Working with Nominated Persons, Families and Carers under the *Mental Health Act 2014:* **Practice Guide**

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Acknowledgements

This guide was developed by The Bouverie Centre and was informed by focus groups and key informant interviews that were conducted with practitioners, consumers, family members and other important stakeholders within Victorian mental health and other relevant services. The guide was also informed by a targeted review of the literature[1]. In addition, guidance was provided from a Working Group comprising representatives of peak consumer and carer bodies, practitioner and educator representatives, a young person in a carer role and a parent with an experience of mental illness.

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[1] Working with Nominated Persons, Families and Carers Literature Review, May 2014

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Use of terms

A range of terms are used in this Practice Guide in addition to those that are defined by the Act. The meanings of frequently used terms are explained below.

Consumer and Patient
Common terms used to refer to people accessing mental health services include 'consumer', 'client', 'service user' and 'patient'. The terms 'consumer' and 'patient' have been selected for use throughout this guide because of their respective uses in the Act. The term 'consumer', consistent with the Act, will be used here to refer to a person who is or was seeking or receiving mental health assessment, treatment or care from a mental health service provider. Similarly, the term 'patient' will refer to a person who is subject to a compulsory order under the *Mental Health Act 2014*.

Carer and Family
The term carer has a particular meaning within the *Mental Health Act 2014* (and the *Carer Recognition Act* 2012) and will be used in this document to mean a person, including a person under the age of 18 years, who provides care to another person with whom he or she is in a care relationship. As such, a carer may be a blood relative, another family member, a domestic partner, a colleague or friend, a member of a particular community or kinship group, or a child or young person of the consumer.
The term family will be used to describe a consumer's family of origin or procreation. Family members may or may not be in a specific caring role but nonetheless may be affected by their relative's mental illness. Consistent with the Act, this includes dependent children of parents experiencing mental illness.

Clinician
Clinician will be the generic term used in this document to describe the authorised psychiatrist, other medical practitioners and mental health practitioners.

Practitioner
Consistent with its use in the Act, the term 'practitioner' or 'mental health practitioner' will be used in the guide to refer to a person employed by a designated mental health service and who is a registered nurse, psychologist, occupational therapist or social worker. The term practitioner does not include the authorised psychiatrist whose role is defined separately within the Act. The term 'MHCCS practitioner' will be used to describe a person employed by a publicly funded mental health community support service.

Significant People
This term will be used to describe significant relationships within a person's life, including 'family', 'carer', 'friend' and 'support person'. For instances where any one or combination of these people may be intended 'significant people' will be used, however there will be times when the more specific term 'carer' is required.

Abbreviations and acronyms

AO	Assessment Order
ATSI	Aboriginal and/or Torres Strait Islander
CALD	Culturally and Linguistically Diverse
COPMI	Children of Parents with a Mental Illness
CTO	Community Treatment Order
CTTO	Community Temporary Treatment Order
DHS	Department of Human Services
ECT	Electroconvulsive Therapy
FaPMI	Families where a Parent has a Mental Illness
ITO	Inpatient Treatment Order
ITTO	Inpatient Temporary Treatment Order
MHCSS	Mental Health Community Support Service
TO	Treatment Order
TTO	Temporary Treatment Order

Scope and Purpose of the Practice Guide

This Practice Guide provides information and guidance to clinicians about the provisions of the *Mental Health Act 2014* related to working with nominated persons, families and carers. The primary audience is authorised psychiatrists and practitioners employed in public mental health services, however, the guide is likely to be relevant to MHCSS practitioners as well as to general practitioners and other human service professionals who may work with people experiencing mental illness.

The Act provides for the assessment, detention and treatment of people with mental illness and also includes important protections to ensure compulsory treatment is only used where necessary. The principles underpinning the Act endorse a recovery orientation to mental health care and within this framework promote the use of supported decision making over substituted decision making wherever possible. The principles of the Act also recognise the role played by families and carers in mental health care. As such, the provisions relating to the nominated person, families and carers are consistent with the National Practice Standards for the Mental Health Workforce[2] and the Framework for Recovery Oriented Practice[3].

Within the Act, the role of the nominated person and carers sits alongside provisions relating to the presumption of capacity, the use of advance statements and access to second opinions as mechanisms to facilitate supported decision making. The establishment of a new advocacy program, though not part of the Act, is a further measure that enables supported decision making. The nominated person is designed to provide support to the patient, represent their interests to the treating team and assist the patient in exercising their rights in the context of compulsory treatment. The value of involving families and carers is recognised within the Act both in terms of their role in supporting a patient's decision making about treatment and in terms of carers having their own needs acknowledged. The Act also makes specific reference to the obligations of the treating team to recognise and protect the wellbeing and safety of dependent children and young persons. In instances where a young person is a consumer of mental health services, the Act is clear about the need for their best interests to be considered as the driver for decision making.

The Guide aims to inform clinicians about what they need to do in order to comply with the provisions of the Act relating to working with the nominated person and carers. It also aims to articulate how meeting the requirements of the Act can be incorporated within contemporary recovery oriented care. Given that legislative provisions cannot possibly prescribe all practice, this guide endeavours to build a bridge between legislation and practice in a mental health setting. This is done by locating the principles and provisions of the Act within recovery oriented and family inclusive practice. In recognising that practice in mental health involves the use of professional judgement, this guide highlights the factors that clinicians need to consider in their decision making in the more complex circumstances they encounter. We also invite clinicians to look beyond simply meeting the requirements of the Act. The new roles of the nominated person and carers under the Act provide a real opportunity to improve the experience and effectiveness of mental health care for consumers and the significant people in their lives, particularly their carers and families.

[2] National Practice Standards for the Mental Health Workforce, (September 2002), Commonwealth Department of Health and Ageing, Canberra
[3] Framework for Recovery Oriented Practice, (2011), Victorian Department of Health, Melbourne

A Recovery and Family Inclusive Orientation

The nominated person provisions and those relating to carers are informed by both similar and differing principles within the Act. The nominated person role is based on principles of supported decision making and the importance of promoting and protecting the rights of the consumer in the context of compulsory treatment. The provisions in relation to carers also acknowledge their role in supported decision making and the promotion of consumers' rights but also emphasise the importance of recognising, respecting and supporting the role played by families and carers. This is especially important when family includes dependent children and young carers.

In clinical practice the differing but overlapping principles underpinning the nominated person, family and carer provisions are brought together by the value of working collaboratively with the consumer and the significant people (nominated person, carers, family members including children or friends) in a consumer's life. The consumer's personal and social relationships are a key domain in recovery oriented practice and are critical to an individual's well-being. The people who support a person with a mental illness need support in their role and should also have the impact of mental illness and of a caring role recognised and addressed.

The clinician, by working together with the consumer and the people who are significant in their lives, can support the consumer's recovery and respond to the needs of those people in a caring or otherwise supportive role. Cultivating and supporting a productive three-way relationship between the consumer, the people who are important in their lives and clinicians has the potential to harness their value in what is ideally a shared endeavour. For clinicians who approach practice in this way, carers and the nominated person role are valuable resources that can be mobilised and supported to assist in the consumers' recovery.

An Orientation to the Guide

This Guide assumes that the nominated person, families and carers provisions are a further elaboration and codification of best practice in mental health care. This guide further assumes that many clinicians already practice in a recovery oriented family inclusive way and that this form of practice is within the scope of all clinicians. Nonetheless, meeting the necessary provisions of the new Act and practicing according to its principles may be challenging for clinicians in differing ways. As such, clinicians do require information, training and support in operating in a changed legislative environment. This guide is one of a number of resources available to support clinicians in making the transition to working under the new Act. An orientation to this guide is provided below.

Overview of Roles

The Guide firstly describes the role of the nominated person as it is defined in the Act. It also provides a brief orientation to the practice implications for working with the nominated person. The carer role is defined within the terms of the Act and the practice implications associated with identifying and working with carers are briefly described.

Requirements of the Act

This section of the guide summarises relevant sections of the Act to tell clinicians what they need to know to meet the requirements of the Act. This spans obligations to consult with and inform the nominated person and carers across the range of compulsory orders, forms of treatment, second opinions and restrictive interventions.

Phases of Practice

Comprehensive practice guidance commences from the *Phases of Practice* section to assist clinicians in supporting consumers and carers to make the most effective use of the nominated person and carer provisions within the Act. It unpacks how clinicians can play a role in both an Establishing Phase (setting up the nominated person role and the involvement of carers) and Enabling Phase (working with the nominated person and carers during periods of compulsory assessment and treatment).

Processes and Practice Tips

Processes and Practice Tips provide guidance about how the nominated person and carer provisions can be enacted within practice. A Pathway for Establishing the nominated person and *Client Scenarios* further illustrate the practice approaches.

Issues and Approaches

For both Phases of Practice*, Issues and Approaches* addresses further questions that may arise in the course of working with the consumer, nominated person and carers and offers suggested approaches for responding to these issues.

