

# Less Restrictive Way Guidelines

## Table of Contents

1.	Introduction .....	3
2.	Less Restrictive Way.....	4
3.	Capacity.....	4
3.1	Meaning of capacity to consent to be treated.....	4
3.2	Capacity assessment.....	5
3.3	Capacity assessment and children/young people .....	6
3.4	Enhancing capacity .....	7
3.5	Fluctuating capacity .....	10
3.6	Residual capacity .....	10
3.7	Reviewing capacity .....	11
3.8	Documenting capacity .....	11
4.	Identifying and Recording Decision Makers .....	12
4.1	Substitute decision makers.....	13
4.2	Recording persons who may give consent (substitute decision makers).....	15
4.3	Recording when a substitute decision maker is consenting .....	17
5.	Consent to Treatment .....	18
5.1	How can I best obtain informed consent in mental health services? .....	18
5.2	Can consent be given for restrictive practices such as physical restraint, acute sedation and seclusion? .....	20
5.3	What if the consent for treatment is refused or withdrawn?.....	21
5.4	Where do I record consent?.....	21
6.	Providing Mental Health Treatment and Care with the consent of a substitute decision maker .....	22
6.1	Reviews when consent is provided by a substitute decision maker.....	23
6.2	Treatment in the community .....	25
6.3	Treatment in an inpatient unit .....	26
6.4	When the AHD is not adequate to provide consent.....	27
6.5	Risk and safety .....	27
6.6	Disputes about decisions.....	27
6.7	Leave from the inpatient unit.....	28
6.8	Use of AHD for a person on a Forensic Order, Treatment Support Order or Classified Patient.....	29
6.9	Forensic Order - Disability .....	30
7.	Less Restrictive Way and mental health planning .....	30
7.1	Tools supporting the use of the Advance Health Directive .....	31
7.2	Effective care planning documentation and less restrictive way.....	32
8.	Resources.....	34
8.1	Advance Health Directives & Advance Care Planning .....	34
8.2	Capacity .....	35
8.3	Consent.....	35
8.4	Documentation .....	36
8.5	Supported Decision Making.....	36
8.6	Substitute Decision Makers .....	36
8.7	Treatment and Care (including less restrictive way).....	37
8.8	Restrictive Practice.....	38
8.9	Support and safeguards to less restrictive way .....	38
8.10	Educational resources .....	38
8.11	Legislation and Standards .....	39
8.12	Telehealth.....	39

9.	Appendices .....	39
9.1	Appendix A: Decision making pathway – adults.....	40
9.2	Appendix B: Decision making pathway – child and youth .....	42
9.3	Appendix C: Capacity Assessment for Mental Health Treatment – Adults Form and Guide for Use 43	
9.4	Appendix D: Capacity Assessment for Mental Health Treatment – Child and Youth Form and Guide for Use.....	50
9.5	Appendix E: Decision Maker Information Checklist (Child and Youth) and Guide for Use.....	57
9.6	Appendix F: Physical Restraint Information Sheet – Adults .....	62
9.7	Appendix G: Physical Restraint Information Sheet – CYMHS .....	64
9.8	Appendix H: Acute Sedation Information Sheet - Adults .....	66
9.9	Appendix I: Acute Sedation Information Sheet – CYMHS .....	67
9.10	Appendix J: Definitions of supports for decision making in mental health.....	69
9.11	Videoconferencing.....	71
10.	FURTHER READING.....	72

# 1. Introduction

The *Mental Health Act 2016* (MHA2016) promotes the use of a 'less restrictive way' for a person to receive treatment and care for mental illness. That is, where a person lacks capacity to consent to mental health treatment, consideration needs to be given to the identification of the alternatives to gain consent that will have the least impact on a person's autonomy and rights.

These guidelines were developed to assist clinicians to understand the meaning, and use, of less restrictive way. They aim to link resources that can inform good practice, and address some of the practical issues experienced by clinicians in supporting less restrictive options. Using examples and suggestions, they may be used to inform decision making, local protocols, documentation practices, and education. Throughout these guidelines, explanatory resources and references are provided. These guidelines are intended to help clinicians to access existing resources when confronted with different challenges, or to further develop skills and knowledge. All links are provided in the Resources section of these guidelines.

Least restrictive way enhances and upholds the rights of people with mental illness. Much of what less restrictive way promotes is not new; it is just being highlighted in the mental health context in legislation.

Substituted decision making is an essential part of less restrictive way. The introduction of the Advance Health Directive – Mental Health (AHD-MH) means that people with mental illness can have more of a voice at times when they lose capacity. These guidelines can assist clinicians in recognising and supporting the use of Advance Health Directives (AHD) in care and to navigate the decisions that occur in care under any substitute decision maker. This document does not provide guidance in helping a person develop an AHD, as there already exists a range of resources to help. Clinicians are encouraged to explore the tools and information provided under AHDs in the Resources in this guideline to assist with the development of an AHD.

The term 'restrictive practices' is commonly used in mental health but is different to the less restrictive way defined under the MHA2016. These guidelines are not focused on the reduction and elimination of restrictive practices that are used under the MHA2016, such as physical restraint, acute sedation and seclusion. Whilst reduction of restrictive practices is wholly supported, these practices are only mentioned as they pertain to issues of consent and providing care under substitute decision makers. The approaches described in these guidelines may encourage open discussion and prevention of restrictive practices. A range of other programs and resources are accessible to help clinicians reduce the use of seclusion, restraint and acute sedation; some of these are provided in the Resources section of this guideline.

## A note about terminology

Throughout this document, the term 'person', 'child' or 'young person' has been predominantly used to describe the person with mental illness receiving treatment and care by mental health services. This is to foster a recovery-oriented and person-first approach. At times, the terms 'consumer' or 'patient' have been used when they are the terms used in another document or in common usage (e.g. consumer information leaflet, inpatient) or where it is the legal term (e.g. 'involuntary patient').

## 2. Less Restrictive Way

'Less restrictive way' is outlined in section 13 of the MHA2016. It is a consent hierarchy to facilitate treating people on a voluntary, rather than an involuntary, basis. The Act states:

“there is a **less restrictive way** for a person to receive treatment and care for the person’s mental illness if, instead of receiving involuntary treatment and care, the person is able to receive the treatment and care that is reasonably necessary for the person’s mental illness in 1 of the following ways –

- (a) if the person is a minor—with the consent of the minor’s parent
- (b) if the person has made an advance health directive—under the advance health directive
- (c) if a personal guardian has been appointed for the person—with the consent of the personal guardian
- (d) if an attorney has been appointed by the person—with the consent of the attorney
- (e) otherwise—with the consent of the person’s statutory health attorney”

## 3. Capacity

The information below should be read in conjunction with the following documents:

- *Chief Psychiatrist Policy [Treatment Criteria and Assessment of Capacity](#)*
- *[Guide to Informed Decision-making in Health Care](#) (2<sup>nd</sup> ed.). (especially pp 18-21)*
- *[Advance Care Planning Clinical Guidelines](#) (p. 14-15)*

### 3.1 Meaning of capacity to consent to be treated

Section 14 of the MHA2016 defines the meaning of 'capacity' to consent to treatment. Capacity to consent means the person:

- (a) is capable of understanding, in general terms:
  - i. that the person has an illness, or symptoms of an illness, that affects the person’s mental health and wellbeing; and
  - ii. the nature and purpose of the treatment for the illness; and
  - iii. the benefits and risks of the treatment, and alternatives to the treatment; and
  - iv. the consequences of not receiving the treatment; and
- (b) is capable of making a decision about the treatment and communicating the decision in some way.

**All adults are presumed to have capacity** to decide on receiving or refusing health care, except where it can be shown that they lack capacity to make these decisions. A capacity assessment will assist in forming an opinion regarding a person’s capacity to consent to treatment.

**For children and young people under 18 years of age, capacity to consent to treatment (Gillick competence) needs to be established** (is not presumed). A capacity assessment will assist in forming an opinion regarding a child or young person’s capacity to consent to treatment.

In Queensland, there is no statutory law around the specific age at which a child or young person becomes competent to consent to treatment. Capacity is determined by whether the child or young person has, for example, sufficient understanding, maturity and intelligence to enable them to understand what treatment is being proposed, and the risks, benefits and impact of that treatment.

**Capacity is decision specific** – in other words, a person’s capacity to consent to treatment is distinct from the person’s capacity in relation to, for example, managing finances or driving a motor vehicle. Additionally, a person might have the capacity to consent to some aspects of treatment and care but not to others. In relation to mental health treatment, capacity is the ability of that person to give informed consent to treatment at a particular time. See the *Chief Psychiatrist Policy [Treatment Criteria and Assessment of Capacity](#)* for further detail.

## 3.2 Capacity assessment

### **When does capacity need to be assessed?**

Capacity to consent to any type of medical treatment generally needs to be established prior to the treatment commencing.

Under the MHA2016, some mental health treatment may take place without consent being obtained by the clinician. However, seeking to obtain consent for undertaking mental health treatment is an integral requirement for upholding a less restrictive way to treat a person under the MHA2016.

A person will not meet the treatment criteria for involuntary treatment if they have capacity to consent to their own mental health treatment.

The treatment criteria for a person, as set out in section 12 of the MHA2016, includes all of the following:

- (a) the person has a mental illness
- (b) the person does not have capacity to consent to be treated for the illness
- (c) because of the person’s illness, the absence of involuntary treatment, or the absence of continued involuntary treatment, is likely to result in:
  - i. imminent serious harm to the person or others, or
  - ii. the person suffering serious mental or physical deterioration.

For (b), the person’s own consent only is relevant.

### **Who should assess capacity?**

All clinicians should complete a capacity assessment for the treatment decision that they are proposing within their scope of practice. For example, any admitting doctor can assess a person’s capacity to consent to admission to hospital.

However, a clinician who does not understand the treatment being proposed, may not be able to assess the person’s understanding of the treatment, and therefore would not be the appropriate clinician to assess the person’s capacity to make that treatment decision.

If there are any doubts about a person’s capacity, a more senior clinician should be consulted, or a second opinion should be sought.

For certain decisions that may involve a higher level of treatment, for example, making a person subject to a treatment authority when a less restrictive way may exist, local protocols should be developed to ensure that

capacity assessments are undertaken and/or reviewed by appropriate senior clinicians (e.g. a consultant psychiatrist).

### **How do you undertake a capacity assessment?**

Capacity assessment is not a linear process, in which you ask a series of questions and complete a form. It is more like a 'mental state' examination, in which you have a conversation with a person, and identify the key criteria for determining the person's capacity, through the discussion and the person's responses.

A capacity assessment may also include support people being present, to assist the person with understanding the proposed treatment, weighing up the risks and benefits of the treatment, identifying alternative treatment, and communicating their decision about the treatment.

A person's capacity to decide about treatment is not dependent on whether they make a decision which you think is best; it is important to recognise each person's right to choose according to their values, situation and beliefs.

For further education about capacity assessment, please refer to the capacity assessment education tools and [Resources](#) at the end of this document.

## **3.3 Capacity assessment and children/young people**

For complete information, refer to the [Guide to Informed Decision-making in Health Care](#) (2<sup>nd</sup> ed.) Part 3 *Informed decision-making and consent for children and young persons*.

When completing a capacity assessment with children and young people, conversation should have a focus on maximising the child or young person's opportunity to demonstrate their capacity. The more complex the proposed treatment, or more serious the consequences, the stronger the evidence will need to be of the child or young person's capacity to consent to the specific treatment.

The skills used in completing any assessment, whether it's a risk assessment or a clinical assessment, are applicable to conducting a capacity assessment with children or young people. The key to this is being able to maximise the time clinicians may have for assessment and by using language and communication that enhances engagement and understanding between the child or young person and clinician.

As children or young people mature, their capacity to consent also generally increases. For many children and young people, the level of involvement of parents, family and carers may vary over time, depending on the child or young person's level of maturity at the time. This may result in the capacity assessment for a child or young person being an involved process at various times. It may also result in conflicting views from the child or young person, and the person who may be in a position to consent to treatment for the child or young person.

