

Mental Health Act 2016

Chief Psychiatrist Policy

Treatment criteria, assessment of capacity, less restrictive way and advance health directives

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General

If a person is not able to consent to treatment of their mental illness, an authorised doctor may make a Treatment Authority to authorise involuntary treatment for the person, if:

- the treatment criteria apply to the person, and
- there is no less restrictive way for the person to receive treatment and care for their mental illness.

The person's views, wishes and preferences **must** be considered.

Scope

This policy is mandatory for all authorised mental health services (AMHSs). An authorised doctor, authorised mental health practitioner (AMHP), AMHS administrator, or other person performing a function or exercising a power under *Mental Health Act 2016* (the Act) **must** comply with this policy.

This policy only applies in circumstances where a health practitioner assesses that a person does not have capacity to make decisions about their own healthcare.

This policy **does not** apply to persons on a Forensic Order (Mental Health) or a Treatment Support Order. However, this policy applies to persons on a Forensic Order (Disability) who require treatment for a mental illness.

Clinicians should work collaboratively with and in partnership with patients to ensure their unique age-related, cultural and spiritual, gender-related, religious and communication needs are recognised, respected and followed to the greatest extent practicable. Clinicians should consider the timely involvement of appropriate local supports and provide treatment and care with a recovery-oriented focus.

This policy **must** be implemented in a way that is consistent with the objects and principles of the Act.

Policy

1 Treatment criteria

The Act clearly defines the treatment criteria which form the basis for a person being placed on a Treatment Authority. An authorised doctor can only make a Treatment Authority if satisfied that:

- the treatment criteria apply to the person, and
- there is no less restrictive way for the person to receive treatment and care for the mental illness.

Key points

The treatment criteria for a person are the following:

- The person has a mental illness, and
- The person does not have capacity to give or withhold consent to be treated for the illness, and
- because of the person's illness, the absence of involuntary treatment, or the absence of continued involuntary treatment, is likely to result in:
 - imminent serious harm to the person or others, or
 - the person suffering serious mental or physical deterioration.

All criteria **must** be fully met for a person to be placed on a Treatment Authority.

1.1 Presence of a mental illness

A comprehensive mental health assessment will involve a clinical assessment and information gathering across a number of areas, including presenting problems, current functioning, medical, family, developmental history, cultural background, health related history and forensic and legal history.

The unique cultural, communication and other needs of Aboriginal and Torres Strait Islander peoples and those from a culturally and linguistically diverse background **must** always be recognised and taken into account.

A mental state examination **must** also be conducted. The Act provides a clear definition of mental illness, including examples of matters that do not indicate the presence of a mental illness.

Key points

Mental Illness (section 10).

Mental illness is a condition characterised by a clinically significant disturbance of thought, mood, perception or memory.

However, a person must not be considered to have a mental illness merely because:

- the person holds or refuses to hold a particular religious, cultural, philosophical or political belief or opinion; or
- the person is a member of a particular racial group; or
- the person has a particular economic or social status; or
- the person has a particular sexual preference or sexual orientation; or
- the person engages in sexual promiscuity; or
- the person engages in immoral or indecent conduct; or
- the person takes drugs or alcohol; or

- the person has an intellectual disability; or
- the person engages in antisocial behaviour or illegal behaviour; or
- the person is or has been involved in family conflict; or
- the person has previously been treated for a mental illness or been subject to involuntary assessment or treatment.

A decision that a person has a mental illness **must** be made in accordance with internationally accepted medical standards.

Collateral information forms a crucial component of the assessment and should be sought where available and appropriate from relevant others, including carers, family members and other health professionals and relevant documents such as the person's medical record.

The clinical formulation, an essential component of mental health assessment, **must** be clearly documented, along with the assessment in the patient's health record.

Outcomes and decisions arising from assessment **must** be communicated with the person and their relevant support persons.

1.2 Assessment of capacity to consent to be treated

The Act requires that clinicians presume that a person has capacity to give or withhold informed consent to treatment.

A clinician **must** seek the informed consent of the person before administering treatment for a mental illness.

