Respecting® Patient Choices
Advance Care Planning

Submission to Victorian Law Reform Commission Review of Victoria's Guardianship and Administration laws.

20 May 2011

Respecting Patient Choices®

The Respecting Patient Choices® (RPC) Program at Austin Health aims to provide best practice in advance care planning to all Australians and has been working at the forefront of this field for the past 9 years. The RPC program was funded in 2002 by the National Institute of Clinical Studies and, from 2003 to present, by the Commonwealth Department of Health and Ageing and by the Victorian Department of Health

The Australian RPC advance care planning program is based on the Respecting Choices™ model from the Gundersen Lutheran Medical Foundation, La Crosse, Wisconsin, USA. The Australian RPC Program has been completely adapted to the Australian health sector. The key elements of the RPC model are:

1. Providing training to doctors, nurses and allied health workers to be able to discuss advance care planning (ACP) with patients and their families.
2. Providing a comprehensive system for documenting and communicating patient choices.
3. Providing information materials to explain advance care planning to patients, and
4. Ensuring executive and organisational support for advance care planning.
5. Enabling the organisational system changes required to implement advance care planning effectively.

The guiding principle of the RPC Program is:

'If your choices for future health care are known, they can be respected.'

RPC supports the right of patients to have a say in their health care, now and for the future.

The five aims of RPC are to:

1. initiate conversations with adults regarding their views about future medical care
2. assist those individuals with advance care planning
3. ensure that their plans are clear
4. ensure that their plans are available when required
5. ensure that their plans are followed appropriately when decisions are required.

The advance care planning process includes:

- making sure that the patient is fully informed regarding their illness and treatment options,
- giving the patient the opportunity to reflect upon, and discuss with their loved ones, their goals and values in life,

- assisting the patient to identify their views regarding an acceptable outcome if their condition should deteriorate
- supporting the patient to record their views and to appoint a trusted a substitute decision-maker.

The two critical success factors of the RPC model, which distinguish it from other ACP models:

1. The RPC training course equips health professionals with the skills, knowledge and confidence to facilitate advance care planning discussions and the advance care planning process. The Training has been further developed in 2007 into an e-learning module (including the role of the relevant legislation) and a one day communication skills workshop.
2. The attention to the organisational systems changes required for success and sustainability. Implementation of the RPC Model is facilitated by Implementation Guidelines which assist each health care setting to develop policy and protocols to ensure success.

COMMENTS ON CONSULTATION DOCUMENT

Chapter 5 Principles of Laws

Question 2 Do you agree with the Commission's draft statement of purpose for the new guardianship laws?

We support the draft statement of purpose.

Question 4 Are there principles you think should be added or removed from these general principles?

We recommend that the following principle be added – "All adults have the right to be informed of their right to make decisions that may affect their lives."

Our experience over the 10 years that we have been supporting people undertaking advance care panning, is that many people are unaware of their right to be involved in decisions about their medical treatment, including their rights to request further information, obtain second opinions, and to refuse or place limits on treatments, either for themselves or for those for whom they are acting as agents.

Chapter 6 Clear and Accessible Laws

Question 5 Do you agree with the Commission's proposal that Victoria's various substitute decision-making laws be consolidated into one single Act?

Question 6 Do you agree with the Commission's proposal that the term "medical decision" or "health decision maker should replace "person responsible" in legislation? If so, which?

We do not have a strong opinion regarding the consolidation of Victoria's substitute decision making laws into one act. The key issue for us is to ensure that the instruments that operationalise the substitute decision making laws are clearly defined and understood by all stakeholders.

We prefer the term "health decision maker" over "medical decision maker" as the former differentiates the role from purely "medical" decisions. In addition, "medical decision maker" may be misinterpreted as referring to a medical doctor. However, we are aware that different

terms are in use in other states, and that three states use "person responsible". It would be beneficial if the same terms were used across jurisdictions.

Question 11 Should the Public Advocate play a greater role in producing community education materials and educating the community about substitute decision making? What other bodies could play a role?

Question 12 Would an education and awareness campaign assist the community to better understand and make use of guardianship laws?