Working with Complexity

Lastly the *Working with Complexity* section provides information and advice for responding to circumstances where there may be complexity by virtue of issues of age or culture.

Appendices

The *Appendices* include definitions of terms and relevant legislative and practice principles as well as a brief literature review in relation to the nominated person role.

Overview of Roles and Practice Implications

The Nominated Person

The nominated person is a new role established within the Act that has not previously operated within the Victorian mental health system.

The role of the nominated person

Within the terms of the Act, the role of a nominated person is to—
'(a) provide the patient with support and to help represent the interests of the patient
(b) receive information about the patient in accordance with this Act
(c) be one of the persons who must be consulted in accordance with this Act about the patient's treatment
(d) assist the patient to exercise any right that the patient has under this Act'

Practice implications

The authorised psychiatrist has specific obligations to have regard to the views of the nominated person and to inform the nominated person at key points during a patient's compulsory assessment and treatment. Practitioners have an important role in informing consumers of the option of having a nominated person and, if requested by the consumer, may be involved in assisting the consumer to identify and appoint a nominated person. This includes being an 'authorised witness' who can witness the written appointment of a nominated person.

The Carer Role

Unlike the nominated person, the concept of carer is a generally understood and accepted role within current mental health care that is most often performed by a family member. However the new Act involves specific obligations to consult with and inform carers.

Care, Care Relationship and Carer

The terms *Care, Care Relationship and Carer* used within the Act are defined in the Carer Recognition Act (2012). In the Carer Recognition Act:

care means 'the provision of ongoing support, assistance or personal care to another person'

'A person is in a care relationship if he or she provides another person, or receives from another person, care because one of the persons in the relationship—
(a) has a disability; or
(b) is older; or
(c) has a mental illness; or
(d) has an ongoing medical condition (including a terminal or chronic illness or dementia).'

A ***carer*** means 'a person, including a person under the age of 18 years, who provides care to another person with whom he or she is in a care relationship.'

Practice implications

The authorised psychiatrist has the same obligations as they do to the nominated person, to have regard to the views of the carer and to inform the carer at key points during a patient's compulsory assessment and treatment. In contrast to the nominated person where there is no discretion about consulting or informing, in determining whether to seek the views of the carer or to inform them about treatment decisions or orders, the authorised psychiatrist has to be satisfied that these actions will directly affect the carer and the care relationship.

Requirements of the Act

This section of the guide describes what clinicians need to do to meet the requirements of the Act. It is recognised that public mental health services deliver services in the context of multidisciplinary teams of which the 'authorised psychiatrist' is a member. Therefore, whilst the Act requires that the authorised psychiatrist ensure that 'reasonable steps' are taken to inform the nominated person and carer at particular points during a compulsory patient's care and have 'regard to the views' of the nominated person and carer; in practice within treatment teams, parts of these functions may be delegated to other team members and form a part of team practice.

Table 1: Requirements for Compulsory Orders, (page 9)

Table 2: Requirements for Protection of Rights, Leave and Treatment (page 10) and

Table 3: Requirements for ECT and Restrictive Interventions (page 11)

set out the requirements for the authorised psychiatrist to have regard to the views, to inform the nominated person and carer and to provide information under the Act for compulsory patients.

Table 1: Requirements for Compulsory Orders

Section of Act	Point in Care	*Required action of Authorised Psychiatrist*	*Required documentation*
ASSESSMENT ORDERS			
Division 1 Assessment Orders **30 Making an AO** **35 Variation of AOs** **37 Revocation or Expiry of AO**	Making, varying, revoking or expiration of an AO	As soon as practicable after being notified that the AO is made, varied, revoked or expired, the authorised psychiatrist must ensure that reasonable steps are taken **to inform** the nominated person and a carer	Give the nominated person and a carer a copy of the Order (or varied Order) and the relevant statement of rights.
TEMPORARY TREATMENT ORDERS and TREATMENT ORDERS			
Division 3 Temporary Orders **46 Authorised psychiatrist may make TTO** **48 Community or Inpatient TTO**	Making of a TTO and Determining whether the TTO is CTTO or an ITTO	In determining whether the treatment criteria apply to the person, the authorised psychiatrist— must, to the extent that is reasonable in the circumstances, **have regard to** the views of the nominated person and a carer	
Division 3 Temporary Orders **50 Information and other requirements in relation to TTOs** **Division 5—Variation of TTOS and TOs** **59 Requirements in relation to varied TTOs and TOs** **Division 6—Revocation and Expiry of TTO and TOs** **63 Notification requirements for expired or revoked TTO and TOs**	Information and other requirements in relation to TTOs and Variation, Revocation and Expiry of TTO and TOs	As soon as practicable after a TTO is made or varied, revoked or expired, the authorised psychiatrist must— (a) notify the Tribunal that the Order has been made or varied; and (b) ensure that reasonable steps are taken— (i) to **inform** the following persons in relation to the person subject to the Order that the Order has been made—the nominated person and a carer	Give the nominated person and carer a copy of the Order and the relevant statement of rights.

Table 2: Requirements for Protection of Rights, Leave and Treatment

Section of Act	*Point in Care*	*Required action of Authorised Psychiatrist*
PROTECTION OF RIGHTS		
Part 3 Protection of Rights **Division 2 Right to Communicate** **17 Persons to be notified**	Restriction of patients right to communicate	Must ensure that reasonable steps are taken to **inform** the patient and the nominated person and carer about the restriction and the reason for it.
LEAVE OF ABSENCE		
Part 4 Compulsory Patients **Division 7—General provisions** **64 Leave of absence with approval**	Leave of absence with approval	In determining whether to grant a leave of absence to a person, to grant a leave of absence subject to conditions or to vary its conditions or duration under this section, the authorised psychiatrist must, to the extent that is reasonable in the circumstances, have regard to all of the following— the views of the nominated person and a carer (amongst others).
Part 4 Compulsory Patients **Division 7—General provisions** **64 Leave of absence with approval**	Revocation of leave of absence	As soon as practicable after the authorised psychiatrist grants a leave of absence or varies or revokes a leave of absence, the authorised psychiatrist must ensure that reasonable steps are taken— to notify the following persons in relation to the person who is subject to the Order of the decision— the nominated person and a carer.
TREATMENT		
PART 5—TREATMENT **Division 1—Capacity and informed consent** **71 When a patient does not give consent to treatment** **Division 3—Medical treatment** **76 Matters authorised psychiatrist must take into account if consenting to medical treatment of patient**	When a patient does not give consent to treatment Medical Treatment	In determining whether there is no less restrictive way for the patient to be treated, or whether a medical treatment would benefit a patient, the authorised psychiatrist must have regard, to the extent that is reasonable in the circumstances, to the views of the nominated person and carer (amongst others)
Division 4—Second psychiatric opinions **82 Powers of a psychiatrist giving a second psychiatric opinion**	Second psychiatric opinions	In the case of a psychiatrist giving a second psychiatric opinion, the authorised psychiatrist must have regard, to the extent that is reasonable in the circumstances, to the views of the nominated person and carer (amongst others) and that reasonable steps are taken to give a copy of the report to the nominated person and a carer.

Table 3: Requirements for ECT and Restrictive Interventions

Section of Act	*Point in Care*	*Required action of Authorised Psychiatrist*
ECT		
PART 5—TREATMENT **Division 5 Electroconvulsive treatment (ECT)** **93 Application to Tribunal to perform ECT on a patient who is not a young person** **94 Application to perform ECT on a young person**	ECT on a patient (including a young person)	In determining whether there is no less restrictive way for a patient (including a young person) to be treated, the authorised psychiatrist must, to the extent that is reasonable in the circumstances, have regard to the views of the nominated person and carer (amongst others) In the case of a young person, where they are subject to a protective order, the carer will be the Secretary to the DHS.
RESTRICTIVE INTERVENTIONS		
PART 6—RESTRICTIVE INTERVENTIONS **Division 1—General** **107 Notification of use of restrictive intervention**		An authorised psychiatrist must take reasonable steps to ensure that, as soon as practicable after commencement of the use of a restrictive intervention on a person, the nominated person and a carer are notified of its use, the nature of the restrictive intervention and the reason for using it.

Phases of Practice

In a consumer rights, recovery oriented and family inclusive approach to practice, the challenge is, 'how can the involvement of significant people in a consumer's life best occur?' In the context of the Act this involves specific consideration of how clinicians can work with carers and the new role of the nominated person.

A useful conceptualisation of working with carers and the nominated person is to understand this as occurring in two phases. The first is an **establishing phase** where the clinician works with the consumer and the significant people in their life to identify who might be involved and how. The second, **enabling phase**, involves working with the identified people when a consumer becomes subject to compulsory treatment. The broad phase approach adopted in relation to involving carers can be applied to the clinician's role in relation to the nominated person, although there are some important differences in the legislative requirements that apply to each group.