If a dispute arises between a child or young person and their parent or guardian, and the child or young person is assessed as having capacity, the child or young person's decision should be followed if the treating team considers it is in the child's or young person's best interests. The reasons should be documented in the clinical notes to evidence how consent for the treatment was obtained. In these circumstances, it is recommended that advice is sought from a consultant psychiatrist or clinical director, particularly if the treatment involves significant risks.

## 3.4 Enhancing capacity

### 2.2.1 Communication

Refer to [Guide to Informed Decision-making in Health Care](#) (2<sup>nd</sup> ed.). Part 5 Communication and cultural issues in informed decision-making in clinical health care.

The onus is on the clinician to explain the treatment options being proposed and the risks and benefits in a way that is accessible to the person. Whatever appropriate means available should be used to enhance capacity, for example, use of interpreters or cultural support people, providing information in writing, verbally or pictorially, and using models, videos or diagrams. A capacity assessment is still valid if the person can demonstrate understanding, weigh up the risks and benefits, and communicate their decision, no matter which communication medium is used.

It is important to have the person communicate their understanding of the proposed treatment and consequences of having/not having the treatment, in their own words or communication method – nodding agreement is not sufficient to establish capacity.

Language and communication difficulties are common elements for many people, including children and young people, who may need to access mental health services. These challenges can have a direct effect on a person's emotional state and functioning, particularly at times of high stress. It can also provide significant challenges for clinicians, children, young people, families and carers involved in an assessment process. This has the potential risk that a person may be assessed as not competent, because a clinician does not recognise this difficulty, and does not adapt their approach to the person's needs.

### 2.2.2 Environment

The information below should be read in conjunction with the following documents:

- Chief Psychiatrist Policy [Treatment Criteria and Assessment of Capacity](#)

The environment plays a large part in how a person can take in information and make a decision. Stressful, noisy or disruptive environments can impact on a person's capacity, or mask decision-making ability. A person may feel coerced into a decision because they are intimidated by the environment and perceive that they have no choice – this is a particularly important consideration for Aboriginal and Torres Strait Islander people, children and young people.

Factors including the time of day, being sedated, hungry, in pain or anxious can all impact on decision-making ability. Allowing limited time to make a decision can make a person feel pressured. Consider how urgent the treatment is and if it is possible to give the person time to take in the information and weigh up their options. The more these needs are addressed, the more the person's capacity may be enhanced.

### Example:

Joshua is a young man admitted following a first episode of psychosis. Joshua's psychiatrist, Dr Khan, is proposing to treat him with an antipsychotic medication. Dr Khan asks Joshua to have a support person with him for the appointment. Joshua brings his mother, Lisa. They meet in a private interview room, and Dr Khan forwards her phone to avoid any other interruptions. She offers Joshua and Lisa a drink and checks that they are comfortable. Dr Khan talks about the reasons the medication is being suggested, the evidence about its benefits, the risks and side effects, and other treatment options. Dr Khan also fully describes the blood tests and regular checks that are required, and why these are necessary. She asks questions to prompt Joshua and Lisa to consider how the treatment may fit in with Joshua's lifestyle and choices, e.g. times of day when he would not want to be feeling sleepy, how he feels about blood tests. Dr Khan makes notes about his responses.

Joshua asks questions about if he will still be able to play sport, and how the possible weight gain may affect his activities. Lisa mentions that Joshua 'didn't do well at school' and has trouble taking in written information, so Dr Khan provides a simplified information sheet from the [Choice and medication](#) resources which includes pictures and plain English text. She also gives a link to an online consumer information video. Dr Khan would like to start the treatment soon; however, she recognises that Joshua and his mother may need some time to think about the treatment. She organises to talk to them again that afternoon. At the afternoon meeting, Joshua can recall the discussion, provide a simple explanation about how the treatment works, the benefits and risks, and identifies some ways that he might address potential side effects. Lisa states that she can provide support around Joshua taking the medication and getting to the clinic for his blood tests and check-ups. Joshua is able to communicate his decision to start the treatment. Dr Khan is satisfied that Joshua has capacity to consent to the treatment.

## 2.2.3 Supported decision making

Refer to:

- [Decision-making support and Queensland's guardianship system: A systemic advocacy report \(2016\)](#)
- [8.5 Supported decision making resources](#)
- [Appendix J: Definitions of supports for decision making in mental health](#)

Section 14(3) of the MHA2016 provides that a person may still have capacity, while being supported by another person in understanding matters about the proposed treatment and making a decision about the proposed treatment.

Supported decision making may enhance the capacity of a person. Consider how family or support people can help a person understand the treatment being proposed and put it into context for their lifestyle and condition. A support person can ask the questions that a person may have difficulty asking. They can also provide useful information on the person's strengths and needs, and how they may relate to the treatment decision.

Supported decision making does not mean that the support person is making the decision about treatment. It also does not mean that a person lacks capacity if the support person is helping them to weigh up the risks and benefits of the treatment.

If there are concerns that a family member or support person is overly influencing a person's decision, clinicians can talk to the person both with and without the support person present, to gauge the person's views and understanding. In most situations, however, family and carers want to work with the person and the treating team to address the mental health needs of the person, and can be an excellent resource for helping the person understand and decide on treatment.

People who provide support for decision making generally know the person well, or are familiar with the person's values. For example, a cultural support person may understand and help to communicate the cultural factors that the person will value in making their decision. A cultural support person can be anyone from the person's support network that can assist with identifying and meeting cultural needs<sup>1</sup>. See the [Guide to Informed Decision-making in Health Care](#) "5.4 What are the consent issues for Aboriginal and Torres Strait Islander patients?" for further information to assist.

**Example:**

Jacinta has presented to hospital with her Aunty Denise, with symptoms of psychosis. The psychiatrist, Dr Matthews, notes that Jacinta identifies as an Aboriginal woman, and asks Michael, the Aboriginal and Torres Strait Islander Mental Health Worker, to be part of the interview. Michael introduces himself and Dr Matthews and asks Jacinta if she would like her Aunty or someone else to help her with the interview. Jacinta says she wants her Aunty to stay.

During the discussion, Denise helps Jacinta to explain what has been happening to her (e.g. "You know how you've been telling me about the noises you keep hearing?"), and Michael helps to rephrase the assessment questions in ways Jacinta can better understand. Dr Matthews feels that an inpatient admission may be beneficial to Jacinta. Denise asks questions that are important to Jacinta's values and culture (e.g. "Will she be able to see family?" "We have trouble with another mob – are any of them here?" "Can Jacinta go out sometimes, so she doesn't feel so closed in?"). Jacinta feels more comfortable to talk about her fears of being in hospital, which helps Dr Matthews to discuss the treatment options more fully. They also discuss what can be done if the fears of being away from family get too much, such as asking to call Aunty Denise, and talking with Michael. Jacinta says she will give admission 'a go'.

For children and young people, options which will engage the child or young person in the process of assessment may also include engagement with parents and carers, to enhance the understanding of the young person. Engagement with others can also provide the clinician with an understanding of the challenges a child or young person may be experiencing which can impact on the outcomes of the capacity assessment. These may include, for example, long standing developmental delays, intellectual impairment, speech and communication difficulties, and behavioural difficulties which can directly affect engagement or "mask" a child or young person's capacity (may present better or worse than their capacity would indicate).

When a child or young person is assessed as competent and able to provide consent, this does not stop parents or carers from being involved in care, with the child or young person's agreement. Likewise, a child or young person being assessed as not competent to consent to treatment does not stop their involvement in decisions about care.

True supported decision making involves discussion and negotiation with all key people, and can be a dynamic process requiring regular review.

---

<sup>1</sup> To clarify the meaning of cultural support person: this can be anyone that the person identifies as understanding of their culture to provide support on the basis of understanding cultural values. The Mental Health Review Tribunal asks to specify a cultural support person for the purposes of Tribunal reviews and hearing. The cultural support person used during capacity assessment and other assessment and treatment may be the same person, but doesn't have to be. For more information about cultural support and the Mental Health Review Tribunal, talk with your local Aboriginal and Torres Strait Islander Mental Health Worker or the Mental Health Act Administrator Delegate.

## 3.5 Fluctuating capacity

Refer to:

- [Guide to Informed Decision-making in Health Care](#) “1.8 What if there is doubt about a patient’s capacity to give consent or their capacity appears borderline or fluctuates?” p.20-21.
- [Advance Care Planning Clinical Guidelines](#) (p.14-15)
- Chief Psychiatrist Policy [Treatment Criteria and Assessment of Capacity](#), especially with regard to determining stable capacity to revoke a treatment authority.

For a person with an episodic illness, or a person whose mental state or cognition are being affected by either the illness (e.g. manic symptoms) or the treatment (e.g. sedation), capacity may not be easy to establish. It may fluctuate rapidly (minutes or hours) or slowly (days or weeks). In these circumstances, it may be important to complete a series of capacity assessments to establish that a person has stable capacity.

The frequency and duration of assessments for establishing capacity may vary greatly, depending on the person’s condition, effects of current treatments, and the level of risk or consequences of the decision being made.

Example 1:

John has been receiving treatment and has been having side effects, including feeling quite sedated. The clinician would like to take a blood test. John’s inability to retain the information provided to him means the clinician is not confident that John has the capacity to consent. She waits for a few hours when John is more alert and tries again; this time John can retain the information and communicate his decision. For this simple and routine procedure, this is adequate stability of capacity.

## 3.6 Residual capacity

While a person may not have capacity to decide on certain aspects of health care, they may still have capacity to decide on other health or lifestyle choices. Acknowledging the individual’s autonomy, providing choices and allowing the opportunity to decide where possible is important for providing less restrictive care and recovery-oriented practice.

Treating teams can provide education and support to substitute decision makers to help them to understand the extent of their decisions, an individual’s rights to autonomy, and how to assist a patient to make the choices for which they have capacity (refer to the Resources section of this guideline for information that may assist).

When working with children and young people, clinicians should promote discussion about treatment and care with the child or young persons’ parents/legal guardian, in addition to the child or young person. This is particularly important as the child’s or young person’s capacity may change over time. This is also beneficial to establish an understanding of the child’s/young person’s capacity in decision making about other areas of their life. The active inclusion and participation of all parties is important to the child’s or young person’s recovery and promotes a shared understanding of capacity and consent to treatment.

## 3.7 Reviewing capacity

The information below should be read in conjunction with the following documents:

- Chief Psychiatrist Policy [Treatment Criteria and Assessment of Capacity](#)
- Chief Psychiatrist Policy [Advance Health Directives and 'Less Restrictive Way' of Treatment](#)
- [Advance Care Planning Clinical Guidelines](#) (p.14-15)

If the person has been assessed as lacking capacity, and another person authorised to consent to their treatment is making decisions for them; or the person is an involuntary patient under the *Mental Health Act 2016*; it is important to review capacity regularly to ensure that once a person has decision-making capacity, they can make their own treatment decisions.

At a minimum, a person who is being treated with the consent of another person authorised to consent to their treatment, should have their capacity to consent to their treatment reviewed at least at every care planning review. For inpatient treatment, the treatment and care should be reviewed by the Clinical Director at, or around, 14 days after admission. Regular assessment of capacity by the treating consultant should occur prior to the review by Clinical Director. Further assessments of capacity and treatment should occur at planned regular intervals (see sections 6.1 and 6.3).

If an adult lacks capacity in an ongoing way, an authorised doctor should contact the Office of the Public Guardian to consider whether guardianship arrangements are appropriate for the person.

Further suggestions for safeguarding a person's less restrictive treatment options through regular capacity reviews are provided below in [Section 4 'Identifying and recording substitute decision makers'](#).

## 3.8 Documenting capacity

Refer to [CIMHA Clinician's Handbook Vol 6: MHA](#) for further details of CIMHA documentation.

There is no set way to document a capacity assessment. However, documentation should reflect the discussion that occurred with the person, the information provided and if it was adequately received and recalled, how the person was able to articulate the weighing up of the decision, and how and what the person communicated in terms of the decision.

### **CIMHA Tip:**

Capacity assessments can be documented as a progress note in CIMHA. It is recommended that this is done under the 'Assessment' category of clinical notes.