An effective community education campaign that clarifies the purpose of the legislation and the roles of substitute decision makers will be essential for effective uptake of the new legislation. This type of campaign could be effectively delivered by the Office of the Public Advocate but would need to be appropriately resourced.

Education should also be directed to health professionals and lawyers, and should also be delivered by medical and legal professional bodies to their membership. .

Question 13 What type of data do you think needs to be collected and made available and from what bodies?

We suggest collection of data to assess the uptake of personal appointments, the extent of the appointments made, revocation of personal appointments, and appeals to VCAT in reference to personal appointments. These data sets would assist in the effective evaluation of the success of new law reforms and allow evaluation and improvement of community education programs.

To minimise the burden of data collection and privacy concerns, we suggest a detachable slip be added to each personal appointment form requesting submission of basic demographic information and information about the type and scope of appointment made. This could contain a "tick box" consent by the appointer, and could be posted or faxed to a central agency (e.g. Office of the Public Advocate). This would not require disclosure of identifying data about the appointor or agent, but would enable the take-up and extent of appointments to be monitored.

Chapter 7 Supported Decision Making

Question 14 Do you agree with the Commission's proposal to introduce new supported decision-making arrangements?

Question 15 Do you agree with any or all of the proposed roles of supported-decision makers?

Question 16 What steps would need to be taken in order to ensure that these appointments operated fairly and efficiently?

Supported decision making would be a considerable improvement on the current process for decision-making by people who may be unable to make decisions alone, particularly those with dementia. The distinction between 'supporters' and co-decision makers is an effective reflection of the complex and variable nature of decision making capacity, and will support the continued involvement of individuals who are experiencing progressive reductions in capacity, in the decision making process.
Clarity of roles – extensive guidelines regarding their powers, responsibilities, their distinction from other forms of personal/VCAT appointments, and their potential impact on the person with reduced capacity would be essential for successful acceptance, adoption and

performance of these roles. This would require extensive community and professional education.

Chapter 8 Personal Appointments

Question 26 Should the number of enduring appointments be reduced from three to two by removing the option of appointing an agent under the Medical Treatment Act 1988 (Vic) and by requiring people to use an enduring guardianship appointment for medical treatment matters?

Question 27 Should there be only one type of appointment with a range of possible powers?

In general, we support the reduction of the number of enduring personal appointments. We agree that a person should be able to nominate more than one agent to deal with all aspects or specific aspects of their affairs. We are concerned however that the consolidation of medical, lifestyle and financial decision making powers into one appointment might have the unintended consequence of limiting the appointment of medical substitute decision makers, for the following reasons:

- Different levels of capacity may be required by people appointing financial, lifestyle and medical substitute decision makers. We would not want the combination of all three roles into one appointment to reduce or limit a person's ability to appoint a medical or health decision maker by applying the same measure of capacity as that required to appoint a financial decision maker.

- In our experience, the professionals who are usually involved in discussions around Medical Enduring Power of Attorney (MEPOA) are medical or health professionals. Doctors – particularly GPs – often witness MEPOAs and are willing to do so, but may not wish to become involved in witnessing other forms of guardianship appointments. If doctors are not able to witness appointments of medical decision makers, uptake may be reduced.

We would also like to draw attention to the overlap in aged care, particularly, of the treatment, personal care and financial aspects of care. Selection of an aged care facility may have a significant impact on – or be determined by - a person's financial status.

For these reasons it may be preferable to combine financial and lifestyle substitute decision making powers into one appointment, but retain a separate appointment for a MEPOA.

Simplicity and clarity of the options and roles and ease of use will be essential. The document(s) that operationalise these roles should be seen as essentially the appointor's document, for their use. The appointer should be able to change agents or amend their roles without reference to a solicitor as this would provide a barrier to initial uptake and maintenance of the document due to cost, access and inconvenience.

There is need for provision of bridging arrangements to enable appointments of agents under the exiting legislation to be honoured, rather than voided by the new legislation.

Question 28 Should an ongoing registration system be created for enduring powers?

Question 30 Should registration be voluntary or compulsory?

Question 32 What is the best time for the registration to occur?