The Establishing Phase

The establishing phase identifies who might be in the role of carer and nominated person, clarifies how they will be involved in the consumer's care and specifically what role they will play in the event of the consumer being subject to compulsory treatment. Core to this phase are practices that include the clinician:

- Adopting a contextual view of the consumer that means talking about the consumer's family, friends and broader social network as part of routine engagement and assessment.
- Enquiring about who the important people in the consumer's life are, and the nature of their involvement and relationship
- Discussing with the consumer if and how these people might be involved in their mental health care and the extent of this involvement, including whether an individual might want this person to be their nominated person
- Exploring options with the consumer about how communication can best occur between the consumer, the clinician and the people they have identified as being involved in their mental health care. Dependent on the consumer's preferences this may involve convening a three way meeting of these parties.
- Clarifying what roles people may play in the event of the consumer being subject to compulsory treatment. This might include discussion about what the nominated person role will involve and what the nominated person and carer can expect in terms of communication from the treating team.

This guide makes the assumption that the clinician has an obligation to inform the consumer and the significant people in their lives about their rights under the Act. This should include the role of the nominated person and carers and what will or can occur in the event of the consumer being subject to compulsory orders. However depending on the needs and preferences of the consumer, there may be no active role for the clinician in the establishment of a nominated person. For example, the consumer might make their own arrangements for appointing a person to this role. In other instances the consumer may appreciate being informed about the option of a nominated person but wish to discuss it further with someone not directly involved with their clinical treatment such as a family member, friend or their MHCSS practitioner. In other circumstances there may be a very active facilitation role for the clinician, including being a witness to a nomination.

Potential opportunities for discussion of the nominated person provision and carer role

- As part of advising a consumer or patient of their rights as part of their entry to a service or inpatient unit.
- As part of a discussion about how important people in a consumer's life will be involved in their treatment and care. This could be an initial discussion with the consumer on their own and then subsequently as an item for discussion in a three way meeting involving the consumer, family members and the practitioner. This discussion could consider the pros and cons for family members or someone outside the family taking on the role of the nominated person, e.g. will it jeopardise relationships within the family if a family member is involved in their relative's care as a nominated person?
- Soon after a period of compulsory treatment in hospital. The discussion of the appointment of a nominated person might be seen as a having a supportive person who can represent their preferences when they are under an order.
- In a discussion with the client about preventing relapse. This might be part of a discussion about, 'if despite everyone's best efforts you end up in hospital, what can we put in place to make the experience as positive and productive as possible?'
- Where a carer and consumer have decided that the carer being a nominated person provides for greater surety that the consumer's preferences will be heard.
- In a discussion between a clinician and consumer about making an advance statement. A nominated person could be proposed as an additional measure to ensure the consumer's preferences are articulated to the treating team.
- When a carer, family member or significant other expresses concerns that their knowledge of the consumer was not considered during compulsory treatment.
- When a consumer is a patient under the terms of the Act (either in hospital or in the community) and wants to have a trusted person appointed to support them and represent their preferences to the treating team.

Establishing: Processes and Practice Tips

At each point in the processes outlined below that refer primarily to the nominated person, it is recommended that the clinician consider the role of the family/carer, particularly if the consumer does not elect them to be the nominated person. The table below describes key steps in the process of appointing a nominated person and provides practice tips to facilitate this process.

Processes	Practice Tips
Informing the consumer of the provisions within the Act to have their treatment preferences represented to the treating team if they are under compulsory orders	**Inform** the consumer of the range of options available for the consumer including an advance statement, the nominated person role and the role of the carer. **Provide** written information and time to assist the consumer in understanding these options. **Explore** how each of these options might be of benefit to the consumer.
Identifying existing supports including whether the consumer has a carer and if the consumer wishes to appoint a nominated person Does the consumer want to choose a person to take on the role of nominated person, keeping in mind that this is a voluntary provision and there is no compulsion for anyone to have a nominated person?	**Explore** with the consumer who the significant people are in their life. **Explain** the role of the nominated person and carer, how a nominated person is appointed and how these roles will operate if the consumer is subject to compulsory treatment. **Discuss** with the consumer the implications of having a nominated person and the role of a carer.
Choosing a nominated person and identifying who might be seen as a carer This is a process the consumer may want to undertake on their own or with the support of a clinician.	**Ask** who the consumer would like to be their nominated person and who may be viewed as their carer. **Explore** with the consumer their hopes and expectations for having the nominated person or a carer in the event of compulsory treatment. **Explain** the need for the nominated person to be someone who is able and willing to undertake the role. **Explore** the implications of potential choices including the impact on existing family relationships and friendships. This should include the pros and cons of a family member or someone outside the family being appointed as the nominated person.
Informing a proposed nominated person of the nature and scope of their role	**Explore** with the proposed nominated person their understanding of the role. **Discuss** with the consumer and the nominated person how the role might work in practice
The appointing of a nominated person Making a written, signed and dated nomination, including: • Name and contact details of the nominated person. • Statement signed by the nominated person agreeing to be the nominated person • Statement signed by the consumer nominating the proposed person as the nominated person • Authorised witness signature, including	**Facilitate** the drafting, signing and authorisation of a nomination. **Explore** the ongoing implications of the nomination including arrangements for confirming the continuing operation of the role. **Explain** the option of revoking a nomination. **Provide** all parties with a copy of the signed nomination.

statement that they believe the person making the nomination understands the nominated person provisions and its' consequences and that they saw the person sign the nomination.	
Revoking a nomination Making a written, signed and dated revocation, including: • Statement of revocation • Statement signed by the consumer identifying the nominated person as the person they wish to revoke as nominated person • Authorised witness signature, including statement that they believe the person making the revocation understands the meaning and consequences of the revocation and that they saw the person sign the statement.	**Explore** the implications of revoking the nomination. **Facilitate** the drafting, signing and authorisation of a revocation **Explain** that the consumer must take reasonable steps to inform the nominated person of the revocation If the consumer is a patient at the time of the revocation, the nominated person must inform the authorised psychiatrist.
Declining to act as a nominated person The nominated person should take reasonable steps to inform the consumer and the treating team that they have declined to continue to act as nominated person.	**Explore** (with the nominated person) the implications of declining to continue to act as the nominated person. **Explore** (with the consumer) the implications of not having the previously appointed nominated person acting as the nominated person in the future. **Explain** the option of making a new nomination

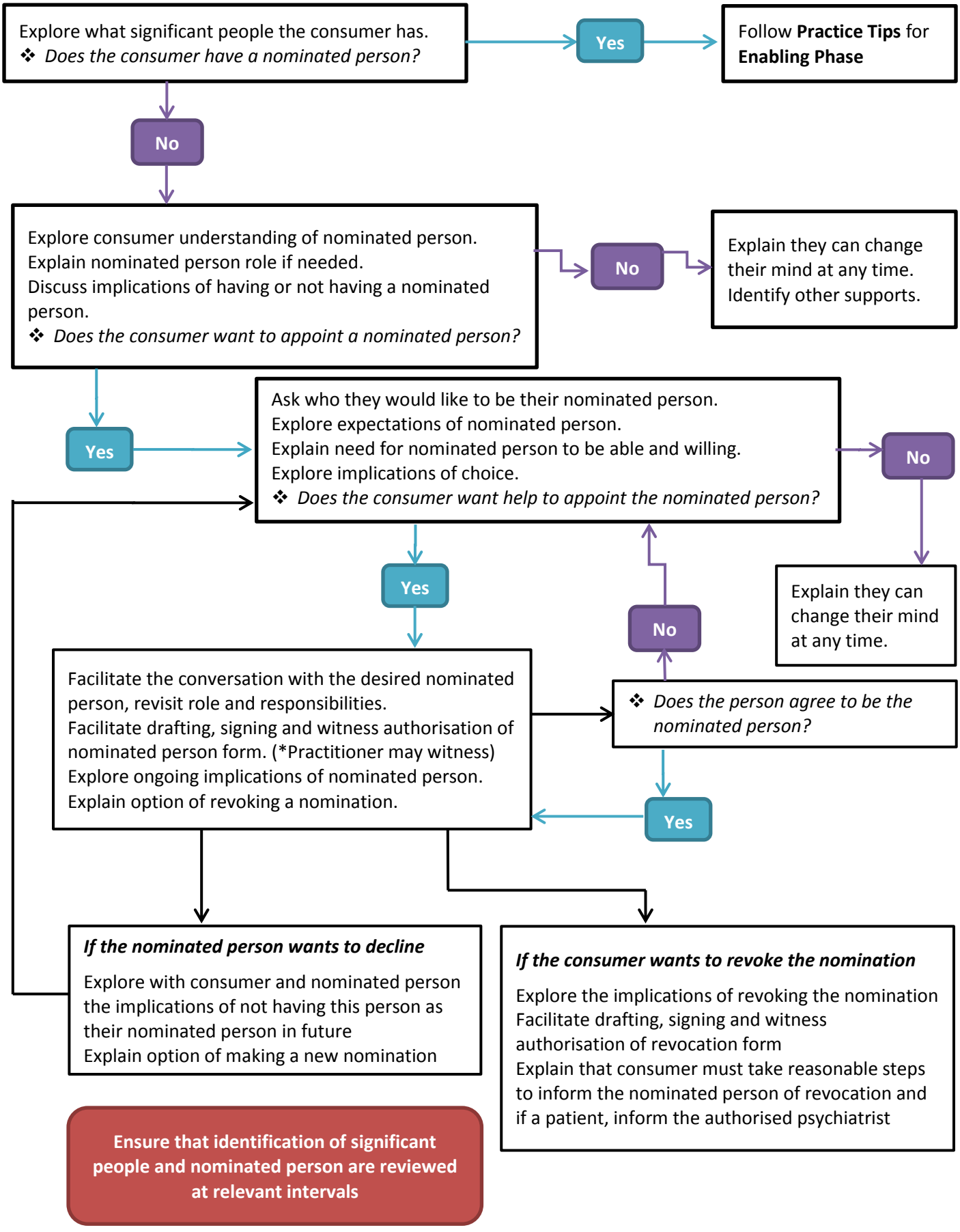
Scenario 1: Establishing a nominated person in a MHCSS