The *Capacity Assessment for Mental Health Treatment and Guide for Use* ([Appendix C Adult](#), [Appendix D Child and Youth](#)) was developed to assist clinicians in documenting the outcomes of the capacity assessment as it relates to treatment of the person's mental illness. It provides a structured format for recording the outcomes of a capacity assessment, and includes recording of supports for decision making, and fluctuating capacity. An adult and a child or youth version of these forms is available on the [Mental Health Act 2016 website](#).

When a person is assessed as lacking capacity to consent to treatment, it is important that a substitute decision maker is identified. Please see the *Decision Making Pathways for Less Restrictive Way* ([Appendix A Adults](#), [Appendix B Child and Youth](#), [Appendix E Decision Maker Information Checklist CYMHS](#)).

## 4. Identifying and Recording Decision Makers

Refer to:

- [CIMHA Clinician's Handbook Vol 6: MHA](#)
- Chief Psychiatrist Policy [Advance Health Directives and 'Less Restrictive Way' of Treatment Framework on the Consent to Mental Health Treatment and Care by the Public Guardian](#)

When a person lacks capacity to decide on mental health care, less restrictive way options should be identified, and consent for treatment should be sought from one of the following (in the order listed):

- (a) if the person is a child or young person—with the consent of the child or young person's parent or legal guardian;
- (b) if the person has made an advance health directive— under the advance health directive;
- (c) if a personal guardian has been appointed for the person—with the consent of the personal guardian;
- (d) if an attorney has been appointed by the person—with the consent of the attorney;
- (e) otherwise—with the consent of the person's statutory health attorney.

Refer to the *Decision Making Pathways* ([Appendix A Adults](#), [Appendix B Child and Youth](#)) which step out the decision processes for less restrictive way decision making.

The identification of a person who may give consent for treatment is not a 'menu of options'. For example, a statutory health attorney cannot be used to consent to treatment simply because they are immediately available, if there is an AHD in place, or if the person has a guardian appointed for those matters. The hierarchy is based on a legal framework designed to protect the rights of the person.

The Queensland Civil and Administrative Tribunal (QCAT) may be contacted to identify a potential substitute decision maker for an adult and may be able to make an interim decision in a matter of days. This may shorten the period a person is required to be subject to a treatment authority.

When a substitute decision maker cannot be identified for an adult, the Public Guardian may be able to make health care decisions for that person. This may be an appropriate option for people requiring a substitute decision maker in an ongoing capacity, or where the risk is not sufficient to warrant treatment under the MHA2016. In these situations it is recommended that an [Application for Mental Health Treatment and Care Consent Form](#) be completed and submitted to the Office of the Public Guardian (see [Guide and Application Form for Mental Health Treatment Consent from the Public Guardian](#)). In acute management or high risk situations, the MHA2016 may be the practical less restrictive way to provide treatment while other decision makers are being sought.

The Public Guardian considers requests for consent to mental health treatment and care on a case by case basis, taking into consideration the appropriateness of providing consent in the person's circumstances. More information can be found in the [OPG Policy – Consent to Mental Health Treatment and Care by the Public Guardian](#).

Document the identified decision maker in CIMHA under the AHD/ Sub.Dec. Makers tab on the consumer demographics section as outlined in the [CIMHA Clinician's Handbook Vol 6: MHA](#).

## 4.1 Substitute decision makers

Refer to resources:

- [8.6 Substitute Decision Makers](#).
- [Appendix J: Definitions of supports for decision making in mental health](#)

### 4.1.1 Parent (of a minor)

Refer to:

- [Decision making pathway - child and youth](#)

For children and young people under the age of 18 who do not have capacity to consent to treatment, the substitute decision maker is the parent or legal guardian.

For children or young people who do not have a parent or legal guardian (see 4.1.3 *Guardians* below) available to consent to treatment, they may be in the custody or guardianship of the Department of Child Safety, Youth and Women, and it may be necessary to obtain consent for treatment through the Department of Child Safety, Youth and Women.

Separately, if the clinician has child protection concerns regarding the child or young person, they may, or in the case of doctors and registered nurses, must, inform the Department of Child Safety, Youth and Women of these child protection concerns (under the *Child Protection Act 1999*).

**Table 1(a): CIMHA alerts for substitute decision makers (minors)**

Substitute Decision Maker	Alert on CIMHA
Chief executive or Suitable Person	Child Protection Order in existence

### 4.1.2 Advance Health Directives

Refer to:

- [Advance Health Directive \(AHD\) Checklist](#)
- [Advance health directive for mental health: guide and form](#)
- Chief Psychiatrist Policy [Advance Health Directives and 'Less Restrictive Way' of Treatment](#)
- [CIMHA Clinician's Handbook Vol 6: MHA](#) (p.15-22).

It is important to ask the person and their family/carers if they have an AHD if one is not immediately accessible. If the AHD pertains to mental health treatment, it can be relied on to provide consent for treatment when a person is lacking capacity. It may also provide consent for other health treatment.

An AHD must be followed by health care professionals, whether provided in person, or accessed electronically (i.e. a copy on CIMHA, The Viewer or on My Health Record).

The Advance Health Directive – Mental Health (AHD-MH) has been developed by Queensland Health to provide more specific issues of consent related to mental health treatment and to capture the person's views, wishes and preferences. For more detailed information about the AHD-MH and how a person may develop one, refer to the [Advance health directive for mental health: guide and form](#) and other resources listed in section 7 of this guideline. Please note this form is under review.

Physical restraint can only be used in situations that satisfy the criteria in section 270 of the MHA2016. The previous version of the AHD implied that a person could consent to the use of physical restraint under certain circumstances. Only circumstances that satisfy section 270 can justify the use of physical restraint.

It is the responsibility of the clinician to check that the AHD provided, in whatever version or form it is given, is the current AHD. Any previous AHDs that have been made by the person should still be requested, as AHDs are not revoked on the making of a new AHD unless expressly revoked in the most recent AHD. Any directions provided in previous AHD which are inconsistent with the directions provided for in the most recent AHD are revoked.

When an AHD has been received it is important to check that it has been completed correctly. Refer to the [Advance Health Directive \(AHD\) Checklist](#). If the AHD has not been completed correctly, the AHD is not valid for providing legal consent. If a person has started to develop an AHD, but has not had it signed, the treating team can still work with the person's directions or expressed views, wishes and preferences, and include them where possible in treatment planning. However, in these circumstances, the AHD cannot legally be relied on for providing consent for treatment decisions.

If one or more attorneys have been appointed in an AHD, the attorney/s must have signed the relevant section to accept the appointment as attorney before they are able to act as an attorney (i.e. substitute decision maker). If the attorney has not signed, they cannot provide consent. The remainder of the AHD may still be valid, provided the sections described in the [Advance Health Directive \(AHD\) Checklist](#) are completed accurately.

If an original AHD is provided in hardcopy and is not available on CIMHA, the AHD must be checked to ensure it is completed correctly in accordance with the [Advance Health Directive \(AHD\) Checklist](#) prior to it being scanned and uploaded into CIMHA.

**CIMHA tip:**

If the AHD-MH document is appropriately signed, it is to be recorded under the '**AHD/Sub. Dec. Maker**' tab, scanned and a copy uploaded. For full instructions for this process, see [CIMHA Clinician's Handbook Vol 6: MHA](#) p.15-22.

It is preferable for a certified copy to be provided; however, an original copy provided to a clinician, by the person who made the AHD, is adequate proof to be able to act upon.

The 'start date' that is recorded is *the date which the document was signed*. It does not refer to the date which the person was assessed as lacking capacity, or the date that the document was received by the service.

All substitute decision making documents that are available on CIMHA are also available on The Viewer. The ACP (Advance Care Planning) tab in The Viewer may also have other documents, so it may be useful to check this.

### 4.1.3 Guardians

When a person says that they are an appointed guardian for a person, an instrument of appointment must be produced.

The Queensland Civil and Administrative Tribunal (QCAT) on appointing a guardian will issue an instrument of appointment which will confirm that appointment and state what types of decisions the appointed guardian can make. The appointment may also have conditions, and these will be stated within the instrument of appointment.

For a child or young person, the guardian may be appointed under a court order (e.g. Family Court Order) or be the legal guardian appointed under the *Child Protection Act 1999*.

A clinician must check the instrument of appointment prior to taking the guardian's consent for a treatment.

#### 4.1.4 Attorneys

A person can appoint a person/s to be their attorney for health matters in the event that they lose capacity to make decisions about future treatment and care. To appoint a person as an attorney, an enduring power of attorney form, published by the Department of Justice and Attorney-General must be completed. Alternatively, an attorney for health matters may be appointed in an AHD. The enduring power of attorney form may state conditions about who, when, and what decisions can be made.

A clinician must check the enduring power of attorney form or AHD (if an attorney has been appointed within an AHD) prior to taking the attorney's consent for a treatment.

#### 4.1.5 Statutory Health Attorney

Refer to: [Statutory Health Attorney fact sheet](#)

A statutory health attorney is not appointed by the person. Statutory health attorney is defined in the *Powers of Attorney Act 1998* to mean a person who, is the first, in listed order, of the following people who is readily available and culturally appropriate to exercise power for the matter—

- (a) a spouse of the adult if the relationship between the adult and the spouse is close and continuing;
- (b) a person who is 18 years or more and who has the care of the adult and is not a paid carer for the adult;
- (c) a person who is 18 years or more and who is a close friend or relation of the adult and is not a paid carer for the adult.

If no-one listed in (a) – (c) is readily available and culturally appropriate to exercise power for a matter, the public guardian is the adult's statutory health attorney for the matter.

From the Office of the Public Guardian Policy *Consent to mental health treatment and care by the Public Guardian*:

Under the Powers of Attorney Act 1998(s 63) the Public Guardian may act as the statutory health attorney of last resort where there is no readily available or culturally appropriate adult to consent to certain health care decisions. The Public Guardian's discretion to act as statutory health attorney is not limited by the MHA2016. The Public Guardian will not provide consent to mental health treatment and care as statutory health attorney where consent may be acquired using a 'less restrictive way.' This accords with section 4 of the Chief Psychiatrist's policy '*Advance Health Directives and 'Less Restrictive Way' of Treatment*', under which doctors are not required to seek the Public Guardian's consent before considering a Treatment Authority.

If there is a disagreement about which of two or more eligible people should be the statutory health attorney or how the power should be exercised, see the *Guardianship and Administration Act 2000*, section 42 (disagreement about health matter). If the Statutory Health Attorney does not appear to be taking the views and wishes of the person into consideration, the making of a treatment authority should be considered.

In accordance with the *Chief Psychiatrist Policy [Advance Health Directives and 'Less Restrictive Way' of Treatment](#)* a Statutory Health Attorney cannot consent to a person's admission to an inpatient unit.

If decision making for treatment is required in an ongoing way, and the person continues to lack capacity, it may be in the person's best interests to pursue a less restrictive decision-making process, e.g. application for guardianship. This would also be appropriate if the Statutory Health Attorney does not appear to be taking the person's views and wishes into consideration.

## 4.2 Recording persons who may give consent (substitute decision makers)

Refer to:

- [CIMHA Clinician's Handbook Vol 6: MHA](#)
- [Guideline: The use of the standard suite of clinical documentation](#)

Clinicians should document discussions regarding substitute decision makers within standardised clinical documentation. If information about substitute decision makers has previously been entered into CIMHA, the system will automatically populate summary information about current substitute decision makers into standardised clinical documentation.

There are alerts on CIMHA that relate specifically to substitute decision makers. These are:

**Table 1(b): CIMHA alerts for substitute decision makers**

Substitute Decision Maker	Alert on CIMHA
Guardian	Guardian
Enduring Power of Attorney	Power of Attorney in existence

However, these alerts do not contain sufficient, or necessarily current, information to be relied on to authorise consent for treatment.

Some services may include these alerts in their CIMHA business rules. It is important to be aware of the local rules used in your service, and also the limitations associated with alerts (e.g. where the alert has not been removed if it is no longer current).