Question 33 Who should have access to the register? What safeguards should be put in place to protect an individual's privacy while allowing appropriate people access to it?

We are not in favour of a central registry for medical enduring powers, on the grounds that creating an effective registry that meets the needs of all users will be administratively difficult and costly, for the following reasons. Health services often need to identify substitute decision makers immediately for example, in the event of an acute illness where an individual is unable to communicate their wishes. To meet these needs a registry would need to be accessible 24/7, with accurate up-to-date information, with minimal time lags from lodgement to display of information. Any delay in activation after the creation of the appointment would cause further uncertainty. Failure of the registry to operate effectively (inaccessible, inaccurate, not up to date) would provide a disincentive of health services and other agencies to refer to it and would undermine the effectiveness of the legislation.

We would prefer a system whereby the appointment was owned and managed by the appointor and the substitute decision maker, with health service staff trained – and supported by protocols – to ask patients or family to identify the MEPOA and document this information in the patient's record.

We also recommend that the substitute health decision maker be a field entered onto the proposed Personally Controlled Electronic Health Record (PCEHR). Respecting Patient Choices is currently holding discussions with NEHTA, the National E-Health Transition Authority, about the potential to include health decision making agents such as Medical Enduring Power of Attorney on the electronic patient-held record. This would enable immediate access to the agent's identify by a health service.

Chapter 9 Documenting Wishes about Your Future

Instructional Medical Directives

Question 38 Do you think that the law concerning instructional medical directives should be set out in legislation?

We believe more detailed information about how instructional for medical directions would be operationalised is required before stakeholders can comment on the proposal. Greater detail would also enable more specific questions to be posed.

Our concern is that the medical directives as outlined Option B are not supportive or consistent with current advance care planning practice and, unfortunately, may undermine current understanding and acceptance of advance care planning by presenting a rather "black and white" view of blanket acceptance or refusal of specific treatments, rather than a more subtle and personalised approach to decision-making based on consideration of desired outcomes.

There is a significant difference between making a decision about (a) a specific treatment for a current and known medical condition supported by information about all the available options, their potential benefits and side effects, and (b) decisions made about future treatments for hypothetical situations without supporting information or knowledge of likely outcomes.

Our practice in assisting people to develop advance care plans is to focus more on desired patient outcomes than treatments. Decisions about treatment options are then assessed in terms of which option would be most likely to achieve the patient's preferred outcome. We do not consider it advisable for people to make advance decisions about specific treatments for hypothetical conditions in the future. To do so may not be in their best interests. It would be more productive for a person to state their desired outcomes in terms of what level of physical and mental function they would consider an acceptable outcome, so that in the event of an actual condition, their agent would be able to discuss treatment options and likely outcomes with the treating team and make decisions accordingly.

Section 9.83 removes the requirement for informed consent, that a person refusing treatment must receive information about the nature of the condition, and the benefits versus risks of each available treatment. A person cannot make an informed decision without knowledge of the options and probable outcomes of each. We strongly recommend that the requirement for informed consent be retained in the legislation.

We would welcome the opportunity to discuss this with the Commission, and to provide case examples which will give you a better understanding of best practice advance care planning and of the issues that are of most concern to people who make advance care plans.

Lifestyle Instructional Directives

Question 39 Do you think it should be possible to make statutory instructional directives about things other than medical treatment?

Question 40 What types of things should be possible to include in an instructional directives?

We support the inclusion of the right to refuse treatments in instructional directives, based on the informed evaluation of likely outcomes of such treatments as unacceptable. However we have strong reservations about inclusion of demands for treatments or lifestyle outcomes in instructional directives. While refusal of treatments should be binding, doctors are not legally bound to provide a treatment if it is not going to benefit the patient, even if the patient has requested the treatment in his or her instructional directive.

Similarly, we have reservations about including demands for non-medical choices in instructional directives that would become binding on a health service. For example, a refusal to be admitted to a nursing home may be unworkable, if there is no alternative to nursing home care after all other options have been exhausted. This scenario would also have a detrimental effect on the capacity of the health system to meet demand, restricting patient flow through the system and reducing access to emergency cases.