Paul (27 yrs), who has been working with Heather, has been quite well over the last few months. Heather wonders if this would be a good time to ask Paul if he wants to appoint a nominated person. Paul has a number of people who 'support' him, including his parents (whom he doesn't live with), but he is uncertain who his 'key' support people might be. As Heather discusses the nominated person role it becomes apparent to Heather that Paul's expectations about the role of the nominated person are unclear. Paul voices concerns, asking if things are not working out with the nominated person, what can he do? What if the nominated person doesn't want to do it anymore? Paul is interested in understanding more.

Practice considerations:

- An initial discussion regarding the nominated person could take place:
  - About how important people in Paul's life can support him in his treatment and care;
  - About having a trusted person informed and to represent Paul's views and interests;
  - After a period of compulsory treatment and when Paul is stable about preventing relapse.
- Explore with Paul his support network and the 'key' people that he relies upon.
- Clarify Paul's expectations, the implications and his concerns regarding the nominated person role.
- Check in with Paul that he has understood what has been discussed.
- If Paul is not nominating a carer, discuss the implications for Paul's carers regarding their ongoing involvement.
- Seek Paul's consent and advice of who to contact and invite them to attend a meeting to discuss and clarify the nominated person appointment
- Step Paul through the formalising of the nominated person nomination.

Clinician Pathway Establishing Phase



Establishing: Issues and Approaches

In considering implementing the nominated person provision there will be instances when questions will arise for the clinician, the consumer, family, carer or significant people. It is important that clinicians are well informed and have ready access to additional support and information when questions arise.

Issue	Approach
What if the consumer does not choose the identified carer/family member as the nominated person and; 1. The carer is actively involved and wants to be informed or 2. The clinician is uncertain of the level of carer involvement	• **Consider** offering a meeting with identified carer, consumer and nominated person to discuss the decision and implications. • **Consider**, with the consumer, mechanisms for sharing of information with the identified carer.
What if the intended nominated person lives far away, e.g. interstate?	• **Consider** how available the nominated person may be for the purpose of being contacted (by phone, email) regardless of their physical location.
What if the proposed nominated person is deemed to be unsuitable by the clinician?	• It is not the role of the clinician to determine suitability • If a clinician is asked to witness a nomination they only need to establish that the consumer and the proposed nominated person understand the meaning and consequences of the decision. There are three requirements in the provision - willing, available and able to fulfil the functions and responsibilities of the nominated person. • **Consider** sensitively discussing your concerns with the consumer who has made the nomination and explore why they chose the nominated person. • **Inform** them of the role of the nominated person and implications of taking on that role. • **Consider** bringing the consumer and proposed nominated person together to discuss the relationship and functions of the role.
What if the consumer wants their child/young person to be the nominated person and they are under 18?	• There are no age limitations for the appointment of a nominated person. If this occurs, consider the following: • **Explain** the details of the role in the context of the parent/child relationship, the family, the developmental age of the child and the potential impact of the role on him/her. • Whilst it is not uncommon for children to have significant caring responsibility for a parent, consideration should be given to making sure that this is an appropriate role that can be supported, especially for younger children. • **Explore** other possibilities whilst not excluding their request . • **Consider** a meeting with the consumer, the child and the clinician and other significant adults who can support him/her in the role.
What if the consumer is not able to nominate anyone as a nominated person?	• There is no requirement for a consumer to have a nominated person. • **Explore** with the consumer other options for representing their treatment preferences such as an advance statement or having access to an advocate.

Scenario 2: What if the consumer does not choose their carer/family member as the nominated person?

Tony, aged 27, lives with his parents, who consider themselves Tony's 'primary carers'. In the case manager's discussion with Tony about appointing a nominated person, Tony decides to nominate a close friend, whom he has known for a number of years and plays music with in a band at his local day program. The case manager is regularly contacted by the family carers who express their concerns about Tony's mental health and the influence of others on Tony. The family are particularly concerned about Tony nominating someone other than a family member who knows him well.

Practice considerations:

- What might Tony's decision mean for the family's caring role and relationship? Discuss with Tony the possibility of talking through his choice with his parents and any role you might have in supporting this. Explore the consequences of Tony's parents not being informed of his final decision if this is likely.
- Would a family meeting be helpful in this situation? Explore this with Tony and with his consent invite relevant family members to attend a meeting (including Tony) to discuss and clarify the nominated person appointment and implications for Tony's carers regarding their ongoing involvement. This includes clarifying with Tony and his parents that in the event of compulsory treatment the parents may be deemed to be carers under the Act and informed and consulted in the same way as the nominated person.
- What if Tony does not wish to attend such a family meeting? With Tony's agreement consider offering to discuss Tony's preferences with his carers.

Enabling: Processes and Practice Tips

The Enabling phase will occur when the consumer becomes a patient within the terms of the Act. At this point the role of the nominated person becomes active and the obligations of the authorised psychiatrist to consult and inform the nominated person and carer come into play. In reality, it would be expected that clinicians would include significant people (family, carer, friend) in treatment planning and decision making whether or not the treatment being undertaken is under a compulsory treatment order. Good practice for all consumers (not only those on compulsory treatment orders) requires decision making supported by the sharing of relevant information with people that the consumer determines are important in their lives.

Determining the impact of treatment on the care relationship

Before the authorised psychiatrist can inform or consult a carer they must first be satisfied that the carer and the carer relationship is or will be affected by the treatment decision. This presumes that in the first instance the clinician is aware of the existence of a carer and the nature of the relationship between the carer and consumer.

Identification of carers

Service specific procedures already support how carers are identified and included in treatment decision making. This established practice will be the foundation for further consideration of how the carer and care relationship may be directly affected by treatment decisions. Where these practices and procedures are not currently in place, services should take steps to ensure that carers are routinely identified and consulted.

Some questions for clinicians to consider in deciding whether the carer or care relationship is affected:

- How does the consumer view the care relationship?
- How does the carer view the care relationship?
- What type of care is provided?
- Does the consumer live with the carer?
- Does the consumer rely on the carer for basic living needs, such as cooking, shopping, managing medication, independent living skills?
- Does the consumer rely on the carer for emotional support?
- How recently has the support been provided?

Clinicians should be aware that a child or young person may have significant caring responsibilities even if this is not immediately evident.

The purpose of the table below is to identify the important elements which may contribute to the successful enabling of the nominated person provision at various points in the consumer's treatment. It describes considerations for the client, family members, carers and significant people. It is important to once again note that many of the practices applying here are likely to be relevant to the role of carer.

The **Enabling** phase will include consideration of:

Process	Practice Tips
Working well with the patient, their nominated person and carer	**Ensure** the patient, their nominated person and carer have accurate and understandable information at all times.
Obligations to inform or consult the nominated person and carers	**Consider** clarifying how this will be done during the period of compulsory treatment. What are the communication pathways? **Consider** the context of family and carer.
How the nominated person and carer will be provided with information relevant to the patient's treatment	**Ask** the nominated person and carer about the best way for them to receive information – where, when and how? **Ensure** the information about the patient's treatment is communicated in a manner that is clear and does not use jargon. **Clarify** the process of coming to a treatment decision.
How the nominated person's and carer's views will be sought in relation to the patient's treatment	**Inform** the patient of the need to provide information about their preferences to the nominated person and/or carer. **Consider** whether you have a role in facilitating this provision of information? **Consider** the use of advance statement.
How the nominated person's views are taken into consideration in determining the treatment plan	**Consider** how much information the nominated person has about the patient's diagnosis and treatment, how that is understood and acted on. **Consider** what service forums (meetings, reviews, planning etc.) might be appropriate.
How treatment decisions that are not consistent with the patients, nominated person's or carer views will be determined and communicated to the patient, nominated person and carer	**Clarify** the decision making process in terms of the authorised psychiatrist needing to consider (but not being bound by) the views of the nominated person and carer. **See** 'Adequate information' definition (Appendix 1) in regard to informing the patient and nominated person.
Responsibilities of and to a nominated person and carer– consumers, significant people, clinicians during compulsory treatment, post compulsory treatment	The authorised psychiatrist needs to take reasonable steps during compulsory treatment to inform the nominated person and carer of a decision about treatment and, in determining treatment, consult the nominated person and carer on their views. This occurs in the context of the authorised psychiatrist considering a range of other views, including the patient's.