## 4.3 Recording when a substitute decision maker is consenting

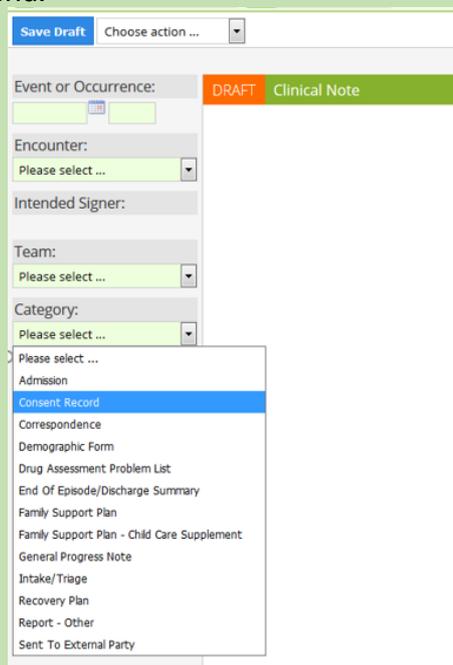
Refer to:

- [CIMHA Clinician's Handbook Vol 6: MHA](#)
- [CIMHA Clinician's Handbook Vol 7: Clinical Notes v1.0](#)

When a person is being treated with the consent of a substitute decision maker, this needs to be recorded by a clinical note in CIMHA.

### **CIMHA tip:**

Using the 'Consent Record' note to identify when a substitute decision maker has provided consent may make this record of the consent given easier to locate. This can be done by adding a new clinical note, and selecting 'Consent Record' from the Category drop down menu:



The screenshot shows a web-based form for creating a clinical note. At the top, there is a 'Save Draft' button and a 'Choose action ...' dropdown. Below this, the form is titled 'Event or Occurrence: DRAFT Clinical Note'. The form includes several dropdown menus for 'Encounter:', 'Intended Signer:', 'Team:', and 'Category:'. The 'Category:' dropdown is currently open, displaying a list of options: 'Please select ...', 'Admission', 'Consent Record', 'Correspondence', 'Demographic Form', 'Drug Assessment Problem List', 'End Of Episode/Discharge Summary', 'Family Support Plan', 'Family Support Plan - Child Care Supplement', 'General Progress Note', 'Intake/Triage', 'Recovery Plan', 'Report - Other', and 'Sent To External Party'. The 'Consent Record' option is highlighted in blue.

Searching for 'consent' using the filter in CIMHA can also assist in finding a record once it has been made.

Local protocols for recording the patient journey (e.g. patient manager systems or journey boards) should include documenting the identification of substitute decision makers when they are providing consent, and these should be updated when they are revoked. This will allow staff to quickly identify if there is a substitute decision maker who may provide consent for treatment.

It is important to note that, while the point of admission to an inpatient unit is a significant prompt for checking and recording/updating substitute decision makers, it is not the only point at which checks and updates should occur. Community mental health services also need to identify, record, update and follow information related to substitute decision makers. Each care planning review is an opportunity to check the status of less restrictive ways a person can be treated now or in the future, such as checking if an AHD has been developed or requires review.

Child and youth inpatient services may choose to use the *Decision Maker Information Checklist* to record the decision maker and that informed consent has been explained to the decision maker. See the *Decision Maker Information Checklist* and Guide for use ([Appendix E](#)).

## 5. Consent to Treatment

The following resources provide further details about this section:

- [Guide to Informed Decision-making in Health Care](#) (2<sup>nd</sup> ed.)
- Chief Psychiatrist Policy [Treatment Criteria and Assessment of Capacity](#)
- Chief Psychiatrist Guideline: [Child and Youth: Treatment and Care of Minors](#)
- Queensland Health Informed Consent webpage <https://www.health.qld.gov.au/consent>
- [National Standards for Mental Health Services 2010](#)

### 5.1 How can I best obtain informed consent in mental health services?

In mental health the treatment and care provided is not usually a specific procedure, but a combination of psychosocial and medical interventions. It is a requirement for clinicians to fully inform people receiving mental health services what they can expect, what are the benefits and risks of the treatment and care, and gain their informed consent to receive treatment and care.

The [National Standards for Mental Health Services 2010](#) provides the following definition of informed consent:

*Consent obtained freely, without coercion, threats or improper inducements, after questions asked by the consumer have been answered, after appropriate disclosure to the patient, adequate and understandable information in a form and language demonstrably understood by the patient.*

*Such answers and disclosures must be sufficient to enable the consumer to make a fully informed decision based on all relevant factors including the nature of treatment involved, the range of other options and the possible outcomes and implications, risks and benefits for the consumer and others.*

*In the context of mental health, this means that the client provides permission for a specific treatment to occur based on their understanding of the nature of the procedure, the risks involved, the consequences of withholding permission and their knowledge of available alternative treatments. (Commonwealth of Australia, p. 35).*

Recognising that people have choices is of inherent value when applying less restrictive ways of treating mental health conditions. Even when only one treatment option is available, people have a choice – treatment or no treatment. Improving how clinicians obtain informed consent is beneficial in supporting a person's understanding of their illness and recovery pathway.

Informed consent relies on clinicians providing adequate information about the treatment to the person, or to the person consenting on their behalf (e.g. parent/legal guardian or health attorney). Where possible, treatment information should be provided in a range of ways (e.g. verbally, written, or other media like video or websites), and in language that the person understands. If the person is from a Culturally and Linguistically Diverse (CALD) or Aboriginal and/or Torres Strait Islander background, an interpreter or cultural support person may be required (see [Guide to Informed Decision-making in Health Care](#) (2<sup>nd</sup> ed.) Part 5 *Communication and cultural issues in informed decision-making in clinical health care*).

An explanation of the treatment should also include any procedures that are required for the treatment and the purpose of these (e.g. regular blood tests; pre- and post-evaluations of a group program). An explanation of risks and side effects associated with any treatment or care must be given to ensure valid informed consent is obtained, this should include a discussion of alternatives to the treatment to help the person weigh up their options.

For children and young people, supportive discussion allows consideration of their explanation of the basis for their decision regarding the proposed treatment, as well their ability to articulate an understanding of the wider consequences on other people, and possible moral and family issues which may arise with this decision. This discussion will ensure that all persons are clear that consent is informed. It encourages the child or young person to ask clarifying questions and express their thoughts. This creates opportunities to identify if the child or young person may have other language and communication issues which require a different approach for understanding to be established.

Consent can be implied or explicit/expressed (verbal or written) (see [Guide to Informed Decision-making in Health Care](#), p9-11). Written consent, such as completing a consent form, can be important for procedures and treatments that carry a degree of risk which requires clear confirmation that consent has been obtained. A range of consent forms and information sheets are available at the Informed Consent website <https://www.health.qld.gov.au/consent> for specific procedures that are commonly used in mental health, including the following:

- Electroconvulsive Therapy (ECT) – consent form and patient information
- Consent for Anaesthesia (includes consent for sedating medication)
- About your child’s anaesthetic (information sheet – including information on sedation)

The generic consent forms can be used for medications or other specific treatments:

- Generic consent form for child/young person
- Generic consent form for adults

It is useful for the clinician to document the discussion that occurred and the way in which consent was given.

A substitute decision maker cannot consent to a person receiving ECT (this is a Special Health Matter), or being secluded or physically restrained (see 5.2 below).

The *Decision Maker Information Checklist* ([Appendix E](#)) provides a structure for discussing consent with a child/young person’s decision maker, and recording the discussion that may be undertaken as part of the informed consent process for inpatient units. This is not a blanket document for informed consent; each treatment decision requires its own discussion and consent process.

Services may need to consider the treatment and care offered that support mental health recovery and develop written information about these options. This might include brochures on case management, specific therapeutic groups, and psychological approaches being used. Find out what written resources are available in other languages, or contact [Queensland Transcultural Mental Health Centre](#) if you need support.

## 5.2 Can consent be given for restrictive practices such as physical restraint, acute sedation and seclusion?

Refer to:

- [8.8 Restrictive Practices](#) in Resources
- MHA2016 Chapter 8
- [Appendix F: Physical Restraint Information Sheet – Adults](#)
- [Appendix G: Physical Restraint Information Sheet – CYMHS](#)
- [Appendix H: Acute Sedation Information Sheet - Adults](#)
- [Appendix I: Acute Sedation Information Sheet – CYMHS](#)

The use of restrictive practices is regulated under Chapter 8 of the MHA2016. A substitute decision-maker cannot give consent for the use of physical restraint, or seclusion. Additionally, a person cannot provide consent for the use of physical restraint though an AHD.

When restrictive practices are being used under the legislative provisions of the MHA2016, consent is not required. These measures may only be used when there is no other reasonably practicable way to prevent harm and provide required treatment.

Physical restraint may only be used if authorised by an authorised doctor, or a health practitioner in charge of an inpatient unit or other unit within an authorised mental health service, on a patient for one or more of the following purposes, if there is no other reasonably practicable way to achieve the purpose:

- (a) to protect the patient or others from physical harm
- (b) to provide treatment and care to the patient
- (c) to prevent the patient from causing serious damage to property
- (d) for a patient detained in an authorised mental health service – to prevent the patient from leaving the service.

Urgent physical restraint does not fall under the MHA2016. Any physical restraint of a patient should use the minimum force and duration necessary. Hospital and health services should seek their own legal advice regarding physical restraint administered outside of the MHA2016.

It is an offence under the MHA2016 to administer medication to a patient unless the medication is clinically necessary for the patient's treatment and care for a medical condition. Consent provided by the patient or a substitute decision maker does not override this requirement.

If consent is withheld or is not adequate to provide the necessary treatment and care, and the patient meets the treatment criteria (defined in section 12 of the MHA2016), the person should be placed under a treatment authority (section 18 of the MHA2016).

It is important that restrictive practices are explained to the patient and the decision maker providing consent to treatment, even if they are not able to provide consent to these practices. Written information should be provided as part of the service orientation and consent to receive services. An example of this is the information sheet from Your Health in Mind ?reference, on psychiatric hospitals <https://www.yourhealthinmind.org/treatments-medication/psychiatric-hospitals>. The [National Principles for Communicating about Restrictive Practices with Consumers and Carers](#) outline ways to discuss restrictive practices before, during and after use of such practices.

Information sheets on physical restraint and acute sedation are provided in the appendices of these guidelines to assist with discussions with patients and carers.

## 5.3 What if the consent for treatment is refused or withdrawn?

Refer to:

- [Guide to Informed Decision-making in Health Care](#) (especially p. 21-22, and p. 47)
- Chief Psychiatrist Policy [Treatment Criteria and Assessment of Capacity](#)

Although clinicians may consider a proposed treatment to be in the person's best interests, this does not mean that a person (or the person consenting on their behalf) will, or should, consent to treatment. They may have concerns about the treatment, whether the risks outweigh the benefits (in the context of the person's needs), and the timing of the treatment. They may wish for other treatment options to be tried first. They may have fears based on previous adverse reactions or experiences. Whatever the reason, it is important for clinicians to explore these reasons for refusal to consent, and clearly document that consent is not given. It may also assist to encourage the person (or the person consenting on their behalf) to seek further information and options; this may include seeking a second opinion. The [Guide to Informed Decision-making in Health Care](#) provides strategies for addressing concerns related to refusing or withdrawing consent. If these strategies are not effective, or there are ongoing risks or concerns, it may be appropriate to seek legal advice. Where the treatment criteria apply to a person, including lack of capacity, a treatment authority may be necessary to treat the person.

There is a common belief that children and young people can be deemed to have capacity to consent, but not to refuse consent to treatment. This is not the case. A child or young person who has capacity to consent to health care can also refuse health care (see [Guide to Informed Decision-making in Health Care](#) p. 47).

## 5.4 Where do I record consent?

Refer to [Clinician's Handbook Volume 7: Clinical Notes v1.0](#) and [CIMHA Attachment Description Naming Convention Factsheet](#) for detailed steps and information.

### **CIMHA Tip:**

Consent is to be documented in CIMHA as a clinical note; select 'Consent Record' under the clinical note category, and choose either an attachment summary (for completed form to be uploaded) or progress note. It is important to record which decision maker is providing the consent (e.g. the person themselves, parent/legal guardian, health attorney, statutory health attorney) and to check that they are legally able to provide that consent.