An Independent Patient Rights Adviser should also be involved where possible to enable independent provision of advice to the patient in relation to their rights and assist the person with informed decision making.

The principles of supported decision-making apply to assessing capacity, i.e. the person is taken to have capacity to make decisions if the person has capacity with the assistance of someone else. Further information on supported decision making can be found in the [Less Restrictive Way Guidelines](#).

The presumption of capacity can be rebutted, under the test provided in the Act, if it is shown that the person does not have capacity to give informed consent at the time the treatment decision needs to be made.

See Assessment of capacity and less restrictive way flowchart for more information.

Key points

Capacity to consent to be treated (s14, the Act)

The Act provides the following test for capacity, outlining all of the elements that must be addressed in a capacity assessment.

A person has capacity to consent to be treated if the person:

- is capable of understanding in general terms:
 - that the person has a mental illness, or symptoms of an illness, that affects mental health and wellbeing, and
 - the nature and purpose of the treatment for the illness, and
 - the benefits and risks of the treatment and alternatives, and
 - the consequences of not receiving treatment, and
- is capable of making a decision and communicating it in some way.

A person may have capacity to consent to be treated even though the person decides not to receive treatment.

A person may be supported or assisted by another person to have capacity.

This section does not affect the common law in relation to:

- the capacity of a minor to consent to be treated, or
- a parent of a minor consenting to treatment of the minor.

Clinicians **must** be aware that capacity is specific to the decision that needs to be made at the time (e.g. a person's capacity to consent to treatment is distinct from their capacity in relation to managing their finances).

Support **must** be provided to assist the person in making decisions about their treatment, as far as practicable. This includes providing the person and their support person/s with all relevant information (e.g. clinical formulation, nature of treatment proposed, options for less restrictive forms of treatment, etc.). Information **must** be provided in a format that best assists the person to understand including the use of interpreters, visual aids, simple language, etc.

Clinicians **must** ensure the person has been given:

- a reasonable period of time and opportunity to:
 - consider matters involved in the decision,
 - discuss the decision with the health practitioner,
 - to seek advice, support and assistance, and
 - adequate information on the treatment, alternatives, advantages, disadvantages, and beneficial alternative treatments.

A person **must** be provided the opportunity to provide consent at a time, and in a place, that best supports the person's decision-making.

For example, while a busy emergency department during a crisis presentation might be the necessary setting for immediate decisions about acute treatment, it may not be the most desirable timing or location to make an assessment on the person's capacity to consent to subacute or longer-term treatment. These decisions might best be re-assessed in the days following an acute presentation.

1.2.1 Fluctuating capacity

Clinicians **must** be aware that a person's capacity to make treatment decisions can fluctuate over time.

Cross-sectional assessments may not accurately reflect a person's capacity beyond that point in time. Accordingly, capacity assessments must be conducted across a number of examinations to facilitate stability in the clinical opinion.

Notwithstanding the need for a longitudinal view of capacity, decisions under the Act relating to capacity **must** be made on the basis of the assessment at the time of the decision. The only exception to this is where an authorised doctor is considering revoking a Treatment Authority (see section 1.4).

1.2.2 Withholding consent

Clinicians **must** be aware that not consenting to treatment does not necessarily imply a lack of capacity. A person may have capacity to make a decision about treatment but still not consent to it.

While this may result in risks for the person (including clinical risks) if the person has capacity to consent to be treated, the treatment criteria **do not** apply.

Clinicians **must** be aware that a person who meets the treatment criteria for harm can receive treatment as a voluntary patient if the person has capacity to consent to treatment.

Clinicians **must** always consider a person's views, wishes and preferences, including any that might have been formally expressed in an advance health directive (AHD) or in an informal way to treating teams.

Clinicians **must** always consider the views of families, carers, and other support persons.

Clinicians should be cautious of basing an assessment of capacity on 'implied consent'. A person may imply consent by actions such as accepting a tablet into a hand, however, there are limits to implied consent and it should not be relied on as informed consent.

Informed consent **must** be freely given. A clinician **must** not pressure a person to give consent.