We would support the inclusion of *preferences* in relation to lifestyle items, particularly around end-of-life care. This would allow a broader communication of patient choices, but would not legally bind health professionals to follow directives that are not in the patient's best interest or are not deliverable within a particular context.

Hybrid Directives

Questions 41 Should the wishes expressed in a document making a personal appointment be binding, or should they merely be matters that the personally appointed decision maker must consider?

Question 42 If the wishes are merely one of the matters that the personally appointed decision maker must consider, should the person be required to provide written reasons for departing from them?

Question 43 If the wishes are binding upon the personally appointed decision maker, should it be possible to override them in some circumstances? Do you think VCAT should perform this role and (if so) in what circumstances?

We support the inclusion of hybrid directives in future legislation. This will formalise a system that is already in place in current advance care planning practice which combines a person's Statement of Choices and appointment of a Medical Enduring Power of Attorney.

Option B provides too much leeway for the agent to over-ride the person's wishes.

We support Option C. This option provides certainty to the person making the appointment that their wishes will be followed. VCAT should be responsible for considering requests to over-ride an individuals expressed wishes. Requests should be considered with reference to the individual's desired level of functional and cognitive outcome.

A draft Advance Care Planning policy has been developed by the Victorian Department of Health and under consideration by the government. It will be important that this policy and any revised Guardianship and Administration legislation be consistent. We recommend that the Commission consult with the Department of Health to ensure that their intent and requirements are aligned and each supports the other.

Any medical directive pro-forma will need to be easy to complete, clear and simple, to promote its use. Some documents in use in other states are lengthy and daunting, with focus on specific scenarios. As stated already, we strongly recommend a focus on outcomes, rather than treatments for hypothetical situations.

From our experience over ten years developing advance care planning, we have learned that skilled conversations are required to provide advance care plans that firstly, accurately reflect the person's wishes and secondly, provide clear information to the treating staff about what they should or should not do. This would need to be carefully considered in the development of the form.

From a health service and health system perspective, consideration also needs to be given to the impact of patient choices on demand for health services and the capacity of the system to meet overall demand. By focussing on outcomes, the question becomes one of how can care best be provided to meet the specified outcomes, thus providing flexibility for the within the system.

Questions 46 Should there be an electronic registration system in place for advance directives?

Question 47 Should registration be extended to medical and lifestyle instructional directives?

Please refer to our comments under questions 28-33 regarding an electronic registration system.

Chapter 16 Medical Treatment

Question 79 Do you think that the definition of medical treatment should be broadened?

Question 80. Should a broader definition include prescription and administration of pharmaceutical drugs?

Question 81 Should it include paramedical procedures, such as physiotherapy? Should it include complementary health procedures such as naturopathy and Chinese medicine? What else should it include?

We do not agree that the definition of medical treatment should be broadened to include prescription and administration of pharmaceutical drugs and paramedical procedures.

We prefer to see advance care plans and statements of preferences based on a treatment package that is designed to achieve a particular outcome.

Inclusion of pharmaceuticals in the definition would make treatment of incompetent patients with oral medications very difficult.

However, the right to refuse a particular form of treatment for example, on philosophical or religious grounds, would still be possible.

Question 82 Do you think a distinction should be made between minor and other medical procedures when a person is unable to consent? If yes, how should the distinction be made between minor and major procedures?

Question 83 Do you agree that minor medical procedures should not require substituted consent if certain safeguards are met? Do you agree with the safeguards suggested?

Question 84 Do you believe the law should retain the requirement that a medical or dental practitioners must notify the Public Advocate where a person responsible does not consent or cannot be identified or contacted and the practitioners still wishes to carry out the procedure? If not, are there any other safeguards that might be more appropriate in these circumstances?

Distinction between minor and major is problematic. It would be very difficult to operationalise how decisions based on these definitions would be made, as patients' individual contexts and desired outcomes are variable. The proposed distinctions based on the qualities of the treatment, including; level of risk, long term consequences, degree of controversy, – may not accurately reflect the implications of the treatment for the patient. It would be preferable to base decisions on the qualities of the person for whom the treatment is proposed, including; their individual circumstances, disease trajectory, personal preferences and desired outcomes. For example, a decision to commence PEG feeding may be classified by the legislation as neither high risk, controversial or as having long term

consequences, but could be highly significant for that patient and have a major impact on their life. Treatments defined as minor may also be regarded as burdensome or excessive, by patients or their agents, depending on their condition.