Follow the naming convention for attachments to ensure that they are easy to find in searches, with `<Attachment>_<date>` in the Description field, e.g. *Consent for Services\_20180604*.

## 6. Providing Mental Health Treatment and Care with the consent of a substitute decision maker

Refer to:

- Decision Making Pathways for Less Restrictive Way ([Appendix A Adult](#) or [Appendix B Child and Youth](#))
- [8.6 Substitute Decision Makers](#) resources
- [Guide to Informed Decision-making in Health Care](#) p.32-41.

A substitute decision maker can consent to health care when a person lacks capacity to consent to health care. This may be due to a range of reasons, not necessarily related to their mental health.

It is important to recognise that a person may not have capacity to decide about one aspect of their treatment or care but may still be able to give consent in relation to other treatment or care. As much as possible, clinicians should give people the opportunity to make decisions that they have capacity to make for themselves.

However, where a person lacks capacity to consent to treatment, it is important to ensure, where possible, that the substitute decision maker is making decisions that are adequate to meet the reasonably necessary care required for the person.

If the decisions of a substitute decision maker are not adequate to allow the person to receive the necessary treatment and care they require, use the *Decision-Making Pathway for Less Restrictive Way* ([Appendix A Adult](#) or [Appendix B Child and Youth](#)) to assist in determining the next less restrictive option. When a person is made subject to a treatment authority, ensure that the frequent reviews of the person's care are used as opportunities to check if a less restrictive way option is available at that time.

Example:

Nancy is admitted to an older persons' mental health unit under an Emergency Examination Authority. At the end of the assessment period, the treating registrar assesses that Nancy lacks capacity and meets the criteria for involuntary treatment. The registrar checks that there is an AHD, but feels that the AHD is not adequate for her treatment. He puts Nancy on a Treatment Authority under the MHA2016. The consultant psychiatrist reviews Nancy the next day, and whilst agreeing with the capacity assessment, notes that the AHD gives consent for the main medications being used to treat Nancy's mental illness, and feels that the consent provided in the AHD will provide safe and necessary care. The team discuss the treatment needs, and the consultant revokes the treatment authority to treat Nancy with the consent of the AHD.

A substitute decision maker should be supported as much as possible – irrespective of who they are. Some substitute decision makers may not feel prepared for the role. For example, an attorney appointed for personal matters may have considered other aspects of health care, but they may not feel equipped to decide on mental health treatment. They may feel conflicted about the impact it will have on their relationship with the person, for example, if a family member is consenting to have their loved one admitted to an inpatient unit for treatment. The team should provide substitute decision makers with as much information as possible to support their knowledge of the decision, but also their understanding of their role as a substitute decision maker. Refer to the Resources section of this guideline for information that may assist in this education and support process.

For children and young people, the person(s) consenting to treatment on their behalf are usually the child's or young person's parent or legal guardian. The decision-making process regarding treatment will often involve a collaborative discussion between the child or young person, parents or legal guardian and clinicians.

The parent or legal guardian needs to be provided with as much information as possible to make an informed choice. In instances of inpatient admission, the *Decision Maker Information Checklist* ([Appendix E](#)) can assist with this discussion.

For children who are in out-of-home care, the decision maker may vary, depending on the type of child protection order and the treatment being proposed. Refer to the Department of Child Safety, Youth and Women’s [Guide for Health Professionals](#) for guidance on who can consent to different treatments.

## 6.1 Reviews when consent is provided by a substitute decision maker

It is important that there are regular reviews of a person’s capacity to consent to health care, and of the care itself, to safeguard the person’s rights. When a person is admitted or treated with the consent of a substitute decision maker, the person requires ongoing review and support to ensure that they are given as much opportunity to engage in the treatment and care as is possible. Ongoing assessments of capacity to consent are required to ensure that it remains necessary for a substitute decision maker to provide consent on the person’s behalf.

The table below provides an overview of the review requirements and suggested safeguards when substitute decision makers provide consent for a person.

**Table 2: Reviews to be undertaken when a substitute decision maker gives consent for treatment**

Substitute decision maker	Legislative or policy review requirements	Recommended additional safeguards
<b>If the person is a minor - the minor’s parent</b>	No legislative requirement for review	<p>Undertake regular reviews of the young person’s capacity.</p> <p>Encourage shared decision making if the young person has emerging capacity.</p> <p>If there are concerns about the parent’s decision making (e.g. if they may lack capacity, or are making decisions not in the young person’s best interests), seek legal advice. If child protection concerns exist, report to Child Safety.</p> <p>Clarify any concerns about decision making based on a child protection order with Child Safety as soon as possible. See <a href="#">Guide for health professionals: Medical decision making for children and young people in out-of-home care</a>.</p>
<b>Advance Health Directive</b>	<p>Under the <i>Chief Psychiatrist Policy <a href="#">Advance Health Directives and ‘Less Restrictive Way’ of Treatment</a></i> a review of the person’s treatment by the Clinical Director is required at or around 14 days from when a person is being treated as an inpatient under an AHD.</p> <p>Usually this would be the date of admission as an inpatient; however, this is not always the case (e.g. if a treatment authority is revoked during the admission because the AHD</p>	<p>It is important to clearly document the date of when the AHD comes into effect (e.g. when the person was assessed to lack capacity).</p> <p>Inpatient units may develop protocols for including review dates on patient journey boards/ patient management lists.</p> <p>Community services may need to include protocols for review of capacity as part of regular care planning and case management reviews.</p>

Substitute decision maker	Legislative or policy review requirements	Recommended additional safeguards
	<p>consent has become adequate to safely meet the person's treatment needs).</p>	<p>If the person has consented in the AHD to remain in an inpatient unit, but has not specified a duration of treatment, the team should ensure that review of capacity occurs frequently and regularly, after the required 14-day review, or at the direction of the Clinical Director.</p> <p>If the person has specified a duration for treatment, capacity assessment should occur prior to the end of the duration of consent for inpatient treatment. If the person still lacks capacity at that time, and the treatment criteria apply, a treatment authority can be made. This can occur while less restrictive ways are being sought (e.g. guardian).</p>
<p><b>Personal Guardian</b></p>	<p>Under the <i>Chief Psychiatrist Policy <a href="#">Advance Health Directives and 'Less Restrictive Way' of Treatment</a></i> if the person is admitted as an inpatient with the consent of a guardian, a review of the person's treatment by the Clinical Director is required at or around 14 days from person receives treatment as an inpatient with the consent of the guardian.</p> <p>Usually this would be the date of admission for inpatient care; however, this is not always the case (e.g. if a treatment authority is revoked during the admission because the guardian consent has become adequate to safely meet the person's treatment needs after a crisis resolution).</p> <p>QCAT conducts an automatic periodic review as specified in the guardianship order.</p> <p>QCAT can also initiate and conduct a review of any order at any time.</p> <p>Any interested party can request a review if they have evidence of changed circumstances or new information.</p>	<p>If a review is not scheduled soon and the treating team has assessed the person as having capacity, or it is felt that a less restrictive way option will cover reasonably necessary care (e.g. AHD), apply for review of the guardianship through QCAT.</p> <p>Provide support to the guardian to understand the role, responsibilities, and limitations of decision making (<i>see resources listed under 7.5 Substitute Decision Makers</i>).</p> <p>Identify triggers for capacity assessment, including improvement in the person's mental state.</p> <p>If QCAT initiate an ad hoc or periodical review which may lead to a change in guardianship, re-assess capacity.</p> <p>Provide them with all the information needed to make an informed decision.</p>
<p><b>Attorney appointed by the person (enduring power of attorney; attorney appointed under AHD)</b></p>	<p>Under the <i>Chief Psychiatrist Policy <a href="#">Advance Health Directives and 'Less Restrictive Way' of Treatment</a></i> if the person is admitted as an inpatient with the consent of an attorney, a review of the person's treatment by the Clinical Director is required at or around 14 days from when the person receives treatment as an inpatient with the consent of the attorney.</p> <p>Usually this would be the date of admission for inpatient care; however, this is not always the case (e.g. if a treatment authority is revoked during the admission because the attorney's consent has become adequate to safely meet</p>	<p>Undertake regular reviews of the patient's capacity.</p> <p>Provide support to the attorney to understand the role, responsibilities, and limitations of decision making (<i>see resources listed under 7.5 Substitute Decision Makers</i>).</p> <p>Provide them with all the information needed to make an informed decision.</p> <p>If there are concerns about the attorney's decision making (e.g. if they may lack capacity, or are making decision not in the person's best interests), seek legal advice or make a treatment authority.</p>

Substitute decision maker	Legislative or policy review requirements	Recommended additional safeguards
	the person's treatment needs after a crisis resolution).	
<b>Statutory Health Attorney (SHA)</b>	Under the <i>Chief Psychiatrist Policy <a href="#">Advance Health Directives and 'Less Restrictive Way' of Treatment</a></i> a SHA cannot consent to a person being admitted as an inpatient	<p>Undertake regular and frequent reviews of the patient's capacity.</p> <p>Provide them with all the information needed to make an informed decision.</p> <p>If there are concerns about the SHA's decision making (e.g. if they may lack capacity, or are making decision not in the person's best interests, or in conflict with the person's views, wishes and preferences), consult with QCAT for advice, with the possibility of having a guardian appointed or make a treatment authority.</p>

At any point in time, when it becomes apparent that a person has regained capacity to make their own decisions in relation to their mental health treatment and care, assessment and documentation of that capacity should occur. Stability of capacity will need to be determined in some cases and, accordingly, frequent capacity assessment should occur. When a person has capacity to consent themselves the substitute decision maker no longer has authority to consent to any treatment or care; although they may continue to have a role as a supported decision maker, if the person wishes. For example, a statutory health attorney may not make decisions once the person regains capacity, but may still support the person in decision making by helping to provide information in a way the person understands, or putting the consequences of decisions into context in relation to the person's lifestyle and identity.

## 6.2 Treatment in the community

Refer to:

- Chief Psychiatrist Policy [Advance Health Directives and 'Less Restrictive Way' of Treatment](#)
- Chief Psychiatrist Policy [Treatment and care of patients](#)
- Chief Psychiatrist Practice Guideline [Child and Youth: Treatment and Care of Minors](#)
- [Guide to Informed Decision-making in Health Care](#), p 32-41.

A person may lack capacity to consent to treatment whilst being treated in the community.

The same less restrictive way options for obtaining consent for treatment in a facility apply when a person is being treated in the community.

AHDs and other substitute decision makers can provide consent to safely meet the person's treatment and care needs whilst being treated in the community.

Capacity assessments should be completed regularly to ensure that the person can decide on their own treatment when they regain capacity.

When a person gains capacity, reviews are ideal opportunities for case managers to work with the person, to consider future treatment needs, in the community as well as while an inpatient, e.g. if the patient doesn't have an AHD, speak to them about making one.

## 6.3 Treatment in an inpatient unit

Refer to:

- Chief Psychiatrist Policy [Advance Health Directives and 'Less Restrictive Way' of Treatment](#)
- Chief Psychiatrist Policy [Treatment and care of patients](#)
- Chief Psychiatrist Practice Guideline [Child and Youth: Treatment and Care of Minors](#)
- [CIMHA Clinician's Handbook Vol 6: MHA](#)
- CIMHA [Clinician's Handbook Vol 7: Clinical Notes v1.0](#)
- [Independent Patient Rights Advisers Service Model Guidelines](#)
- [Guide to Informed Decision-making in Health Care](#), p 32-41.

### **CIMHA tip:**

On admission to an inpatient unit, ensure that the AHD/substitute decision maker is recorded in CIMHA in '**AHD/Sub. Dec. Makers**' tab.

Admission documentation or a clinical note in the 'Consent Record' category of CIMHA should record that the substitute decision maker is providing consent.