At times a person may lack capacity but not meet any of the other criteria for involuntary treatment. In these circumstances, even though the person may be impaired in many aspects of their functioning, there may still be insufficient grounds to make a Treatment Authority. Alternatives to providing treatment should be explored in these circumstances, including for example the involvement of the Public Guardian.

1.3 Risk assessment

In order for the treatment criteria to be met, the Act requires that:

- because of the person's illness, the absence of involuntary treatment, or the absence of continued involuntary treatment, is likely to result in:
 - imminent serious harm to the person or others, or
 - the person suffering serious mental or physical deterioration.

In practice this is ascertained by a risk assessment. Clinicians should be aware that that even where a person has a mental illness and lacks capacity to consent to treatment, if the criteria for harm are not met then the treatment criteria are not met.

Harm is not limited to physical injury or deterioration in physical health. Clinicians should consider mental health, as well as adverse financial or social impacts, particularly where these are of a significant nature.

Key points

In regard to risk assessment clinicians must:

- assess whether due to the mental illness, the absence of involuntary treatment is likely to result in harm to the person or someone else, or a deterioration of the person's physical or mental health,
- be satisfied that the risk is imminent and results from the patient's mental illness,
- clearly document the risk of harm, how this is attributed to the patient's illness, and the basis for the view that the risk of harm is imminent,
- assess if serious mental or physical deterioration is 'likely' in the absence of treatment, and
- clearly document the basis for decisions, including, for example, the nature and course of the illness and the patient's clinical history.

1.4 Regular assessment and revocation of Treatment Authorities

The following requirements relate to regular assessment of a Treatment Authority once confirmed by an authorised psychiatrist. Refer to the [Chief Psychiatrist Policy Treatment Authorities](#) for more information on assessments for the purpose of making or revoking a Treatment Authority.

Key points

Authorised doctors must:

- undertake regular assessments, at least every three (3) months, to determine if the treatment criteria still apply and a Treatment Authority should continue.
- assess a person if at any time it appears that the treatment criteria no longer apply or there may be a less restrictive way of treatment.

After an assessment, an authorised doctor must revoke a Treatment Authority if the treatment criteria no longer apply or there is a less restrictive way to provide treatment.

- If the authorised doctor is not a psychiatrist, the doctor must consult with an authorised psychiatrist before revoking an authority.

The only exception to this is if a person's capacity is not stable. To avoid a person with fluctuating capacity 'cycling' on and off Treatment Authorities, they may remain on a Treatment Authority until their capacity becomes stable. It is intended that this would apply over a relatively short period of time.

In determining whether capacity is stable, the authorised doctor **must** consider the nature of the mental illness and the functional approach to the capacity assessment.

- Where the person has an established mental illness, and the findings of mental state examinations are consistent over time, repeated capacity assessments **must** show consistent outcomes (i.e. that the person has capacity at each assessment, to establish that their capacity is stable).
- For example, most clinical circumstances would require a minimum of two capacity assessments over a period of up to 3-4 weeks. However, this does not prevent a stable capacity assessment being made in a shorter timeframe if the clinical circumstances warrant it.

See [Chief Psychiatrist Policy – Treatment Authorities](#) for more information.

2 Less restrictive way

Treating a person voluntarily with their own consent is the least restrictive form of health care. Where persons lack capacity to make decisions about their own health care, alternative mechanisms are needed to obtain consent to health care.

A Treatment Authority cannot be made for a person if there is a less restrictive way for the person to receive treatment and care for the person's mental illness.

The Act defines the 'less restrictive way' as alternatives to consent that facilitate treatment and care of persons other than under the Act. Specifically, the Act requires that consideration be given to the following mechanisms, to facilitate treatment and care that is reasonably necessary for the person's mental illness:

- if the person is a minor—with the consent of the minor's parent,
- if the person has made an advance health directive—under the advance health directive,
- if a personal guardian has been appointed for the person—with the consent of the personal guardian,
- if an attorney has been appointed by the person—with the consent of the attorney,
- otherwise—with the consent of the person's statutory health attorney (limitations apply, see section 2.5.2).

The above are listed in the order of priority. If more than one of the above apply, the person is to be treated in accordance with the first of the listed order.