We do not support a change in the legislation to enable medical practitioners to carry out minor treatments where the person responsible does not consent without being required to notify the Public Advocate. To remove this requirement would give practitioners too much leeway to determine what is in the patient's best interest without external review.

Question 96 Should there be separate and distinct principles for medical decision making? If so, what would these principles be?

We support Option C "substituted judgement" as the paramount consideration for all types of substituted and supported decisions. Medical substitute decision making is often carried out under highly stressful and emotional conditions. As such, we support the suggestion that for medical decisions, some additional guidance in addition to the high-level general principles, should be provided for substitute decision makers. At a minimum, these would need to include:

- considering the comparative risks of alternative treatment options,
- the consequences of not carrying out the treatment,
- whether medical treatment would cause unreasonable distress to the patient,
- whether the treatment would be likely to deliver the preferred outcomes the patient may have expressed or recorded
- whether there are reasonable grounds for believing that the patient, if competent, after giving serious consideration to their health and wellbeing would consider the treatment unwarranted.

Chapter 19: Accountability and Review of Substitute Decision Making

Question 102: Do you think that substitute decision makers should declare an oath or sign a statement agreeing to comply with their responsibilities before undertaking their roles.

We support the notion that substitute decision makers should sign a statement confirming that they understand the nature and responsibilities of the role and agree to comply with the stated responsibilities. This should be completed at the time of appointment. In order to ensure that the principal of informed consent is met, the effective provision of information regarding the role would be vital.

Proposed Reforms of the Draft Mental Health Bill

Please see the attached submission by the Respecting Patient Choices Program in collaboration with the Mental Health Clinical Service Unit, Austin Health.

The submission covers our responses to the following proposed legislation items.

- Advance statements – We had specific concerns/suggestions around the content of mental health advance statements, the language used to define compliance with or deviation from expressed treatment wishes, and certification requirements in relation to capacity.
- Nominated Persons – specific suggestions/concerns around certification requirements in relation to capacity, and restrictions on the number of nominated persons that can be appointed.
- Statement of rights: specific concerns/suggestions around the timing of the provision of rights information in regard to advance statements and nominated persons

Austin Health

Respecting Patient Choices
Advance Care Planning

Mental Health Bill Exposure Draft

Submission by the Respecting Patient Choices Program in collaboration with the Mental Health Clinical Service Unit

Austin Health, Melbourne, Victoria

February 2011

INTRODUCTION

Advance care planning is a process whereby a patient, in consultation with health care providers, family members and important others, makes decisions about his or her future health care, should he/she become incapable of participating in treatment decisions.[1]

The Respecting Patient Choices Program, working in collaboration with the Mental Health Clinical Service Unit at Austin Health, is targeting psychiatric advance care planning as a major priority. As such, we are currently conducting research in this area and are developing further collaborations with other stakeholders in the field. The Respecting Patient Choices Program (RPCP) at Austin Health aims to provide best practice in advance care planning to all Australians and has been working at the forefront of this field for the past 9 years. The RPCP was funded in 2002 by the National Institute of Clinical Studies and, from 2003 to present, by the Commonwealth Department of Health and Ageing and by the Victorian Department of Health. We have made significant impacts on previous parliamentary inquiries including the 2009 National Health and Hospital Reform Commission, and the 2007 Inquiry into Older People and the Law.

We are extremely supportive of the inclusion of specific legislation around advance statements and nominated persons in the revised Mental Health Act. This represents a major step towards the protection of the autonomy, dignity and rights of a population of highly vulnerable patients. There is increasing evidence that psychiatric advance care planning produces benefits for both patients and mental health service providers. A number of studies suggest that facilitated advance directives, shared decision making or joint crisis plans can; improve medication adherence[2] and the working alliance between patients and clinicians,[3] increase the uptake of psycho-education,[4] and may reduce involuntary admissions,[5] service use and overall care costs.[6] Legislation in this area is vital in order to underpin future efforts to implement systematised models of facilitated psychiatric advance care planning throughout Mental Health Services in Victoria.

