**Canberra Hospital and Health Services**

**OperationalProcedure**

**Advance Agreements, Advance Consent Directions, and Nominated Persons**

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| Purpose |

The *Mental Health Act 2015* identifies a number of ways that a person can express preferences for treatment, care or support when they have decision-making capacity in anticipation of future temporary or permanent loss of decision-making capacity. These include entering into an Advance Agreement and/or an Advance Consent Direction, and/or nominating a Nominated Person.

This procedure provides guidance to staff to assist people in making Advance Agreements, Advance Consent Directions or to nominate a Nominated Person. It also explains the rights, roles and responsibilities of staff, the person and the Nominated Person in relation to these legislated provisions under the *Mental Health Act 2015*.

This Standard Operating Procedure (SOP) describes for staff the process to

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| Scope |

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| Alerts |

Staff should always refer to the *Mental Health Act 2015* for the most definitive understanding, interpretation and explanation of the *Act* itself, particularly when making any decisions in relation to the *Act*.

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| Scope |

This procedure is relevant to all Canberra Hospital and Health Services staff involved in the treatment of people with a mental illness or disorder.

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| Section 1: Advance Agreements |

An Advance Agreement is a written document stating a person’s preferences for future mental health treatment, care or support. It is used when a person’s ability to participate in decisions about their treatment and support is significantly impaired.

The Advance Agreement includes:

* the person’s expressed preferences for treatment
* the person’s preferences for support, such as practical arrangements for looking after their property or pets, when they are in need of treatment, care or support, and
* contact details about important people such as carers, guardians, legal representatives or a Nominated Person.

The wishes expressed in a person’s Advance Agreement forms the basis of the treating team’s approach in supporting the person’s recovery, particularly during times of illness and reduced ability to communicate these wishes. They are taken into account when making decisions about treatment, care or support. The Advance Agreement will guide the treatment, care or support provided as long as it is effective and considered in their best interest at the time.

If a person’s wishes cannot be followed in accordance with their Advance Agreement (for example, if the preferred person is not available to care for the person’s property), an explanation and alternative agreement will be documented in the person’s clinical record.

## Making an Advance Agreement

* + 1. The preferences stated in the Advance Agreement are discussed and agreed between the person and those identified in their support team. These include personal, clinical (‘treating team’) and other important individuals in the person’s life. A close family member, ‘Nominated Person’ or significant other may assist the person in developing the Advance Agreement.
    2. The Advance Agreement needs to be written and signed by the person, a representative of their ‘treating team’, and their Nominated Person (if they have one). It can also be signed by someone providing practical help to the person (e.g. a carer or close friend).
    3. A copy of an Advanced Agreement must also be given to the Nominated Person, where one is identified (see section 3 of this procedure) and any member of the person’s treating team who does not have access to the person’s MHJHADS clinical record (for example, the person’s General Practitioner).
    4. Sharing an Advance Agreement with others is also the person’s choice. They are not required to provide it to anyone else if they are not comfortable. A person can also give only the relevant sections of the Advance Agreement to those individuals who might need it. For example, information can be left out about medication choices in the copy provided to the person who cares for their pets while they are in hospital.
    5. Once signed, a scanned (pdf) version must be attached in the person’s Electronic Clinical Record (ECR) and titled “**Advance Agreement**” such that the document can be easily located in the ECR and for data collection purposes. It is also highly recommended that a reference to the Advance Agreement should be made via the **ALERT** function on the ECR.

NOTE:

Staff can find copies of the Advance Agreement Form in the Electronic Clinical Record (currently MHAGIC), as well as on the Clinical Forms Register on the ACT Health Intranet and will be provided to people upon request.