It is important to identify that the person is being treated with the consent of a substitute decision maker (e.g. "Treatment and Care Under a SDM" may be used on patient lists and other records).<sup>2</sup>

A person who is admitted with the consent of an AHD or substitute decision maker is not always being admitted reluctantly. For an admission to occur, there will be concerns about the person's risks to themselves or others. Use of an AHD indicates that the person does not have capacity to make decisions about mental health care treatment, but that they have previously provided consent with an understanding of their individual needs for treatment when unwell.

When a person is admitted with the consent of an AHD or substituted decision maker, it is important to, where possible, provide the person with an explanation of provisions that are being used to consent to their treatment. The Independent Patient Rights Adviser (IPRA) can assist with this when talking about their rights and responsibilities (see [Independent Patient Rights Advisers Service Model Guidelines](#)). Any substitute decision makers (e.g. parents, guardian, attorneys) will need to understand the rights and responsibilities of those providing consent.

If an AHD is being relied on for consent, all treatment and care decisions should be consistent with the AHD. The person's views, wishes and preferences are to be upheld wherever possible, in keeping with principles of empowering the person to exercise their rights. It is recommended that where requests cannot be met, these are discussed with the person and/or other substitute decision makers or support persons.

---

<sup>2</sup> Whilst a person's legal status is Voluntary, it is important to identify that a substitute decision maker is in place in order to safeguard the rights of the person and provide care that considers lack of capacity.

## 6.4 When the AHD is not adequate to provide consent

Refer to:

- Mental Health Act 2016
- [Guide to Informed Decision-making in Health Care](#) p 35-36.

Under Section 54 of the MHA2016, if the AHD is not followed (either because a treatment authority is made as other less restrictive ways are not adequate to maintain safety or reasonably necessary care, or the nature and extent of the treatment is inconsistent with the person's views, wishes and preferences), the authorised doctor **must**:

- explain to the person the reasons why the decision has been made, and
- record the reasons for the differing treatment regime in the person's health records.

It is recommended that these reasons are recorded as a clinical note in CIMHA. The person may also be advised of their right to discuss this further with the IPRA, community visitor or support person.

If the views, wishes or preferences of a person are unrealistic or impractical, this can be discussed with the person and/or other substitute decision makers or support persons, and it may be suggested that these points are reviewed in the AHD once the person regains capacity.

The [Guide to Informed Decision-making in Health Care](#) provides information around circumstances in which medical officers are protected for not following the directions in a valid AHD.

## 6.5 Risk and safety

If the appointed substitute decision maker is not making decisions in the person's best interests, is not fulfilling their responsibilities, or is lacking capacity:

- Document rationale for the decision and specific concerns
- Seek local resolution to issues to work in the person's best interest where possible
- Seek legal advice if required

Refer to additional information and resources above at *5.3 What if the consent for treatment is refused or withdrawn?*

If the person is considered at high risk to themselves or others, it is recommended that the *Involuntary and High Risk voluntary patient summary form* be completed on CIMHA as a communication tool. The risk and management plan should also be clearly reflected in the Care Plan.

## 6.6 Disputes about decisions

### 5.6.1 Statutory Health Attorney, Attorney (under AHD or EPOA) as decision maker (adults)

In instances where there is conflict between the person's expressed preferences in relation to their treatment, the recommendations of the treating team, and the decisions being made by the statutory health attorney, attorney under an AHD, or EPOA, it is important to try to resolve issues locally where possible. Refer to the general principles and health care principles under the *Powers of Attorney Act 1998* to remind all parties of the responsibilities involved in upholding the person's rights and working in the person's best interests. Include the Independent Patient Rights Adviser (IPRA) to assist with supporting the person's rights. If local strategies do not resolve the issue, it is best to seek legal advice, or request advice from QCAT.

The above measures may resolve the situation without resorting to involuntary treatment under the MHA2016. If involuntary treatment is the best option available to provide reasonably necessary treatment and care to the person at that time, the treating team can continue to pursue less restrictive ways of consent to treatment and care once available. It is important to review and document decisions and outcomes thoroughly, to help inform future care planning with the person and/or decision makers.

### 5.6.2 Disputes in decision making with child and youth mental health treatment and care

In child and youth mental health there may be disagreements about mental health treatment and care between the young person, parents, legal guardians, and the treating team. Ensure that options are communicated clearly to substitute decision makers and support people and seek a local resolution. There may also be conflict with what is seen to be in the child's or young person's best interests. Seeking a second opinion from a senior medical practitioner may assist to resolve the issue or provide further options for care.

If local resolution does not resolve the issue or is not occurring timely enough to meet treatment and care needs, a treatment authority may be made for any treatment and care required at the time. Legal advice should be sought as soon as possible to explore less restrictive way options. Refer to Part 3 of the [Guide to Informed Decision-making in Health Care](#) for further information.

## 6.7 Leave from the inpatient unit

Refer to:

- Chief Psychiatrist Policy [Advance Health Directives and 'Less Restrictive Way' of Treatment](#)
- Chief Psychiatrist Policy [Treatment and care of patients](#)
- Chief Psychiatrist Practice Guideline [Child and Youth: Treatment and Care of Minors](#)
- [Examinations and Assessments factsheet](#)

A person who is receiving treatment and care under a substitute decision maker may be able to have leave from the inpatient unit, with the consent of the decision maker. If the person has consented to be detained in a locked unit under their AHD, the decision to provide leave from the unit within the timeframe provided by the AHD is one made by the treating team and any attorneys appointed to make decisions related to leave or admission.

If there are identified risks involved, these need to be planned for and mitigation strategies put in place. The Prevention and Response Plans should be documented as per local guidelines for Involuntary AWA Prevention and Response Plans. For children and young people, pre-planning is essential to identifying with parent/legal guardian leave arrangements and plans if there are difficulties, particularly if the child or young person does not wish to return.

If there is an attorney or guardian appointed, discussion with them about the leave arrangements and risk management strategies will be important, including communication of leave times, and plans if the person does not return, such as search procedures, notification and safety issues.

If the person fails to return from leave, it is important to follow the local procedure for a voluntary patient, including internal notifications, searches, documentation and communication with key contacts, including attorneys/guardian appointed to decide on mental health care. A [Recommendation for Assessment](#) may be required to be made if considered appropriate or required due to the person's risk profile or treatment needs.

If the person is located, check if the person can engage in an examination with the consent of the substitute decision maker. If it is assessed that the person requires transport back to the unit as the less restrictive way of providing treatment, consent for transport needs to be sought from the substitute decision maker. If it is safe, the person may be returned to the service by health practitioners, family or others. If it is not safe for the person or others, and there appears no less restrictive way to provide treatment, a [Recommendation for Assessment](#) may be made. The *Recommendation for Assessment* authorises the transport of the person to the authorised mental health service for assessment. As the assessment period had not yet commenced, an *Authority to Transport Absent Person* cannot be used in this circumstance. If authorised mental health service health practitioners require assistance to transport the person to the authorised mental health service a [Request for Police Assistance](#) can be completed.

In the instances where police assistance is requested for transport, a health practitioner must also be present to return the person.

## 6.8 Use of AHD for a person on a Forensic Order, Treatment Support Order or Classified Patient

Refer to:

- Chief Psychiatrist Policy [Treatment and Care of Forensic Order, Treatment Support Order and High Risk Patients](#)

Unlike the criteria for a treatment authority, lack of capacity is not a requirement for the Mental Health Court or Mental Health Review Tribunal (MHRT) to make or continue a forensic order (mental health) (FO-MH) or treatment support order (TSO). A person may have requirements to be treated under the MHA2016 as a result of these orders, potentially against their consent or wishes expressed in person or in a developed AHD. While the treating team can provide the necessary involuntary treatment for the person under the FO-MH or TSO, they can discuss with the person the aspects of the AHD which may still be supported or adhered to as much as possible when they lose capacity and are subject to a FO-MH or TSO. This may include consent to physical health care, aspects of mental health care, and their views, wishes and preferences. It is important to remember that treatment under an AHD only comes into effect if the person is lacking capacity to consent. The person may have the capacity to make these decisions themselves, in which case the person's informed consent for their mental health treatment should be sought.

Example:

Andrew is under a Treatment Support Order (TSO) in the community. He has written up an AHD-MH and his GP assessed Andrew as having capacity to develop the AHD-MH. Andrew has had the AHD-MH appropriately witnessed. At his next appointment, Andrew gives a copy of his AHD-MH to Dr Lars, his psychiatrist, and states that he does not consent to having his long acting injectable (LAI) medication any longer. Dr Lars suggests that they have a conversation with everyone involved to clarify the situation. She includes Andrew's GP, his brother as his identified attorney, and the Independent Patient Rights Adviser. Dr Lars discusses the treatment requirements of the Treatment Support Order which apply whether Andrew has capacity to consent or not, and how this relates to his LAI medication. They discuss what his AHD-MH can be used for whilst he is under the TSO, including his consent to his diabetes treatment. They clarify that Andrew currently has capacity to consent to other health conditions, and accordingly, the AHD-MH does not currently apply. Andrew's brother clarifies when and what he can consent to as the attorney. Dr Lars ensures that Andrew's views, wishes and preferences are clearly identified and that relevant goals are included in the Care Plan. Andrew understands that he will still need to have the LAI medication but will explore options for treatment with Dr Lars as he progresses towards revocation of the TSO.

A person subject to a FO-MH or TSO, or who is a Classified patient (not subject to a treatment authority), may wish to develop an AHD. The person may have capacity to make such a decision. It is important to discuss with the person what the limitations of the AHD would be in their particular situation, i.e. the AHD would not be able to consent to treatment which goes against the conditions of their order, whilst the order is in place.

A person's interest in developing an AHD may be viewed as an ideal opportunity to have a useful, collaborative discussion about treatment options, views, wishes and preferences, which could better inform the review of the care plan for the person.

## 6.9 Forensic Order - Disability

Refer to [Persons with an Intellectual Disability](#) MHA2016 Factsheet.

The MHA2016 provides for the care of people under a Forensic Order – Disability (FO-D) in relation to the person's intellectual disability only, not for the treatment of any subsequent mental illness that may develop, or that are existing and unrelated to their forensic behaviours.

This means that for a person subject to a FO-D, the treating team/clinician will need to determine if the person has capacity to decide on their own mental health treatment, or if a substitute decision maker needs to be identified. It is recommended that all people under a FO-D who are provided with care be assessed for capacity, and any substitute decision makers for mental health treatment and care be clearly documented.

The less restrictive option needs to be determined for people under a FO-D. A person can be treated for their mental illness under a substitute decision maker, if they are on a FO-D. The safeguards as outlined in Table 2 should be considered. If no less restrictive way is available, a treatment authority may be made.

## 7. Less Restrictive Way and mental health planning

Refer to:

- Queensland Health [Guideline: The use of the standard suite of clinical documentation](#) .
- CIMHA [Clinician's Handbook Vol 7: Clinical Notes v1.0](#)
- [Mental Health Service Care Plan](#)

Good quality recovery planning with the person is the best and least restrictive approach to ensuring that the person's treatment needs are met. [Care Plans](#) and care planning reviews provide essential opportunities for therapeutic engagement, to discuss what is working and what isn't, and to identify the person's recovery goals.

Health services often document care in ways which can be confusing for the person receiving treatment, family and carers. It is not uncommon for plans, goals and actions to be located in various different places. The person may not even be aware of some of these plans.

A person's warning signs and triggers will be documented throughout all clinical documentation where relevant, and in particular within the formulation and longitudinal summary. The recovery plan and longitudinal summary are very useful to consider when developing an AHD – when a person knows which management strategies have worked, and which have not, this can inform the person's consent to treatment and views, wishes and preferences. This may also play a very important part in identifying less restrictive ways to provide care.

### Example:

Dennis has had multiple acute admissions over several years to mental health inpatient units when he has become psychotic. Twice he was admitted with suicidal ideation and behaviours. While an inpatient, he has occasionally become verbally aggressive, and was physically restrained and secluded once for physical aggression. Dennis has been able to identify in his recovery plan that his early warning signs for suicide are when he hears a particularly voice telling him 'you're no good'. He also identified that he's more likely to become verbally aggressive when he is unwell and feels that people are 'in my space'. His case manager makes sure that these factors are included in Dennis's risk screen. Dennis and his case manager include strategies in his recovery plan, including who to contact when he starts to hear that voice. Dennis also wants to include, under his 'views, wishes and preferences' in his AHD the statement 'When I am unwell and getting angry or upset, I would prefer that people give me space and calm me down by talking with me from a safe distance'. When physical restraint and seclusion are discussed, Dennis says 'I hope it doesn't come to that again. But if I get angry, I'd rather people didn't touch me'. These strategies are all included in Dennis's care plan, under the recovery goal 'I want to keep myself and other people safe'.