We have a number of specific comments and suggested revisions relating to Section 10 of the exposure draft of the Mental Health Bill.

SPECIFIC PROPOSAL POINTS

Section 10

Division 1 – Advance statements

151. Person may make an advance statement

(1) A person may make an advance statement specifying their wishes and preferences in the event that their capacity to make decisions is significantly impaired by a mental illness which requires treatment.

The exposure draft does not specify age in the guidelines for 151 (1). Does the fact that the act is silent in regards to age imply that children can also make an advance statement? Division 2 –

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[1] Singer, PA. et al (1996). *Canadian Medical Association Journal*, 155(12): 1689-1692
[2] Wilder, C.M. et al (2010). *Psychiatric Services*, 61(4): 380-385.
[3] Swanston, JW. (2006). *The American Journal of Psychiatry*, 163: 1943-1951.
[4] Hamann J, et al. (2006). *Acta Psychiatrica Scandinavica*, 114: 265-273.
[5] Henderson C, et al. (2004). *British Medical Journal*, **329**:136.
[6] Flood C, et al. (2006). *British Medical Journal*, 333(7571):729.

nominated persons, point 156 (1), explicitly states that "a person (including a child) who appears to understand the effect of doing so may at any time choose a person to be his or her nominated person." We would suggest that Division-1, point 151 (1) should be consistent with this.

(2) An advance statement may include—
(a) the ways in which the person wishes to be treated for a mental illness;
(b) the ways in which the person does not wish to be treated for a mental illness;
(c) any other personal preferences which the person may wish to express in relation to their treatment for a mental illness;
(d) whether or not the person consents to the views of family members or carers being obtained in respect of matters relating to their treatment for a mental illness;
(e) the name and contact details of the nominated person.

A holistic approach to person centred care considers preferences for treatment and care across medical and non-medical domains. In order to ensure the efficient communication of preferences, and to reduce burden on patients, these preferences should be included under one advance statement. We would therefore suggest the following alterations/additional items to 151 (2);

(2) An advance statement may include -
(f) the ways in which the person wishes to be treated for associated physical illness
(g) the ways in which the person does not wish to be treated for associated physical illness
(f) any other personal preferences of a non medical nature (e.g. care of children in the event of a treatment admission).

152. Requirements relating to the making of an advance statement
(3) A certification under subsection (1)(d) can only be given by -
(a) a legal practitioner; or
(b) a health professional employed by a mental health service provider; or
(c) a person who is authorised to witness a statutory declaration in Victoria under section 107A of the Evidence (Miscellaneous Provisions) Act 1958.

The requirements for this item state that the certifier must be of the opinion that the person making the advance statement appears to understand the effect of doing so. This implies an assessment of decision making capacity. Given the complex and fluctuating nature of capacity in individuals with mental illness, we are concerned that individuals specified in (3) (a) and (c) may not have the necessary expertise to make such an assessment.

Furthermore, it is likely that only a medical practitioner or a health professional employed by a mental health service provider (i.e. psychiatrist, psychologist, or psychiatric nurse) would have the knowledge to be able to advise the patient with a history of mental illness whether their advance statement is clear and easy to understand by other psychiatric staff.

It is likely that mental health providers, who are consulting advance statements, will feel less confident in the validity of an advance statement certified by an individual falling under (3) (a) and (c), than a statement signed by a medical practitioner or health professional employed by a mental health service provider. Lack of confidence in the validity of advance statements may reduce the likelihood that patient preferences will be followed. We therefore suggest the following change to item 152 (3).
152. Requirements relating to the making of an advance statement
(3) A certification under subsection (1) (d) can only be given by -
(a) a medical practitioner; or
(b) a health professional employed by a mental health service provider.