## Limitations of an Advance Agreement

* + 1. Health professionals will refer to an Advance Agreement for guidance during a time of mental health crisis such as an admission to hospital. The preferences outlined in the Advance Agreement will be used to guide treatment as long as they are in the person’s best interest at the time. Refer to the Decision-making Capacity and Supported Decision Making procedure on the Policy Register for more information regarding assessment of best interests. If a person wants their preferences, which are written in the Advance Agreement, to be binding, they need to include these in an Advance Consent Direction (see section 2 of this procedure).
    2. Advance Agreements are only valid in the ACT, as they are currently not recognised in other states.
    3. Advance Agreements can only be taken into account if the information is available when needed. Therefore, it is important that an Advance Agreement is easily available for the health professionals and support people who are listed on it. A provider of treatment, care or support needs to take reasonable steps to find out if a person has an Advance Agreement. Mental Health Service clinicians will keep a summary of the Advance Agreement on a person’s electronic clinical record, which can be accessed when needed.
    4. Advance Agreements should be reviewed annually and after an episode of care where the Advance Agreement has been or could have been referenced, so that the person, their supports and the treating team can be confident that the information is useful, effective and up to date.

## Ending an Advance Agreement

A person can end an Advance Agreement at any time given they have decision-making capacity (refer to the Decision-making Capacity and Supported Decision Making procedure on the Policy Register for more information regarding decision-making capacity). A person can end an Advance Agreement by informing a member of their treating team verbally or in writing (e.g. by letter or email) that they want it to cease. A person can choose to end the Advance Agreement on that day or on a future specified date.

Additionally, a person can end an Advance Agreement by entering into a new one. If a person ends their Advance Agreement, this must be documented in their clinical record (with a file note labelled **“End of Advance Agreement”)**.The person must be informed that the end of their Advance Agreement has been entered in their clinical record file and must be provided a copy of the information entered (this must **not be the file note itself,** but a copy of the relevant information).

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| Section 2: Advance Consent Directions |

An Advance Consent Direction contains major decisions about treatment that a person consents to receiving if their mental illness or mental disorder results in them not having decision-making capacity. An Advance Consent Direction sets out information including:

* the treatment, care or support the person is willing to receive
* medications or procedures the person is willing, and not willing, to receive, and
* people who may, and may not, be given information about the person's treatment, care or support.

A person must consult with their treating team about their treatment, care or support with regards to an Advance Consent Direction.

An Advance Consent Direction can include consent for Electroconvulsive Therapy (ECT). Refer to the Electroconvulsive Therapy procedure on the Policy Register for more information.

## Making an Advance Consent Direction

To make an Advance Consent Direction a person must have decision-making capacity and have consulted with their treating team. This involves talking to them about options for treatment, care or support for their mental illness or mental disorder.

A close family member, ‘Nominated Person’ or significant other may assist the person in developing the Advance Consent Direction.

The Advance Consent Direction needs to be written down and signed by the person making the direction, a representative of their ‘treating team’, and a witness to both the person and the treating team representative. The witness must *not* be someone providing treatment to the person.

Copies of an Advance Consent Direction must be given to:

* the person making the Advance Consent Direction
* the Nominated Person (where one is identified)
* any member of the person’s treating team who does not have access to the person’s clinical record (for example, the person’s General Practitioner)
* the person’s guardian and ACAT (if the person has a guardian), and
* The person’s attorney if they have a person with power of attorney (*under the Powers of Attorney Act 2006*).

NOTE: Documenting in the Clinical Record:

Staff can find copies of the Advance Consent Direction Form in the Electronic Clinical Record (currently MHAGIC), as well as on the Clinical Forms Register on the ACT Health Intranet. This form will also be provided to people upon request.

Once signed, a scanned (pdf) version must be attached to the person’s Electronic Clinical Record (ECR) and titled “**Advance Consent Direction”** such that the document can be easily located in the ECR and for data collection purposes. It is also highly recommended that a reference to the Advance Consent Direction should be made via the **ALERT** function on the ECR.