The complex interplay of plans can be somewhat simplified if the Care Plan document is developed with specific, measurable and achievable goals, and includes links to other key plans.

One of the key benefits of AHDs in mental health is the collaborative discussion and development of a therapeutic alliance that occurs whilst planning around a person's needs for future care. This is the same benefit that can occur with good care planning – involving the person, family, carers and clinicians in understanding the person's values and goals for recovery. Care plans and recovery plans that identify strengths and develop these as protective factors will help all people involved to support the person effectively.

## 7.1 Tools supporting the use of the Advance Health Directive

Refer to:

- [Guideline: The use of the standard suite of clinical documentation.](#)
- ADA Australia Advance Health Directive – Mental Health Fact sheets
  - FACTSHEET 1: [About Advanced Health Directives for Mental Health](#)
  - FACTSHEET 2: [Decision-making and Capacity](#)
  - FACTSHEET 3: [Frequently Asked Questions](#)
  - FACTSHEET 4: [Glossary](#)
  - FACTSHEET 5: [Useful Resources and Information](#)
  - FACTSHEET 6: [Empowering 8 Steps for consumers to make an AHD-MH](#)

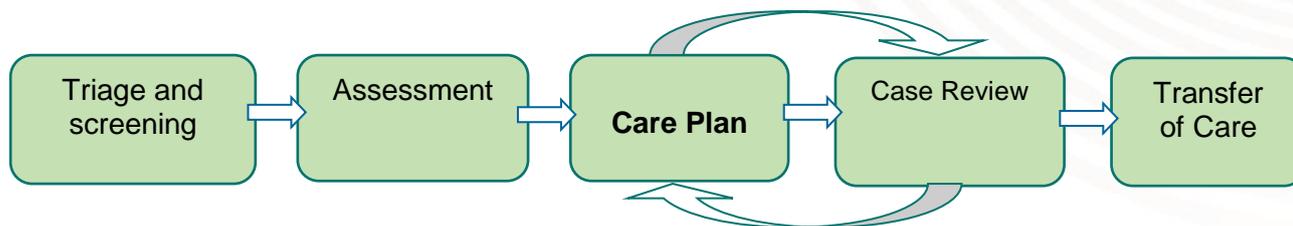
A number of the suite of standardised forms in CIMHA provide prompts to check if a person has an AHD in place. These are opportunities to discuss with the person:

- *Do you know what an advance health directive is?*
- *Have you considered developing one? What might you include?*
- *If there is one in place, is there a need for it to be reviewed and updated?*

The resources and fact sheets listed in the [Resources](#) can assist with this conversation.

The forms that include checks for AHD along the recovery journey are illustrated below.

**Figure 1: AHD-MH checks with standardised forms**



## 7.2 Effective care planning documentation and less restrictive way

A person's recovery journey is not usually linear, as represented above, but junctures in a person's care (such as points of assessment, review and transfer) are important checks to consider with the person:

- Is there a less restrictive way to gain consent to treatment and care?
- Does the team need to re-assess capacity?
- Are there plans in place for times when a person may lack capacity?
- How are we using supported decision making with family, carers and other supports? Can we use this more effectively?
- Has the team had the discussion with the person about future care and the person's views, wishes and preferences – whether recorded in an AHD, care plan, or elsewhere?

In addition to the documentation that prompts clinicians to consider substitute decision makers, care planning documentation can assist clinicians to provide the less restrictive way by ensuring robust, good quality plans are developed collaboratively and communicated effectively. **Figure 2: Care planning as central to the Less Restrictive Way** (see below) provides an illustration of the interplay of documents – the importance of thorough, holistic assessment, how any goals and needs identified through assessment should be included in the Care Plan, and how other decision making and communication tools and processes inform care planning and review.

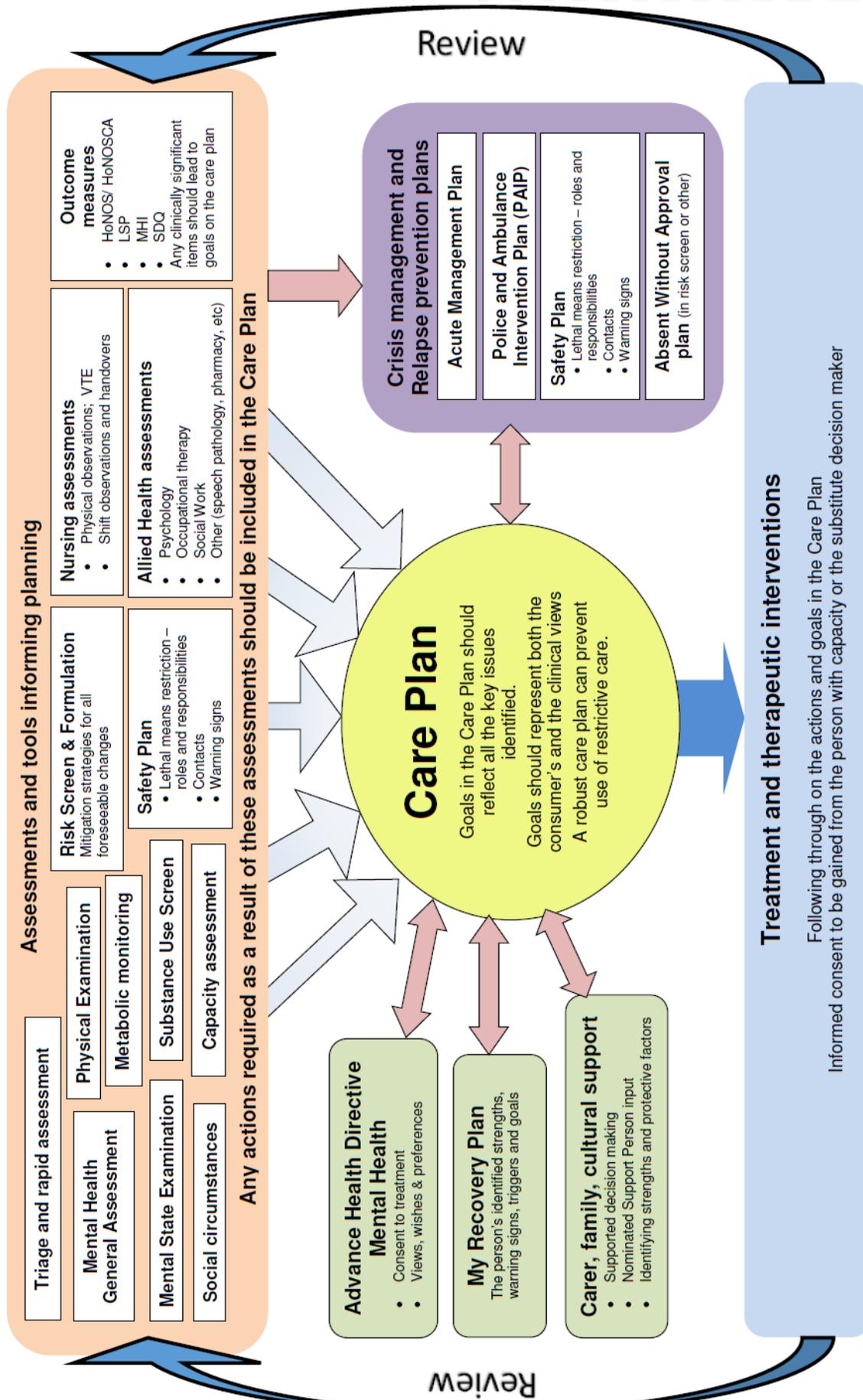
The Care Plan is a living document, requiring regular revision and updates to ensure that the person's key needs are being addressed, and to evaluate the efficacy of treatment and interventions.

Teams can develop goals and strategies with the person and carers/decision makers that effectively integrate the identified needs and the person's strengths and recovery goals. In most cases, this will result in a less restrictive way of providing treatment and care.

Goals that are SMART (Specific, Measurable, Achievable, Realistic and Time-framed) are easier to work towards and see progress. When everyone involved understands the specific goals, how and when they are to be achieved, and the responsibilities of each person, there is generally less confusion and disagreement. Ensure that the person's values are supported, and that supported decision makers and substitute decision makers are included in decisions and changes to Care Plans.

Figure 2: Care Planning as central to the Less Restrictive Way

**CARE PLANNING AS CENTRAL TO LESS RESTRICTIVE WAY**



## 8. Resources

The following resources are provided with hyperlinks to documents online. This does mean that viewing this guideline in hardcopy will be a disadvantage; it may also mean that document locations have changed and links are broken. The online addresses are often very long and unwieldy to put into a printed document. It is suggested that in instances where hyperlinks cannot be used, search the document title with a search engine, or look through the relevant websites where full links are provided.

All Queensland Health *Mental Health Act 2016* documentation, policies and guidelines are available from the *Mental Health Act 2016 website*: <https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/clinical-staff/mental-health/act>

Resources are grouped according to topic.

### 8.1 Advance Health Directives & Advance Care Planning

- Chief Psychiatrist Policy [Advance Health Directives and 'Less Restrictive Way' of Treatment](#)
- Queensland Health [Advance Health Directive and less restrictive way of treatment fact sheet](#)
- [Advance health directive for mental health: guide and form](#)
- [Revocation of advance health directive form](#)
- [Advance health directives brochure](#)
- ADA Australia resources [www.adaaustralia.com.au](http://www.adaaustralia.com.au) :
  - [About Advance Health Directives for Mental Health](#) video [approx. 7 mins]
  - [Completing the AHD-MH Form](#) video [approx. 12 mins]
  - Clinician resources
    - FACTSHEET 1: [About Advanced Health Directives for Mental Health](#)
    - FACTSHEET 2: [Decision-making and Capacity](#)
    - FACTSHEET 3: [Frequently Asked Questions](#)
    - FACTSHEET 4: [Glossary](#)
    - FACTSHEET 5: [Useful Resources and Information](#)
    - FACTSHEET 6: [Empowering 8 Steps for consumers to make an AHD-MH](#)
    - FACTSHEET 7: [International Case Note](#)
- [Advance Health Directive \(AHD\) checklist](#)
- CRISIS IN CONTROL - a film about psychiatric advance directives [about 12 mins long]

In this documentary filmmaker Dr Delaney Ruston explores psychiatric advance directives; forms allowing a person to indicate treatment choices in case of a mental health crisis when decision-making may be compromised. How will this tool help her father who lives with schizophrenia? How has it already helped others? <https://www.youtube.com/watch?v=-QUi2QGodl4>

Office of Advance Care Planning: <https://metrosouth.health.qld.gov.au/acp>

- [My Care, My Choices website](#)
- [Advance Care Planning \(end of life\)](#)
- [Advance Care Planning Clinical Guidelines](#)
- [6 steps to advance care planning](#)
- [Statement of Choices](#)
- [My Health Record: advance care planning documents](#)

Advance Care Planning Australia

<https://www.advancecareplanning.org.au/>

Phone: 1300 208 582

Provide support and advice to people and health professionals in developing and using advance care planning. The website includes a range of resources and guides. Mostly focused on end-of-life advance care planning, but many of the tools and resources may also be applicable to mental health advance care planning. Also provides online courses for health professionals <https://learning.advancecareplanning.org.au/>

My Health Record – Advance Care Planning

<https://myhealthrecord.gov.au/internet/mhr/publishing.nsf/Content/acp>

Provides details about how to create and upload advance care planning document to the national eHealth database, My Health Record.

## 8.2 Capacity

- Chief Psychiatrist Policy [Treatment Criteria and Assessment of Capacity](#)
- *Assessing Adult Capacity for decision-making: Social Work Guide & Practice Toolkit*. This resource is available to social workers only (password required) to support practice <https://msh-qld.libguides.com/SWLibguide>

See educational resources below.