This ordered approach is supported by the *Powers of Attorney Act 1998* and the *Guardianship and Administration Act 2000* which outline a hierarchy of consent arrangements if a person does not have capacity to consent to health care at the relevant time.

- Under an advance health directive (AHD), a person may consent to future health care and/or appoint an 'attorney' to consent to the person's health care if the person does not have capacity at a future time. A person may also express their views, wishes and preferences in the way health care is to be provided in an AHD.
- Alternatively, a person may appoint an attorney under an Enduring Power of Attorney (EPOA) to consent to personal matters, such as future health care, if the person does not have capacity at a future time.
- The Queensland Civil and Administrative Tribunal (QCAT) may appoint a 'guardian' to consent to the person's future health care if the person does not have capacity to make health care decisions. (Under the *Mental Health Act 2016*, a guardian is referred to as a 'personal guardian' to distinguish them from parental guardians).
- If none of the above apply, a statutory health attorney (for example, a spouse) can consent to a person's health care if the person does not have capacity (limitations apply, see section 2.5.2).

The requirement to treat a person in a less restrictive way is subject to this policy, which outlines circumstances where the requirement does not apply (see section 2.5).

See [Guideline to Advance Health Directives, Enduring Powers of Attorney, Guardians and Administrators](#) for more information.

2.1 Obligations of health practitioners

A health practitioner **must**, to the greatest extent possible, follow an AHD if it is consistent with appropriate and safe clinical practice.

- If some elements of an AHD cannot be followed, this does not remove the obligation of a practitioner to consider other elements of the directive.

A health practitioner **must**:

- always make treatment decisions which aim to benefit a person's health and wellbeing. In making treating decisions health practitioners need to consider a person's views, wishes and preferences.
- minimise any adverse impacts on the person's rights and liberties.
- not be unduly influenced by an attorney or guardian to treat a person in a way that is contrary to good clinical practice.

Treating a person under an AHD, or with the consent of an attorney or guardian, does not affect a health practitioner's clinical, ethical, and legal obligations to the person in any way.

If there is a disagreement between a treating practitioner and a support person or the patient (when the person has recovered) over a health practitioner not following an AHD, a Clinical Director should be asked to assist in relation to any clinical matters.

An Independent Patient Rights Adviser should also be informed in these circumstances to enable independent provision of advice to the patient in relation to their rights.

2.2 Requirement to consider a less restrictive way of treatment

2.2.1 If the person is a minor and does not have capacity due to a mental illness

If the person is a minor (under 18 years of age), the doctor or AMHP **must** seek the consent of the minor's parent for treatment if the parent is reasonably available. This would apply, for example, if a minor was brought into hospital by concerned parents. For the purposes of the Act, a parent includes:

- a guardian of the minor (under the [Child Protection Act 1999](#))
- a person who exercises parental responsibility for the minor, other than on a temporary basis (e.g. child minding)
- for an Aboriginal minor – a person who, under Aboriginal tradition, is regarded as a parent of the minor, and
- for a Torres Strait Islander minor – a person who, under Island custom, is regarded as a parent of the minor.

See [Chief Psychiatrist Policy – Treatment and Care of Minors](#) for more information.

2.2.2 If the person has made an AHD, appointed an attorney, or has a personal guardian

Key points

A doctor or AMHP **must** take reasonable steps to find out if the person has made an AHD, appointed an attorney or has a guardian for healthcare appointed.

The doctor or AMHP **must** search the person's health records on the Consumer Integrated Mental Health Application (CIMHA).

The doctor or AMHP **must** also ask any support persons who are with the person whether the person has made an AHD, appointed an attorney, or has a guardian for healthcare appointed.

- The Act authorises QCAT to disclose the name and contact details of a personal guardian.

If an AHD has been made giving consent to health care, the doctor or AMHP **must** decide if the person's treatment and care needs can be reasonably met by the consent stated in the directive.

If an attorney has been appointed under an AHD, the attorney's consent to treatment **must** be sought if the directions are inadequate or if the AHD only appoints an attorney and does not provide any directions.