Enabling: Issues and Approaches

When the nominated person provision is enabled by virtue of a compulsory order being made, this additional support and information may be considered.

Issue	Approach
What if the nominated person is deemed to be unsuitable (by the patient, the nominated person, the carer or the clinician)?	• **The appointment** is ultimately a matter of the consumer's preference. • **Respectfully and sensitively explore** the reasons for their decision. • **Inform** the person of provisions for revocation • **The patient** may revoke the nomination and appoint a new person in this role as long as they understand the implications of this decision. • Is the nominated person willing, available and able to fulfil the functions and responsibilities of the role? There is no age restriction. • Does the nominated person need any support to maintain their role? • **Consider** a meeting with the patient and the nominated person. • The nominated person may decline to continue in the role and should advise the patient and the authorised psychiatrist of this decision.
What if the nominated person or carer is unavailable when required?	• The authorised psychiatrist is required to have regard to the views of the nominated person and carer 'to the extent that is reasonable in the circumstances' and ensure 'reasonable steps' are taken to inform the nominated person. This implies making more than one attempt to make contact and considering more than one mode for contacting them. For example, making a phone call or accessing the nominated person's contact details through a family member. • It is the role of the treating mental health service to ensure the contact details of the nominated person and carer are up to date. • The patient, carer and nominated person should be encouraged to advise the mental health service of any changes to nominated person and carer arrangements.
How is the role monitored if at all?	• There is no legal requirement on the clinician's part to monitor the nominated person role. As part of ongoing care, clinicians should periodically review arrangements in relation to the nominated person and carer to ensure they reflect the consumer's current preferences.
What mechanisms are there for feedback about the role (from nominated person, consumers, clinicians, families and carers)?	• There is no formal mechanism for feedback. As above, good practice would suggest regular review of arrangements, especially if the patient is under a treatment order of extended duration. • **Inform** the nominated person, families and carers as well as the patient that you can support them in their roles.
What if the carer and the nominated person are the same person?	• This is likely to be a common arrangement. When canvassing the views of the carer/nominated person it may help to clarify what views the person is representing. For example, 'as the nominated person what has your mother said to you about her treatment preferences? As her carer what do you think should happen?'

Working with Complexity

The impact of the nominated person and carer provisions of the new Act on clinical practice is likely to be only fully appreciated once the Act has been in operation for twelve months or more. There are currently circumstances in mental health care such as working cross culturally, working with Aboriginal and/or Torres Strait Islander families and with families with dependent children where practice may be more complex. In these circumstances, practice in relation to the nominated person and carer provisions of the Act might be expected to be more challenging. The new provisions however offer clarity about clinicians' obligations to communicate with families and carers. This may reduce difficulties arising when the consumer's preferences are not fully appreciated or where families and carers have been excluded from the consumer's care.

This section provides broad guidance about useful strategies for responding to complexity in providing mental health care. Specific consideration is given to issues that may arise in relation to the nominated person and carer as it applies to families where a parent has a mental illness and in consumers and their families from an Aboriginal and/or Torres Strait Islander or CALD background.

Some useful strategies for dealing with complexity

- Try to understand the response of consumers and family members by putting yourself in their shoes. An appreciation of other perspectives can help you understand what might be driving their behaviour and to adopt a more empathetic response.
- Understanding the impact of mental illness as similar to the impact of other major traumas on family relationships can be helpful in understanding unhelpful behaviours and responding to distress, particularly in acute care settings.
- Adopt a systemic view that understands what is happening in terms of the context in which difficulties occur. This might be an historical context in terms of past experiences of trauma or interactions with services, it might be a cultural context where different beliefs are held about mental illness or it may be the setting in which treatment is occurring.
- Recognise that blame is a very common dynamic in circumstances that appear complex or where there is no 'easy answer.' While blame is a common response to difficulty be alert to the possibility that others may see you as blaming of them or to getting caught up in escalating cycles of reciprocal blame.
- Although there is a natural desire for certainty, recognise that good practice involves making informed judgements about the best course of action in a given circumstance rather than applying a set formula.
- In circumstances where the 'stakes are high' involve supervisors or other relevant senior staff as early as possible rather than trying to manage the situation on your own. Working in isolation makes dealing with the circumstance more burdensome, means that you may miss out on opportunities for resolving the issue and that you place yourself in a less defendable position if something untoward occurs.
- Seek the advice of others with experience and knowledge in the area that you experience as complex, such as peers with relevant experience or expertise, carer or consumer consultants, FaPMI Co-ordinators, bilingual clinicians, Aboriginal and/or Torres Strait Islander health workers.
- Remember to document your actions/decisions and the reasons for the action you have taken. This can demonstrate that you have acted reasonably even in circumstances where your judgement may be subsequently viewed as incorrect.

CALD clients and families

Consumers and families from CALD backgrounds often experience difficulties in navigating mental health services due to language barriers and because of cultural differences between them and the culture and practices of mainstream mental health services. Feelings of shame and embarrassment about a relative's mental illness and the prospect of having to expose 'family business' to outsiders can inhibit help seeking. Familiarity with culturally sensitive practice will be an essential prerequisite for clinicians.

The introduction of an Act with new terminology and practices requires that specific attention is given to assisting CALD consumers and their families to understand this. Requirements in relation to communicating with carers and the nominated person are likely to increase the extent of contact between clinicians and families during periods of compulsory treatment. This suggests an immediate impact on the need to access interpreters or to make use of bilingual clinicians and also supports the value of clinicians devoting time to preparing families when the consumer is well. Use of written materials about the Act in a family's first language is likely to assist in informing CALD consumers and families, although it should not be assumed that individuals will be necessarily literate in their first language. Convening family meetings with the consent and participation of the consumer may be an efficient way for the whole family to understand and discuss the roles of the carer and nominated person.

The appointment of a family member as the nominated person may have both positive and negative implications for family relationships. Families should be made aware of the implications of the role and supported to weigh up the benefits and disadvantages for the proposed nominated person. For example, a younger sibling who is proficient in English might be encouraged to take on the role because this is an extension of their existing family role. This may become burdensome for the young person and have an impact on their sibling relationship. If the nominated person is not proficient in English however the clinician may need to carefully consider how they can be best supported to effectively fulfil their role.

Scenario 3: W**orking with consumers with a CALD background**

Jafar is a 20 year old male from Sudan who lives with his uncle and his uncle's wife and two children and younger sister aged 15. He has had three admissions in a psychotic state which required compulsory treatment. Jafar and his family have limited English, speak Arabic and have recently arrived to live in Melbourne. They have all experienced trauma in Sudan and came to Australia to flee persecution. Jafar has asked his uncle who has been living in Melbourne for two years to be his nominated person.

Practice considerations:

- What do the family and nominated person know and understand about mental illness and the Act?
- Explore what information is available about mental illness and the Act in their first language.
- Explore how the family would like to be supported. Consider offering a range of supports including a family meeting with an interpreter who is appropriately briefed on mental health issues. Explore different avenues of communication and their cultural understanding of mental illness.
- Explore how the nominated person, the rest of Jafar's family and his community are supporting him and understanding the impact of the mental illness on Jafar and his family.
- Explore the best means of communication, the use of interpreters and the potential impact of the uncle taking on a specific role as nominated person.
- Explore how the rest of the family are being supported, given their history of trauma and persecution. Explore other potential supports that may benefit the nominated person and the rest of the family.

Aboriginal and Torres Strait Islander clients and families

The provision of mental health care to Aboriginal and Torres Strait Islander people raises significant challenges for mainstream mental health services. The trauma and loss experienced by Aboriginal and Torres Strait Islander peoples across generations through the use of coercive practices in a range of different contexts contribute significantly to the development of mental illness and creates obstacles to trust so important in the treatment of mental illness. Consistent with a holistic approach to health care, the nominated person and carer provisions of the Act need to operate in a context which acknowledges the person's cultural background and which strives to create cultural safety.

The nominated person and carer provisions of the Act provide opportunities for recognising and supporting the centrality of family and kinship for Aboriginal and Torres Strait Islander people even in the challenging context of compulsory treatment. It is not always obvious who may be able to represent and have authority concerning the family member's health and wellbeing. Good practice encourages clinicians to build a picture of family members, kinship connections and others who might be significant in this case. Members of an Aboriginal and/or Torres Strait Islander person's family and kinship groups can be recognised through the obligation to consult and inform carers. This can help ensure that treatment is provided in a culturally appropriate manner. As well as ensuring that a person's treatment preferences are represented to a treating team, the nominated person can also provide a further opportunity for support for an Aboriginal and/or Torres Strait Islander person who is likely to feel vulnerable in a compulsory treatment setting. The nominated person role may also be valuable for clinicians in providing cultural guidance about who should be invited to meetings regarding the person's treatment and care. Where available, Aboriginal and/or Torres Strait Islander mental health liaison workers will play an important role in helping to inform Aboriginal and Torres Strait Islander people and their families about the role of carers and the nominated person.