154. Effect of an advanced statement

(1) A person, the Mental Health Tribunal or any other body required to make a decision in relation to the treatment of a patient must have regard to an advance statement made by the patient if the person, the Mental Health Tribunal or other body is satisfied that—

We would suggest that in order to ensure that patients' treatment preferences are met wherever possible, the phrase 'must have regard' is replaced with 'must comply with wherever the clinical risks allow'. The procedures described under 154 (4) are consistent with compliance regulation, as such the language throughout point 154 should reflect this.

(3) It is sufficient for the purposes of subsection (2), if a check has been conducted of the patient's medical record to ascertain whether or not the person has made an advance statement.

This will only be sufficient if the legislation also requires advance statements to be filed/stored in a paper based form & electronic form in order to optimise mental health providers' awareness of their existence.

(4) If a person, the Mental Health Tribunal or any other body required to make a decision in relation to the treatment of a patient makes a decision which is inconsistent with the wishes and preferences of the patient expressed in their advance statement, the person, the mental health service provider must—
(a) record the circumstances and the reasons for doing so;
(b) maintain a copy of that record;
(c) give written advice specifying the circumstances and reasons—
(i) to the patient;
(ii) in accordance with section 9(2);
(iii) to the Mental Health Commissioner;
(iv) if the decision has not been made by the authorised psychiatrist, to the authorised psychiatrist.
...

(c)
(i)We would suggest that written advice specifying the circumstances and reasons for non-compliance with a patient's preferences should also be provided to the nominated person and the patient's family (where consent is given under 151 (2) (d)).
(ii) it is unclear which part of the legislation " **section 9(2);**" refers to
(iii) we would suggest that to be consistent with the conditions of Division 2-point 161(3) for an application to the Mental Health Tribunal to revoke a nomination, this point should specify that written advice regarding the circumstances and reasons for non-compliance with a patient's preferences should be reviewed by the Mental Health Commissioner within 10 business days of receipt. There is evidence that other health care related documents that are sent to "the authorities" are simply filed and not reviewed, e.g. the legislative requirement that Refusal of Treatment Certificates, completed under the Medical Treatment Act 1988, are sent to the Victorian Civil and Administrative Tribunal, but are simply filed. The importance of review by the Mental Health Commissioner is that it ensures that decisions are assessed and that the overriding person knows that their decisions will be reviewed.

Division 2 – Nominated persons

158 Requirements relating to the making of a nomination

(2) A certification under subsection (1)(f) can only be given by—
(a) a legal practitioner; or
(b) a health professional employed by a mental health service provider; or
(c) a person who is authorised to witness a statutory declaration in Victoria under section 107A of the Evidence (Miscellaneous Provisions) Act 1958.

Consistent with our comments for Section 10, Division 1, point 152 (3); we would suggest the following change to this item

158 Requirements relating to the making of a nomination
(2) A certification under subsection (1) (f) can only be given by—
(a) a medical practitioner; or
(b) a health professional employed by a mental health service provider;

(5) A person may only have one nominated person at any time.

This is inconsistent with the Victorian Medical Treatment Act 1988 where a patient can appoint an agent and an alternative agent. We would suggest that allowing patients to appoint more than one nominated person will reduce the likelihood that a nominated person cannot be contacted for consultation in regards to treatment decisions.

Division 3 – information about rights

165 Statement of rights for patients

(1) The mental health service provider must ensure that a patient is given a statement of rights as soon as practicable—
(a) after being made subject to an Assessment Order;
(b) before any of the following treatments are administered—
(i) electroconvulsive therapy;
(ii) psychosurgery;
(iii) any treatment which is prescribed for the purposes of this section.
(2) A statement of rights under this section must—
...
(h) provide information about the ability to make an advance statement and to nominate a nominated person;

There is no specific guidance relating to the timing of the provision of information regarding advance statements apart from the phrase "as soon as practicable" in 165(1) Providing patients with information regarding their ability to make an advance statement when they are acutely unwell (e.g. after being made subject to an Assessment Order), may reduce the likelihood that advance statements will be completed due to fluctuations in capacity.

We would also suggest that if legislation is supportive of patients being informed of, and able to exercise their rights, it is vital that they are not only informed of their right to make an advance statement, but that there are services in place to enable and support them in the completion of an advance statement.

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