## Limitations on Advance Consent Directions

* + 1. If a person who has an Advance Consent Direction does not have decision-making capacity and resists treatment they have previously given consent to, the treating team can only give the treatment on ACAT’s orders.
    2. *For example, Graham who has a diagnosis of severe anxiety has previously developed an Advance Consent Direction with his treating team. As part of his Advance Consent Direction he agreed to take certain medication if his anxiety worsened. His health has now deteriorated and he is refusing to take the medication. The treating team still believe that this medication is the best treatment for Graham. The team cannot give Graham this medication without applying to ACAT. If ACAT orders the medication be given, the team can administer it to Graham.*
    3. The treating team may only give different treatment to that outlined in the Advance Consent Direction if they believe the treatment, care or support, for which the person has previously given consent, is not safe or appropriate and:
* the person agrees, and
* the guardian, attorney, health attorney agree, or
* ACAT orders the treatment, care or support be given.

## Ending an Advance Consent Direction

* + 1. A person can end an Advance Consent Direction at any time if they have decision-making capacity. A person can end an Advance Consent Direction by informing a member of their treating team verbally or in writing (e.g. by letter or email). A person can choose to end the Advance Consent Direction that day or at a future specified date.
    2. A person can also end an Advance Consent Direction by entering into a new one. If a person ends their Advance Consent Direction, this must be entered into their clinical record with a file note labelled “End of Advance Consent Direction”). The person must be informed that the end of their Advance Consent Direction has been entered in their clinical record and a copy of the information is to be provided to the person (not the file note itself but the relevant information).

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| Section 3: Difference between Advance Agreements/Advance Consent Directions and Health Directions |

* 1. A Health Direction is a written statement advising of the medical treatment a person *does not* consent to being given, or the medical treatment they want withdrawn (generally or specifically) in the event they do not have decision-making capacity. Advance Agreements and Advance Consent Directions are more specifically designed to identify the mental health treatment, care or support that a person does consent to in the event they do not have decision-making capacity.
  2. Health Directions are made under the *Medical Treatment (Health Directions) Act 2006* (ACT), whereas Advance Agreements/Advance Consent Directions are made under the *Mental Health Act 2015*. If a person makes an Advance Consent Direction and then makes a Health Direction, then the Advanced Consent Direction will no longer apply to any area of treatment outlined in the Health Direction.
  3. If a person makes a Health Direction and then a guardian is appointed for that person under the *Guardianship and Management of Property Act 1991* then the guardian must make decisions that are consistent with the Health Direction. Additionally, if a person with a Health Direction has an Enduring Power of Attorney (which deals with health matters), then the Health Direction is revoked.

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| Section 4: Nominated Persons |

A Nominated Person is identified in the *Mental Health Act 2015* as someone who can help a person with a mental illness or mental disorder by ensuring the person’s interests are respected if they require mental health treatment, care or support. Nominated Persons also receive notifications and information as outlined in the *Act* and are consulted on decisions in related to the treatment, care or support provided to the person experiencing the mental illness or mental disorder. Hence, it is highly recommended that a reference to a Nominated Person should be made via the **ALERT** function on the ECR (currently MHAGIC).

A Nominated Person does *not* have the power to make treatment or other decisions on behalf of the person with a mental illness or mental disorder.

A Nominated Person can be a close relative or close friend, a carer, neighbour or any other individual. A person may also nominate another individual as an ‘alternate Nominated Person’.

A Nominated Person is not civilly liable for anything that they do (or not do) honestly (and without recklessness) in being a Nominated Person under the *Mental Health Act 2015*. This is designed to assist the Nominated Person to perform their role effectively and properly.

## Nomination criteria

* + 1. Only a person who is living with a mental illness or mental disorder can have a Nominated Person under the *Mental Health Act 2015*. They need to have the capacity to make that decision at that time.
    2. The Nominated Person must be an adult (18 years or over), be able to undertake the functions of the role, be easily available, and agree to the nomination.

## Situations in which a Nominated Person must be consulted

If the Person with a mental illness or mental disorder is receiving treatment, care or support at an approved mental health facility or community care facility, the person in charge of the facility is required to ‘take all reasonable steps’ to:

* ask the person receiving treatment, care or support whether they have a Nominated Person
* ensure that details and the written nomination of the Nominated Person are kept with the person’s records
* ensure that the currency of the nomination and Nominated Person’s details are checked periodically, and
* ensure that ACAT is given the Nominated Person’s name and contact information, if ACAT is involved in decisions about the person.