Scenario 4: When an Aboriginal person is a compulsory patient whose mother is the nominated person

Carly is a 36 year old Aboriginal woman who lives with her mother, Beryl and Carly's three children aged 16, 12 and 10. Beryl plays a major role in caring for the children. Carly has a long history of bipolar affective disorder and ongoing use of marijuana in the context of a trauma background. Beryl is Carly's nominated person. Carly has been admitted to hospital as a compulsory patient following a manic episode.

Practice considerations:

- Appreciate that Beryl's role within the family is not unusual for Aboriginal families and not necessarily a reflection of Carly's ability to care for her children. Support Beryl to help her grandchildren understand more about their mother's condition. Carly's experience of being a compulsory patient is likely to make her feel especially vulnerable given her own and her communities' experience of trauma.
- Acknowledge Beryl's role within the family, not only as Carly's nominated person. It might be useful to involve an Aboriginal liaison worker or other relevant Aboriginal service to help clarify information being provided to Carly and Beryl at important points during Carly's care.
- Explore culturally specific resources available. An Aboriginal liaison worker within the hospital or other Aboriginal agencies already involved may support Carly and her family during her admission.
- Ask Carly and Beryl who you might invite to a family meeting. The clinician could also consult with Carly, Beryl and an Aboriginal worker or services for guidance about the best way of convening and conducting such a meeting.

Young people under the age of 18

Under the nominated person and carer provisions of the Act, children may be deemed to be in a caring role and as such must be informed and consulted about their parent's treatment at key points in their care. A consumer may also choose a child or young person as their nominated person. Beyond these specific provisions, the principles of the Act make reference to the need for mental health services to protect the well-being of dependent children of their clients. This creates a clear obligation to protect the best interests of children whether or not they are in a formally acknowledged caring or nominated person role. For consumers who are parents, parenting is an important domain of recovery oriented practice.

Although the appropriateness of dependent children caring for parents experiencing a mental illness is a contested issue, the reality is that in the absence of other forms of support, young people do assume caring roles. In this context there is a strong imperative for clinicians to sensitively explore with the consumer the implications of their young person taking on this role. Such exploration should include gaining an understanding of the roles and responsibilities children have had in the past or hold currently, the kinds of supports the child has within and external to family and the status of the parent-child relationship.

Consideration of the appointment of a young person to the role of the nominated person for their parent should similarly be discussed, preferably outside the context of the parent being acutely unwell or under compulsory orders. In the event of a young person assuming the nominated person role, the clinician should consider making arrangements for the young person to receive the support of a trusted adult or advocacy worker at least for the period that the parent is under compulsory orders. This is to safeguard the well-being of the young person and to assist them in representing the views and interests of their parent.

Scenario 5: When a Nominated person is under 18

Mary is a single parent of Jade, who is 13 years old. With no siblings and very limited family support and social networks, Jade has had significant caring responsibilities from a very young age. This has included monitoring her mother's medication, calling the crisis team and/or ambulance, staying home from school when her mother has been particularly unwell and managing much of the running of the home. Jade has more recently been asking questions about her mother's diagnosis and treatment and requesting to meet with Mary's case manager, who is uncomfortable with giving this much information to Jade even though Mary consents to it. Mary asks that Jade be her nominated person and is adamant that there is no-one else available or whom she trusts.

Practice considerations:

- Affirm Jade's role in providing care and support to Mary so far. Explore the strengths in the relationship as well as inviting discussion/curiosity about the potential challenges for Jade in taking on this role.
- Explore Mary's social networks and supports thoroughly, especially who has offered to help in the past.
- Offer resources for Mary and Jade about support for families where a parent has a mental illness, including information about young carers, crisis/help lines and COPMI (Children of Parents with a Mental Illness) www.copmi.net.au
- Explore Jade's role and developmental progress e.g. school progress and attendance, social supports.
- Facilitate a conversation between Mary and Jade (and any other significant people) about Mary's illness and treatment. If Jade accepts the role of nominated person, ensure she has an accurate and age appropriate understanding of the role and responsibilities and where to receive support.

Appendix 1: Definitions

The definitions contained below are those derived from the *Mental Health Act 2014* relevant to an understanding of the nominated person and carer provisions.

Advance Statement is a document that enables a person to record their preferences for treatment in the event that they become unwell and require compulsory mental health treatment.

Adequate Information is considered to have occurred for the purposes of informed consent if the following has been provided:

a) an explanation of the proposed treatment or medical treatment including:
    i. the purpose of the treatment of medical treatment and;
    ii. the type, method and likely duration of the treatment or medical treatment
b) an explanation of the advantages and disadvantages of the treatment or medical treatment, including information about the associated discomfort, risks and common or expected side effects to the treatment or medical treatment;
c) an explanation of beneficial alternative treatments that are reasonably available, including any information about the advantages and disadvantages of these alternatives;
d) answers to any relevant questions that the person has asked;
e) any other relevant information that is likely to influence the decision of the person;
f) a statement of rights relevant to his or her situation in relation to the proposed treatment.

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.

Capacity to give informed consent under the *Mental Health Act 2014* refers to a process of assessment that determines whether a person:

a) understands the information he or she is given that is relevant to the decision
b) is able to remember the information that is relevant to the decision
c) is able to weigh information that is relevant to the decision
d) is able to communicate the decision he or she makes by speech, gesture or any other means.

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

Carer means a person, including a person under the age of 18 years, who provides care to another person with whom he or she is in a care relationship.

Care relationship for the purpose of the *Mental Health Act 2014* is a person in a care relationship if he or she provides another person, or receives from another person, care because one of the persons in the relationship:

a) has a disability; or
b) is older; or
c) has a mental illness; or
d) has an ongoing medical condition (including a terminal or chronic illness or dementia).

Compulsory patient means a person who is subject to:

a) an Assessment Order; or
b) a Court Assessment Order; or
c) a Temporary Treatment Order; or
d) 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.

Forensic patient has the meaning given in section 305:

a) a person remanded in custody in a designated mental health service under the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997; or
b) a person committed to custody in a designated mental health service by a supervision order under the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997; or
c) a person detained in a designated mental health service under section 30(2) or 30A(3) of the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997; or
d) a person deemed to be a forensic patient by section 73E(4) or 73K(8) of the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997; or
e) a person detained in a designated mental health service under section 20BJ(1) or 20BM of the Crimes Act 1914 of the Commonwealth; or
f) a person who is an international forensic patient within the meaning of section 73O of the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997; or
g) a person taken from a prison to a designated mental health service in accordance with a direction made by the Secretary to the Department of Justice under section 306.

A person does not cease to be a forensic patient under subsection (1) if he or she:

a) is on leave of absence from a designated mental health service; or
b) is absent from a designated mental health service without leave.

Health practitioner means an individual who practises a health profession.

Informed consent for the purposes of treatment or medical treatment is given when the person:

a) has capacity to give informed consent to the treatment or medical treatment proposed
b) has been given adequate information to enable the person to make an informed decision
c) has been given a reasonable opportunity to make the decision
d) has given consent freely without undue pressure or coercion by any other person
e) has not withdrawn consent or indicated any intention to withdraw consent

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.

Nominated person is a person nominated by a person to help represent their interests and be a support in the event that the person becomes a patient (Compulsory, security or forensic) under the *Mental Health Act 2014*.

Parent, in relation to a person under the age of 18 years, includes the following:

a) a person who has custody or daily care and control of the person;
b) a person who has all the duties, powers, responsibilities and authority (whether conferred by a court or otherwise) which by law parents have in relation to their children;
c) any other person who has the legal right to make decisions about medical treatment of the person.

Patient means:

a) a compulsory patient; or
b) a security patient; or
c) a forensic patient.

Practitioner means a person employed by a designated mental health service who is a registered psychologist, nurse, occupational therapist or who is a social worker. In this Guide this term does not refer to a psychiatrist, who has specific and separate roles from that of practitioners as defined in the Act.

Reasonable opportunity refers to the person's capacity to make a decision and is based on a person being given reasonable:

a) period of time to consider the matters involved in the decision
b) opportunity to discuss those matters with the registered medical practitioner or other health practitioner who is proposing the treatment or medical treatment
c) amount of support to make the decision
d) opportunity to obtain any other advice or assistance in relation to the decision

Treatment

For the purposes of this Act:

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

Provision of advice, notification or information under this Act

1) The contents of any advice, notice or information given or provided to a patient under this Act must be explained by the person giving the advice, notice or information to the maximum extent possible to the patient in the language, mode of communication and terms which the patient is most likely to understand.
2) An explanation given under subsection (1) must, whenever reasonable, be given both orally and in writing.