If an attorney is appointed under an Enduring Power of Attorney (EPOA) or a guardian for healthcare has been appointed, the attorney or guardian's consent to treatment **must** be sought.

2.2.3 Statutory health attorney

If a person is accompanied by a support person, the doctor or AMHP may ask the person if their relationship with the person enables him or her to act as a statutory health attorney for the person (see [Guide to advance health directives, enduring powers of attorney, guardians and administrators](#)).

A statutory health attorney can only make decisions for a person without capacity if the person does not have an AHD, or a personal guardian or attorney for the relevant matters. Limitations apply for treatment with consent of a statutory health attorney – see section 2.5.2.

2.2.4 If a less restrictive way becomes available at a future time

The requirements under the Act, and in this policy, to treat a person in a less restrictive way have ongoing application.

For example, if a Treatment Authority was initially made for a person, but an attorney becomes available at the health service at a later time, an authorised doctor **must** ask the attorney if they will consent to the person's treatment and care.

2.3 Use of physical restraint in providing treatment and care

The use of physical restraint to provide treatment to a person **must** only occur if less restrictive options are not possible. Where physical restraint is used in providing health care, it **must** be the minimum force necessary in the circumstances.

See [Chief Psychiatrist Policy – Physical Restraint](#) for further detail.

Seclusion and mechanical restraint are specifically regulated under the Act and **cannot** be authorised under an AHD or with the consent of a guardian, attorney or, if the person is a minor, the consent of the minor's parents.

See [Chief Psychiatrist Policy – Seclusion](#) and [Chief Psychiatrist Policy – Mechanical Restraint](#).

2.4 Treatment as an inpatient

An authorised doctor should only treat a person as an inpatient if satisfied it is necessary for the person's health, well-being and safety, and only for as long as is necessary.

Health care planning for a person who is an inpatient should plan for the person's return to the community as soon as practicable.

Key points

The Act requires that a person under a Treatment Authority **must** be placed on a community category unless the person's treatment and care needs cannot be met that way.

- This principle also applies to a person being treated under an AHD, or with the consent of an attorney or guardian.

A person may be treated as an inpatient if:

- the person is an inpatient on a Treatment Authority under the Act
- an AHD expressly consents to being treated as an inpatient
- an attorney appointed by the person or a guardian for healthcare expressly consents to the person being treated as an inpatient, or
- a person requests they remain as an inpatient when they are admitted to hospital, if the person is concerned that their condition may deteriorate and that being treated this way would be beneficial for their own safety and well-being.
- With the consent of a statutory health attorney (limitations apply - see s2.5.2 inpatient with the consent of a statutory health attorney).

2.5 When requirement to treat in a less restrictive way does not apply

2.5.1 Inpatient under an advance health directive or with the consent of an attorney or guardian

Key points

If a person is an inpatient under an AHD or with the consent of an attorney or guardian for **fourteen (14) days** or more, the treatment and care of the person must be reviewed by a Clinical Director at or around **fourteen (14) days** after admission.

- The Clinical Director may determine if the person should remain as an inpatient or if treatment in the community would be more appropriate.

If the person is to remain an inpatient, the authorised doctor also needs to decide the mechanisms for the person's ongoing treatment.

If the criteria for treating the person under an AHD or with the consent of an attorney or guardian and the criteria for treating the person under a Treatment Authority both apply, then the authorised doctor may make a choice as to which of these mechanisms to use, having regard to:

- The person's treatment needs, and
- The person's views, wishes and preferences

If the person continues to be treated as an inpatient under an AHD or with the consent of an attorney or guardian, the authorised doctor should set a further review time to reconsider the mechanisms to use, having regard to the person's circumstances.

2.5.2 Inpatient with consent of a statutory health attorney

A statutory health attorney is not appointed by the person. Therefore, consideration should be given to treating the person as an inpatient under a Treatment Authority and the extensive oversight and protections afforded by the Act, rather than providing inpatient treatment and care with consent of a statutory health attorney. The decision to treat a patient under a Treatment Authority or with the consent of a statutory health attorney in these circumstances should be made on a case-by-case basis.

In making this decision, the authorised doctor must have regard to:

- the person's treatment needs, and
- the person's views, wishes and preferences.

