Queensland Government

Mental Health Act 2016

Treatment Authority

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

Mental Health Act (MHA) 2016, Sections 12–14, 48–58

- A treatment authority allows for the involuntary treatment of a person for a mental illness.
- A treatment authority is made by an authorised doctor. If the authorised doctor is not a psychiatrist, the making of the treatment authority must be reviewed by an authorised psychiatrist.

PART A

1. Person's details

- Not required if label affixed in top right corner.

Surname:	Given name(s):
Residential address:	
Town / Suburb:	State: Postcode:
Date of birth: Age: or	Sex: ☐ Male ☐ Female ☐ Intersex / Indeterminate ☐ Not stated / unknown

2. Reasons for making a treatment authority

- Provide the reasons that you believe the treatment criteria apply and there is no less restrictive way for the person to receive treatment and care.

The reasons you believe the person has a mental illness, including diagnosis:

The reasons you believe the person does not have capacity to consent to be treated for the illness:

DO NOT WRITE IN THIS BINDING MARGIN

TREATMENT AUTHORITY

v1.00 - 01/2017

SW721

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The reasons you believe that not providing involuntary treatment for the illness may result in:
i. imminent serious harm to the person or others; or
ii. the person suffering serious mental or physical deterioration

The reasons you believe that there is no less restrictive way for the person to receive treatment and care for the person's mental illness:

DO NOT WRITE IN THIS BINDING MARGIN

3. Treating AMHS

Name of authorised mental health service (AMHS):

4. Category of treatment authority

- The category may only be inpatient if one or more of the following cannot reasonably be met under a community category:
  - the person's treatment and care needs
  - the safety and welfare of the person
  - the safety of others.

Treatment authority category: ☐ Inpatient ☐ Community

5. Limited community treatment (LCT)

- A single episode of LCT cannot be more than 7 consecutive days.
- 'Escorted' means the patient must remain with a designated health service employee at all times while on leave.
- 'Supervised' means the patient must be in the company of a person approved by the authorising doctor while on leave. The approved person must be specified on the form.
- All LCT types that are authorised must be provided on this form.

Is LCT authorised? ☐ Yes (complete details below) ☐ No

Duration of authorisation (inclusive)	Start date:	End date:

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LCT authorised (more than one type can be authorised)		Conditions / Details associated with authorised level of LCT (include timeframes / hours)
ON GROUNDS	☐ Escorted	
	☐ Supervised	
	☐ Unescorted and unsupervised	
OFF GROUNDS	☐ Escorted	
	☐ Supervised	
	☐ Unescorted and unsupervised	
OVERNIGHT	☐ Supervised	
	☐ Unescorted and unsupervised	

Requirements before LCT is accessed:

☐ Access to LCT is subject to a health practitioner assessment that LCT is appropriate having regard to the patient's mental state

☐ LCT conditions and consequences of non-compliance to be discussed with the patient prior to accessing LCT

☐ Other - specify:

Actions to be taken if LCT conditions not adhered to:

6. Conditions of treatment authority

Is this treatment authority subject to any conditions? ☐ Yes (specify below) ☐ No

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Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

7. Declaration

I have assessed the person and I am 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.

Name:	Designation: ☐ Authorised doctor ☐ Authorised psychiatrist
Address:	
Town / Suburb:	Postcode:

Signature:	Contact number:	Date:	Time (24hr):

TO: AMHS Administrator
Mental Health Review Tribunal (if declaration is made by an authorised psychiatrist)

PART B: Review by authorised psychiatrist (if treatment authority was not made by authorised psychiatrist)

8. Authorised psychiatrist review

• If the treatment authority is confirmed, any amendments to the category, conditions or limited community treatment must be recorded on an *Order / Authority Amendment* form.

Date and time examination by authorised psychiatrist commenced:	Date:	Time (24hr):

The treatment authority is:
☐ Confirmed without amendment ☐ Confirmed with amendment ☐ Revoked *(provide reasons)*

Reasons for revocation:

9. Authorised psychiatrist details

Name:	Designation:
Address:	
Town / Suburb:	Postcode:

Signature:	Contact number:	Date:	Time (24hr):

TO: AMHS Administrator
Mental Health Review Tribunal

DO NOT WRITE IN THIS BINDING MARGIN