Appendix 2: The mental health principles, *Mental Health Act 2014*

Mental Health Bill 2014 Parliament of Victoria

1) The following are the mental health principles (with the principles that most relate to the nominated person and carer provisions **highlighted in bold)**
    a. persons receiving mental health services should be provided assessment and treatment in the least restrictive way possible with voluntary assessment and treatment preferred;
    b. persons receiving mental health services should be provided those services with the aim of bringing about the best possible therapeutic outcomes and promoting recovery and full participation in community life;
    c. persons receiving mental health services should be involved in all decisions about their assessment, treatment and recovery and be supported to make, or participate in, those decisions, and their views and preferences should be respected;
    d. persons receiving mental health services should be allowed to make decisions about their assessment, treatment and recovery that involve a degree of risk;
    e. persons receiving mental health services should have their rights, dignity and autonomy respected and promoted;
    f. persons receiving mental health services should have their medical and other health needs, including any alcohol and other drug problems, recognised and responded to;
    g. persons receiving mental health services should have their individual needs (whether as to culture, language, communication, age, disability, religion, gender, sexuality or other matters) recognised and responded to;
    h. Aboriginal and/or Torres Strait Islander persons receiving mental health services should have their distinct culture and identity recognised and responded to;
    i. children and young persons receiving mental health services should have their best interests recognised and promoted as a primary consideration, including receiving services separately from adults, whenever this is possible;
    j. children, young persons and other dependents of persons receiving mental health services should have their needs, wellbeing and safety recognised and protected;
    k. carers (including children) for persons receiving mental health services should be involved in decisions about assessment, treatment and recovery, whenever this is possible;
    l. carers (including children) for persons receiving mental health services should have their role recognised, respected and supported.

2) A mental health service provider must have regard to the mental health principles in the provision of mental health services.

3) A person must have regard to the mental health principles in performing any duty or function or exercising any power under or in accordance with this Act.

Appendix 3: Framework for Recovery Oriented Practice

Principles of Recovery Oriented Practice
Framework for Recovery Oriented Practice, (2011), Victorian Department of Health, Melbourne

Promoting a culture of hope

- Mental health services promote principles of hope, self-determination, personal agency, social inclusion and choice.
- A service environment supportive of people's recovery is one that sustains and communicates a culture of hope and optimism and actively encourages people's recovery efforts.
- The physical, social and cultural service environment inspires hope, optimism and humanistic practices for all who participate in service provision.

Promoting autonomy and self-determination

- Mental health services have a responsibility to involve people as partners in their mental health care.
- Mental health care aims to promote people's self-determination and to support people's capacity to manage their mental health.
- Lived experience and expertise is recognised, elicited and acted on in all decision-making processes.
- Every person should have access to high-quality recovery-oriented mental health care that is responsive to their particular needs.
- Recovery-oriented mental health care encourages informed risk taking2 within a safe and supportive environment.
- The safety and wellbeing of people accessing the service and their support networks is central to the provision of mental health care and the service environment is organised to ensure people's safety and optimal wellbeing.

Collaborative partnerships and meaningful engagement

- Mental health services provide personalised care through meaningful engagement and collaborative practices, ensuring that people are able to exercise optimal choice, personal agency and flexibility.
- Recovery-oriented mental health care involves working sensitively, responsively, respectfully and collaboratively with people and their support networks.
- Mental health services work constructively with people to make sense of their experiences and to find positive meaning in their personal stories.
- Mental health services work to promote people's mental health, wellbeing and recovery by establishing and sustaining collaborative partnerships with people.

Focus on strengths

- Mental health services provide personalised care through meaningful engagement and collaborative practices, ensuring that people are able to exercise optimal choice, personal agency and flexibility.
- Recovery-oriented mental health care involves working sensitively, responsively, respectfully and collaboratively with people and their support networks.
- Mental health services work constructively with people to make sense of their experiences and to find positive meaning in their personal stories.
- Mental health services work to promote people's mental health, wellbeing and recovery by establishing and sustaining collaborative partnerships with people.

Holistic and personalised care

- Mental health care is personalised and informed by people's particular circumstances, preferences, goals and needs.
- Mental health service providers understand that a range of factors impact on people's wellbeing and the corresponding need to consider people in the context of their cultural values and beliefs, social networks, family, community, housing, physical health, education and employment.
- Mental health care is responsive to the whole person and all the factors that impact on their wellbeing.
- Mental health care is relevant, appropriate and responsive to people's age and developmental stage.
- Mental health care is responsive to the range of different needs people may have, which involves effective collaboration with non-mental health service providers.

Family, carers, support people and significant others

- Family, support people and significant others have a significant and important role in supporting people's recovery.
- Mental health service providers support people to utilise and enhance their existing support networks.

Community participation and citizenship

- People with lived experience of mental illness are capable of making meaningful social contributions, regardless of the presence or absence of symptoms of mental illness.
- Positive relationships, meaningful opportunities and community engagement are important elements of recovery.
- Stigmatising attitudes towards people with lived experience of mental illness adversely impact on their mental health, recovery and wellbeing.
- Mental health services actively promote people's social and community participation.

Responsiveness to diversity

- In supporting people's recovery, high-quality mental health care is personalised, respectful, relevant and responsive to diversity including people's culture and community background, gender and sexual identity.
- Recovery-oriented mental health care considers people in the context of their identity, culture and community.

Reflection and learning

- High-quality mental health care requires ongoing critical reflection and continuous learning.
- Lived expertise based on people's experiences of mental illness and recovery is a valuable resource utilised in the delivery of high-quality mental health care.

Appendix 4: Supporting Decision Making – A Guide to supporting people with a disability to make their own decisions

Supporting decision making: A quick reference guide for disability support workers (2012)
Disability Services Division Victorian Government Department of Human Services

Seven Decision Making Principles

1) Everyone has the right to make decisions about the things that affect them.
2) Capacity to make decisions must be assumed.
3) Every effort should be made to support people to make their decisions.
4) Capacity is decision specific.
5) People have the right to learn from experience.
6) People have the right to change their minds.
7) People have the right to make decisions other might not agree with.

Appendix 5: Principles of the Carer Recognition Act 2012

Carers Recognition Action 2012

A carer should:

a) be respected and recognised:
   i. as an individual with his or her own needs; and
   ii. as a carer; and
   iii. as someone with special knowledge of the person in his or her care; and
b) be supported as an individual and as a carer, including during changes to the care relationship; and
c) be recognised for his or her efforts and dedication as a carer and for the social and economic contribution to the whole community arising from his or her role as a carer; and
d) if appropriate, have his or her views and cultural identity taken into account, together with the views, cultural identity, needs and best interests of the person for whom he or she is a carer, in matters relating to the care relationship, including when decisions are made that impact on the carer and the care relationship; and
e) have his or her social wellbeing and health recognised in matters relating to the care relationship; and
f) have the effect of his or her role as a carer on his or her participation in employment and education recognised and considered in decision making.

Principles relating to persons being cared for

A person being cared for in a care relationship should:

a) be respected, recognised and supported as an individual and as a person in a care relationship, including during changes to the care relationship; and
b) have his or her views taken into account, together with his or her needs, cultural identity and best interests, in how he or she is cared for; and
c) have his or her changing needs considered and taken into account in how he or she is cared for.

Principles relating to care relationships

A person in a care relationship should:

a) have his or her care relationship respected and honoured; and
b) if appropriate, have his or her views considered in the assessment, planning, delivery, management and review of services affecting him or her and the care relationship.

Appendix 6: Working with Nominated persons, Families and Carers; Literature Review

The reform of the *Victorian Mental Health Act 1986* sees a new legislative framework which 'promotes recovery-oriented practice; minimises the duration of compulsory treatment; safeguards the rights and dignity of people with mental illness; and enhances oversight while encouraging innovation and service improvement' (Victorian Government, 2013:1). An important goal of the new Act is to 'embed a supported decision-making framework in public mental health services' (Victorian Government, 2013:1). The principles and practices surrounding supported decision-making are particularly reflected in the Advance Statement provision of the new Victorian Mental Health Act, but for our purpose, how it also informs the Nominated person provision in the role of surrogate decision-maker/s is a an important consideration. For this review we will briefly reference a small number of documents informing Supported Decision Making.

An influential Victorian Government reference relating to supported decision is the Disability Services guides to supported decision making. Two guides were produced: one for people with a disability, and one reference guide for disability support workers (Victorian Government 2012 A and 2012 B). The guides are built around the seven decision making principles which provide a basis from which a person can consider the range of decisions and circumstance relevant to them.

Decision making and capacity

In term of the above documents the notion of capacity in relation to decision making is an important consideration in our focus on the nominated person provision:

- When we talk about a person's decision-making capacity we mean their ability to make decisions about things that affect their daily life.
- It means a person can understand a decision, the choices involved, the consequences to themselves and others and can communicate their choice.
- Some people may need help with some of these elements. This does not affect their capacity to make a decision [or be taken to mean a lack of capacity]. A person's capacity can also change over time (Victorian Government 2012 A).