The person must also be given the opportunity and access to facilities, such as a telephone, to contact their Nominated Person (along with other people e.g. a carer, family, lawyer etc).

There are a range of situations where the Nominated Person must be consulted by various parties, including:

* ACAT, before they make a Mental Health Order.
* The Chief Psychiatrist (or their delegate) before deciding to treat the person with a mental illness or mental disorder under a psychiatric treatment order.
* The Chief Psychiatrist (or their delegate) if they form the belief that the person with a mental illness or mental disorder should no longer be subject to a psychiatric treatment order.
* The Care Coordinator (or their delegate) before making a decision when and where a person is required to attend to receive treatment, care or support under a community care order (or a restriction order).
* The Chief Psychiatrist (or their delegate) must, as soon as possible after authorising the involuntary detention of a person, take all reasonable steps to give required information about the detention to the Nominated Person.
* A Nominated Person may appear and give evidence at the hearing or a proceeding in ACAT or the Supreme Court regarding the person who nominated them.

## Ending a nomination

The Nomination can be ended in the following three ways:

1. The person who made the nomination has decision-making capacity and tells a member of their treating team, orally or in writing, that they no longer want the Nominated Person to perform the functions of a Nominated Person for them
2. The Nominated Person informs a member of the person’s treating team, verbally or in writing, that they are unable to perform the functions of a Nominated Person, and
3. The Chief Psychiatrist decides on reasonable grounds that the Nominated Person is unable to perform the functions of a Nominated Person.

The member of the person’s treating team who is told about a nomination ending is obliged to ensure that:

* as soon as practicable, information about the end of the nomination is entered in the person’s clinical record by writing a note titled **“End of Nomination for (insert Nominated Person’s name) ”**;
* the person is told that the information has been entered in their clinical record; and
* the person is given a copy of the information entered in their record (not the file note itself but just the relevant information).

If the Chief Psychiatrist ends the person’s nomination they must advise the person who made the nomination, the Nominated Person and a member of the person’s treating team and record their reasons for doing so. They must also advise the person about advocacy services and, if the person has decision-making capacity, ask if there is another person they wish to nominate.

Regardless of who ends the nomination, it ceases effect on the day the verbal or written notice is given, or at a later date if specified in writing.

## The difference between an Enduring Power of Attorney and a Nominated Person

A person with enduring power of attorney can make decisions about a wide range of matters, which must be specified in the written document appointing them. This can include decisions about a person’s finances and property, as well as their treatment. The Enduring Power of Attorney can make these decisions when the person does not have capacity to do so themselves.

In contrast, a Nominated Person is more specifically consulted on decisions and involved in support for a person. In a general, a Nominated Person advocates for an individual by taking into account the person's wishes at a particular time, even if it differs to what the person would want when they don't have decision-making capacity.

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| Related Policies, Procedures, Guidelines and Legislation |

## Policies

* Consent to Treatment Policy
* Confidentiality, Privacy and access to MHJHADS Clinical Records
* Mental Health Officer Procedure
* Collaborative Planning
* Clinical Management in Mental Health Services
* Clinical Management of a Deteriorating Community-Based Mental Health Consumer

## Legislation

* *Mental Health Act 2015*
* *Children and Young People Act 2008*
* *Public Advocate Act 2005*
* *Human Rights Act 2004*
* *Carers Recognition Act 2010*
* *Health Records (Privacy & Access) Act 1997*

**Standards**

* Australian Charter of Healthcare Rights
* [National Standards for Mental Health Services 2010](http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-servst10)
* National Safety and Quality Health Service Standards 2012

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| Search Terms |

Advance Agreement, Advance Consent Direction, Consent, Nominated Person, Nomination, Information sharing, ECT, Electroconvulsive Therapy

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