my knowledge				
	The module has improved my confidence				

In relation to the workshop overall:

(Tick your response to each item)		Strongly disagree	Disagree	Agree	Strongly agree
	The workshop was well-presented				
	The pace of the workshop was appropriate				
	The handouts were helpful				

(Tick your response to each item)		Strongly disagree	Disagree	Agree	Strongly agree
	The presenter/s demonstrated a high level of expertise on the topic				
	The role play scenarios were useful				
	There was enough opportunity for discussion				
	I will be able to use what I learned in this workshop in my daily work				
	The workshop was a good way for me to learn about mental health advance statements				

Were there any modules / activities in the workshop that you found particularly good and/or useful?

Were there any modules / activities in the workshop that were not as good and/or useful?

What changes could be made to improve the workshop?

Appendix 6: Possible workshop activities

These activities are suggestions only. You can devise activities that can be used as ice-breakers, that you may wish to have as backup, or as part of your workshop/s.

Module 1 Reflective exercises (use as part of Module 2 ice-breaker activity and to review Module 1 learning)

1. Tom tells you that he has a good friend he met the last time he was in hospital. He states he wants to bring his friend to his next appointment to help him make his advance statement. He states he is thinking about making his new friend his nominated person.

Reflective exercise

- Which of the principles underpinning supported decision making you would use to support Tom to continue to develop his advance statement?
- How do the identified principles apply?
- What is your personal view of this?

2. Tom attends church every Sunday. Tom states that he becomes very anxious and worries that something very bad will happen to him and/or his family if he cannot go to church on a Sunday. Tom wants to add 'attending church on Sundays' to his treatment preferences.

Reflective exercise

Would you advise Tom to add this preference to his advance statement? If so, where would you best advise Tom to state this preference in his advance statement?

a) In treatment preference section

b) In the 'additional information' section

c) In a separate statement indicating his lifestyle and personal preferences

d) Any of the above

Activity (suggested could be used as an ice-breaker activity – Module 2 or 3)

Ask workshop participants to think of an example when an advance statement would have been helpful in a work situation. Discuss in small groups, and/or in the larger group. It can also be used as an 'ice-breaker, with participants introducing themselves and their example.

Activity (suggested could be used as an ice-breaker activity – Module 2 or 3)

Ask workshop participants to imagine they are a person who accesses mental health services, and think about what treatment preference/s they would state in their advance statement, should they become a patient. Discuss in small groups, and/or in the larger group. It can also be used as an 'ice-breaker, with participants introducing themselves and their imagined preferences.

Activity (suggested to be used during Module 3 for discussion)

Reflective activity – Perception of risk and view of a person

Perception of Increasing Risk

You have five minutes to discuss this image with the person next to you and prepare a short summary of what you see in the image. Some of the concepts you may wish to discuss include:

- What you and your colleague think the image is representing?
- Who you think the image represents (for example, person who accesses your service, a member of the mental health workforce, a person in the community, a carer, family member, nominated person, child, parent, member of the legal profession, client of forensic services et cetera)?
- Why you think the image is fading as the perception of risk increases?
- How does this relate to making and/or using an advance statement?

Present your summary to the workshop participants for discussion.

_____