The decision-making capacity of the mental health consumer as related to developing an Advance Statement is judged according to the Mental Welfare Commission for Scotland 2013 in relation to the specific decision being made and not to general capacity which is described as "not proportional to wisdom" (2013: 8). The commission sees the importance of providing guidance to capacity assessment as well as the role of the advocate.

The Respecting Patient Choices Department of Austin Health conducted a nation-wide survey of clinicians and a state-wide survey of consumers and carers regarding the use of and opinions about Psychiatric Advance Directives during 2012 and 2013. A list of recommendations was provided to the Victorian Department of Health (2014) which are relevant in the nominated person and carer provisions.

- Address capacity (perception of capacity, the fluctuating course of capacity, methods for supporting and bolstering decision making capacity in consumers, capacity and diagnosis) and the value of supported decision making (see also Ogloff – *Capacity, consent, risk & clinical decision making*).
- The need for ***consumer and family/carer education and training*** which should empower consumers to make informed decisions about who they choose to involve.
- Highlight the benefits for consumers of involving family members and other supporters and provide options and methods for achieving this.
- Discuss the purpose and benefits of Mental Health AS (MHAS) across a variety of settings and treatment needs.

- Include discussion regarding the rights of consumers, and their right to refuse (if voluntary) or disagree with treatment, as well as disseminate findings from international research that indicate that MHAS with treatment refusals are low in number.

(Victorian Department of Health 2014:2)

Nominated person provision

The most relevant literature that has informed and allows close reflection on Victoria's new Mental Health Act regarding the nominated person provision is the Mental Health (Care and Treatment) (Scotland) Act. This Act was passed by the Scottish parliament in 2003. There are some differences between the two legislations. However, the literature (information and analysis) surrounding the implementation and review of the Scottish Act and the Named Persons provision is the most relevant and available for this literature review.

The appointment of a Named Person

A study assessing the Named Person's role and its interaction with other forms of patient representation found that the taking up of the Named Person provision was around 75% of all short term detention orders and compulsory orders. However, 74% of these were 'default' Named Person (Dawson et al, 2009). The level of 'awareness' and 'uptake' in this study is similar to uptake of other psychiatric advance planning provisions (Berzins and Atkinson 2010). The 'default' clause is something unique to the Scottish Act, and requires that if the 'patient' has not nominated a Named Person then the 'primary carer' or 'nearest relative' should become the Named Person. A report from a review of the Act suggests that nearly three quarters of Named Persons were carers or nearest relatives (Limited Review of the Mental Health (Care and Treatment) (Scotland) Act 2003: Report). Therefore, 'the majority of Named Persons were likely to be carers due to few patients actively appointing a Named Person' (Dawson et al, 2009). As Victoria does not have a 'default' provision, this finding suggests that the appointment-uptake of the nominated person provision by 'patients' in Victoria will be a primary issue for mental health service both in promoting and implementing the nominated person provision with consumers.

Among the review studies there was a consensus about possible reasons for patients not actively nominating a Named Person. These included the service users' lack of knowledge, understanding and information about the role; 'information overload' at the time of acute crisis; seen as an acknowledgement that 'they will become ill again' when in recovery (Dawson et al, 2009; Berzins and Atkinson 2009, 2010).

Berzins and Atkinson's (2009) study of service users' and carers' views of the Named Person provision in part identified a lack of awareness, but also included a lack of professional support with making a nomination. Another study by Brezins and Atkinson found that for 'policy influencers' the provision required promotion and support from a professional. There is evidence from MHOs as well as review recommendations regarding integrating discussion around Named Person into standard assessment, care planning and review procedures (Brezins and Atkinson 2010; Limited Review of the Mental Health (Care and Treatment) (Scotland) Act 2003: Report). At the same time, there were concerns by Mental Health Officers (MHOs) that their involvement beyond providing written information could be perceived as a conflict of interest (Brezins and Atkinson 2010: 456). On this last point, this study suggests that for mental health professionals having responsibility for a client subject to the Act, the issues of information sharing and the level of disclosure were problematic in terms of patient confidentially and the patient/clinician relationship.

In terms of who is named as the Named Person, in a small study sample of carer views of the early implementation of the Named Person provision, a large proportion of Named Person nominates were relatives and most felt empowered in this role - although there were some important exceptions, especially when there was disagreement and relationships were endangered due to previously unknown information surfacing (Ridley, Hunter and Rosengard 2010). Brezins and Atkinson also found that not only service user, but carer interviewees supported the provision's emphasis on 'choice and the recognition that not all nearest relatives would be the most appropriate person involved' (2009: 209). Interestingly, the study also

noted that service users in some circumstances felt that not nominating a carer/family member as Named Person was a way of 'taking the pressure off them (the carer)' as well as being protective of their relationship with the carer relative. The study concluded that not all non-carer nominations are due to 'relationship break down', which in turn contrasts a different light on how 'burden' is 'usually' discussed (2009: 214).

Brezins and Atkinson's service user and carer study concluded that for service users, 'knowing their wishes' and 'being able to carry them out' were the two primary considerations in the process of nominating a Named Person. This meant that Named Persons are nominated by service users in terms of their 'closest relationships'. For some service users this meant that it was a friend rather that a relative who they 'more than likely' would discuss their feelings about care and treatment (2009: 211). When it came to service users with partners, most often their partner would be nominated as Named Person.

The role of the Named Person: issues and support

In its consultations with stakeholders, Limited Review of the Mental Health (Care and Treatment) (Scotland) Act 2003: Report identifies a number of issues in the Act relating to the Named Person role. Although there are official published booklets providing information about the Named Person role, the review found the role was not being fully understood by service users and Named Persons as well as mental health professionals. In terms of Named Persons, the difficulty to obtain practical information to understand expectations of the role was particularly highlighted (for example responsibilities, level of independence of option in term of representing the interests of the service user). It is noted in both the above review and Dawson et al (2009) that where there is overlay between different forms of patient representation, particularly regarding the Named Person role in relation to an appointed advocate, there needs to be clarification about the differences for Named Persons. Brezins and Atkinson further identified that:

> 'the potential for the Named Person to act independently from the service user was not well understood by many service users, even those that had discussed the provision at length and made nomination (2009: 213).'

All of the reviews identified the need for more direct support for Named Persons to carry out their role and the important role that MHOs can play in this. There are also recommendations for the education and training for both service users and Named Persons facilitated with the involvement of a range of community and advocacy based organisations as well as mental health service providers. The identification of the above issues and recommendations have resulted in a Code of Practice being drafted concerning patient representation which covers the Named Person provision and includes sections of best practice for MHOs (Mental Health (Care and Treatment) (Scotland) Act 2003: Code of Conduct Vol 1).

Considering the Named Person role in relation to carers, Brezins and Atkinson (2009) identified 'carrying out the service user's wishes' as a primary requirement from the service user perspective. In circumstance where carers had been formally appointed, carers reported more confidence in their decision making on behalf of their relative. According to the study, 'a key difference was that the process of becoming a Named Person had promoted discussion between the carer and the service user, allowing future wishes to be shared' (2009: 213). The study further reported that service users felt that appointing a non-carer as Named Person was not a reflection of a breakdown in family relationships, but simply that a relative may be less likely to consider their wishes. The appointment of a friend was also not seen 'as a guarantee of their wishes being carried out' (2009: 212).

Ridley, Hunter and Rosengard (2010) along with Dawson et al (2009) captured a range of carer experiences around the Named Person provision. On the positive side, carers in these studies saw the Named Person nomination affording them 'increased rights' and 'legitimised' their previous often unrecognised caring role (Ridley, Hunter and Rosengard 2010: 478). However, there were perceptions from carers that professionals

were inconsistent about informing service users and Named Persons about the Named Person role and the extent they communicated with the Named Person. Again, it was reported how the Named Person role differs from an advocacy perspective and how the degree of independence of Named Person perspective may not always be well understood by services users. This was seen by carers as an 'inherent tension in the Named Person role sometimes bring carers into conflict with their relative' (Ridley, Hunter and Rosengard 2010: 479).

Those carers who were not additionally the Named Person reported that they continued to struggle for recognition and being undervalued by mental health professionals. They reported an ongoing sense of 'exclusion' which was felt to undermine their role and effectiveness in providing direct care for their relative (Ridley, Hunter and Rosengard 2010: 479).

Information and Resources

- *The New Mental Health Act: a guide to the Named Person* 2005 (Scottish Executive)
- *The Mental Health Act – You are a Named Person: a guide supporting the role of the Named Person* – Part One 2008 (Healthier Scotland-Scottish Government)
- *Mental Health (Care and Treatment) (Scotland) Act 2003*: *Code of Practice Volume One* Chapter 6 (?)
- *Named Person – Guidance for practitioners* Mentalwelfare Commission of Scotland 2006

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