If the person is to be treated as an inpatient with consent of a statutory health attorney, the authorised doctor should ensure frequent review of this arrangement to reconsider the mechanisms to use, having regard to the person's circumstances.

As a minimum, the treatment and care of the person **must** be reviewed by a Clinical Director at or around **fourteen (14) days** after admission. The Clinical Director may determine if the person should remain as an inpatient or if treatment in the community would be more appropriate. A decision about further review timeframe must also be made.

2.6 Ongoing lack of capacity

Situations may arise where a person lacks capacity in an ongoing way. This may apply if the person is being treated under a Treatment Authority, AHD or with the consent of an attorney.

Where this applies, an authorised doctor **must** contact the Office of the Public Guardian to consider whether guardianship arrangements are appropriate for the person.

2.7 Making of an AHD for future health care

Where a person with a mental illness is being discharged from hospital, health service staff are to inform the person of the options to make an AHD or an EPOA for their future health care.

This is also one of the functions of Independent Patient Rights Advisers under the Act.

2.8 Urgent health care

The less restrictive way provisions do not affect the legal authority to treat a person in urgent circumstances without consent under section 63 of the *Guardianship and Administration Act 2000* (Urgent health care).

Consent of an attorney appointed under an AHD or EPOA, or a guardian for healthcare, is not required in urgent circumstances if the attorney or guardian is not available.

3 Records

The Act requires the Chief Psychiatrist to establish and maintain a record system for AHD and EPOAs related to a person's future treatment and care for a mental illness.

This system is established on the Consumer Integrated Mental Health Application (CIMHA).

A person may request an administrator to keep a copy of an AHD or an EPOA related to the future treatment and care for a mental illness on CIMHA.

This applies whether or not the AHD or EPOA deals with other health care. The administrator **must** comply with the request.

CIMHA should also record the appointment of a guardian for a person who has the authority to consent to healthcare.

Refer to the [Mental Health Act 2016 website](#) under 'Treatment and care' for AHD information and templates for consumers.

3.1 Recording of consent

An authorised doctor **must** record in the person's health records (i.e. CIMHA) the fact that a person is being treated under an AHD or with the consent of an attorney or guardian.

Issued under section 305 of the *Mental Health Act 2016*.

Dr John Reilly

Chief Psychiatrist, Queensland Health

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Definitions and abbreviations

Term	Definition
AHD	Advance health directive
AMHP	Authorised mental health practitioner
AMHS	Authorised Mental Health Service – a health service, or part of a health service, declared by the Chief Psychiatrist to be an authorised mental health service. AMHSs include both public and private sector health services. While treatment and care is provided to both voluntary and involuntary patients, additional regulation applies under the Act for persons subject to involuntary treatment and care.
CIMHA	Consumer Integrated Mental Health Application – the statewide mental health database which is the designated patient record for the purposes of the Act.
Clinical Director	Senior authorised psychiatrist who has been nominated by the administrator of the AMHS to fulfil the clinical director functions and responsibilities.
EPOA	Enduring power of attorney
Patient	An involuntary patient, or A person receiving treatment and care for a mental illness in an AMHS, other than as an involuntary patient, including a person receiving treatment and care under and advance health directive or with the consent of a personal guardian or attorney.

Referenced documents and sources

[Chief Psychiatrist Policy – Treatment Authorities.](#)

[Chief Psychiatrist Policy – Child and Youth: Treatment and Care of Minors](#)

[Chief Psychiatrist Policy – Physical Restraint](#)

[Chief Psychiatrist Policy – Seclusion](#)

[Chief Psychiatrist Policy – Mechanical Restraint](#)

[Less restrictive way guidelines](#)

[Guide to advance health directives, enduring powers of attorney, guardians and administrators](#)

[Flowchart – Assessment of capacity and less restrictive way flowchart](#)

[Child Protection Act 1999](#)

[Guardianship and Administration Act 2000](#)

[Guardianship and Administration Act 2000](#)

[Mental Health Act 2016](#)

[Powers of Attorney Act 1998](#)

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Attachment 1 – Key contacts

Key contacts

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