## 8.3 Consent

- [Queensland Health Guide to Informed Decision-Making in Healthcare](#): providing guidance on obtaining consent for health care in adults and minors, and processes for decision-making when capacity to consent is lacking.
- *Informed consent Queensland Health* website: <https://www.health.qld.gov.au/consent> Resources for clinicians, including consent forms and information sheets, and resources for consumers including tips for safe healthcare and informed consent.
- *Choice and medication* – including plain English and low-literacy information sheets on psychotropic medications, which will assist with providing informed consent: <http://www.choiceandmedication.org/queenslandhealth/>

- *Your Health in Mind*: The Royal Australian & New Zealand College of Psychiatrists page provides resources and information that can assist in providing information to consumers and families <https://www.yourhealthinmind.org/treatments-medication>
- National Standards for Mental Health Services: A range of standards relate to informed consent standards and practices.  
<http://www.health.gov.au/internet/main/publishing.nsf/content/mental-pubs-n-servst10>
- *Ottawa Hospital Research Institute Decision Making Aids* – a range of resources that help to enhance capacity, and guide decision making for difficult health and social decisions <http://www.ohri.ca/DecisionAid/>

## 8.4 Documentation

- Queensland Health [Guideline: The use of the standard suite of clinical documentation](#)
- [CIMHA Clinician's Handbook Vol 6: MHA](#) – including guide for use for AHDs and substitute decision makers
- CIMHA [Clinician's Handbook Vol 7: Clinical Notes v1.0](#)
- [CIMHA Attachment Description Naming Convention Factsheet](#)

## 8.5 Supported Decision Making

- [Decision-making support and Queensland's guardianship system: A systemic advocacy report](#), April 2016
- [Office of the Public Guardian Structured Decision Making Framework](#), 2017.
- Office of the Public Guardian, Decision Making <http://www.publicguardian.qld.gov.au/adult-guardian/our-decisions>
- The Public Advocate decision-making support documents:  
<http://www.justice.qld.gov.au/public-advocate/activities/past/decision-making-support-and-queenslands-guardianship-system>
  - [Decision-making support for Queenslanders with impaired capacity: A conceptual framework](#)
  - [A journey towards autonomy? Supported decision-making in theory and practice: A review of literature](#)
  - [Autonomy and decision-making support in Queensland: A targeted overview of guardianship legislation](#)
  - [Autonomy and decision-making support in Australia: A targeted overview of guardianship legislation](#)

## 8.6 Substitute Decision Makers

Office of the Public Guardian <http://www.publicguardian.qld.gov.au/> :

- [Framework on the Consent to Mental Health Treatment and Care by the Public Guardian](#)
- [Application for Mental Health Treatment and Care Consent Form](#)
- [Guide and Application Form for Mental Health Treatment Consent from the Public Guardian](#)
- [Advance Health Directive fact sheet \(general\)](#)
- Guideline for the use of Substitute Decision Makers in the Inpatient Unit

Queensland Civil and Administrative Tribunal <http://www.qcat.qld.gov.au/>

- [Decision-Making for adults factsheet](#)
- [Children and young people matters factsheet](#)
- [Guardianship factsheet](#)
- [Making an application](#)

Enduring Power of Attorney:

- [Enduring Power of Attorney Fact Sheet](#)
- [Enduring Power of Attorney Checklist](#)
- [General principles and the Health Care Principles](#)
- [How to act appropriately as an Attorney in Queensland \(Video\)](#)
- [Enduring Power of Attorney - Long form](#)
- [Enduring Power of Attorney – short form](#)
- [Revocation of Enduring Power of Attorney](#)

Statutory Health Attorney:

- [Statutory Health Attorney fact sheet](#)

Child Safety

- [Guide for health professionals](#): Medical decision making for children and young people in out-of-home care
- [Child Safety Practice Manual](#)
- [Decision-making for the Child](#) – Chapter 3 of the Child Safety Practice Manual
- [Practice resource – Participation of children and young people in decision-making](#)

## 8.7 Treatment and Care (including less restrictive way)

- Chief Psychiatrist Policy [Treatment and care of patients](#)
- Chief Psychiatrist Practice Guideline [Examination and assessments](#)
- Chief Psychiatrist Practice Guideline [Treatment Authorities](#)
- Chief Psychiatrist Practice Guideline [Child and Youth: Treatment and Care of Minors](#)
- [Treatment and Care of Minors fact sheet](#)
- [Examination and assessments fact sheet](#)

## 8.8 Restrictive Practice

- [National Principles to Support the Goal of Eliminating Mechanical and Physical Restraint in Mental Health Services](#)
- [National Principles for Communicating about Restrictive Practices with Consumers and Carers](#)
- Chief Psychiatrist Policy: [Mechanical Restraint](#)
- [Chief Psychiatrist Practice Guideline: Mechanical Restraint](#)
- Chief Psychiatrist Policy: [Seclusion](#)
- [Chief Psychiatrist Practice Guidelines: Seclusion](#)
- Chief Psychiatrist Policy: [Physical Restraint](#)
- [Chief Psychiatrist Practice Guideline: Physical Restraint](#)
- [Chief Psychiatrist Policy: Clinical Need for medication](#)
- [Acute behavioural disturbance management \(including acute sedation in Queensland Health Authorised Mental Health Services \(children and adolescents\) Guideline](#)
- [Acute behavioural disturbance management \(including acute sedation in Queensland Health Authorised Mental Health Services \(adults\) Guideline](#)
- The Department of Health [Acute behavioural disturbances and psychoses](#)
- Office of the Public Guardian Restrictive Practices Decision-Making Framework:  
Provides information about decision making by Guardians in terms of restrictive practices within the *Guardianship and Administration Act 2000*  
[https://www.publicguardian.qld.gov.au/\\_data/assets/pdf\\_file/0010/574084/Restrictive-Practices\\_Decision\\_Making\\_Framework.pdf](https://www.publicguardian.qld.gov.au/_data/assets/pdf_file/0010/574084/Restrictive-Practices_Decision_Making_Framework.pdf)

## 8.9 Support and safeguards to less restrictive way

- Independent Patient Rights Advisers [Independent Patient Rights Advisers Service Model Guidelines](#)
- [Independent Patient Rights Adviser fact sheet](#), Child and Youth Mental Health
- [The community visitor program \(adult\) factsheet](#)
- [Child and Youth Brochure, Office of the Public Guardian](#), including information about the Community Visitor.

## 8.10 Educational resources

- Queensland Centre for Mental Health Learning [www.qcmhl.qld.edu.au](http://www.qcmhl.qld.edu.au) :
  - *QC40 Capacity Assessment and Advance Health Directives* eLearning modules [2 hours]
  - *Capacity Assessment and Advance Health Directives* Face-to-face training toolkit
  - *QC13 Capacity Assessment workshop* [4 hours] – see workshop dates and locations online.

## 8.11 Legislation and Standards

- Queensland Health *Mental Health Act 2016*  
website <https://gheps.health.qld.gov.au/mentalhealth/mha/mha>
- Queensland Government Legislation website for access to current legislation.  
<https://www.legislation.qld.gov.au/>  
Power of Attorney Act 1998  
Child Protection Act 1999  
Mental Health Act 2016  
Guardianship and Administration Act 2000
- Queensland Government website: <https://www.qld.gov.au/law/legal-mediation-and-justice-of-the-peace/power-of-attorney-and-making-decisions-for-others>
- [National Standards for Mental Health Services 2010](#)

## 8.12 Telehealth

Queensland Health Telehealth <https://www.health.qld.gov.au/telehealth>

- [Telehealth Equipment Overview](#)
- [Telehealth Room Set Up Guidelines](#)
- [Telehealth Etiquette Guidelines](#)
- [Telehealth Guidelines](#)
- [Connecting your Apple Device to the videoconference system](#)
- [Emailing Clinical or organisationally sensitive information](#)
- [Case study: Telehealth parent counselling trial and research project](#)

RANZCP Telehealth and Psychiatry <https://www.ranzcp.org/Publications/Telehealth-in-psychiatry>

## 9. Appendices

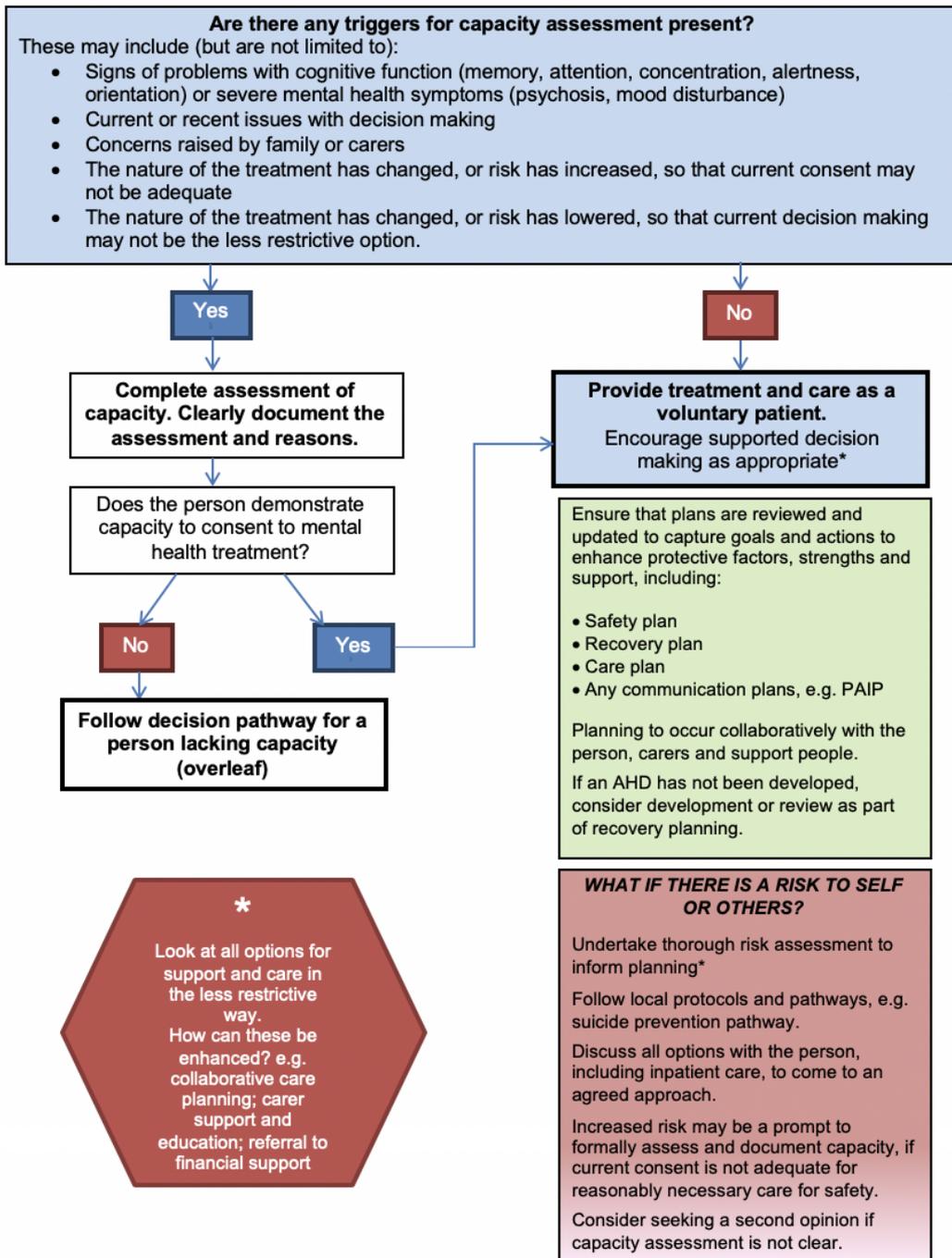
The following resources are also available separately on the Mental Health Act 2016 website as individual documents, which can be printed and used in clinical practice.

## 9.1 Appendix A: Decision making pathway – adults

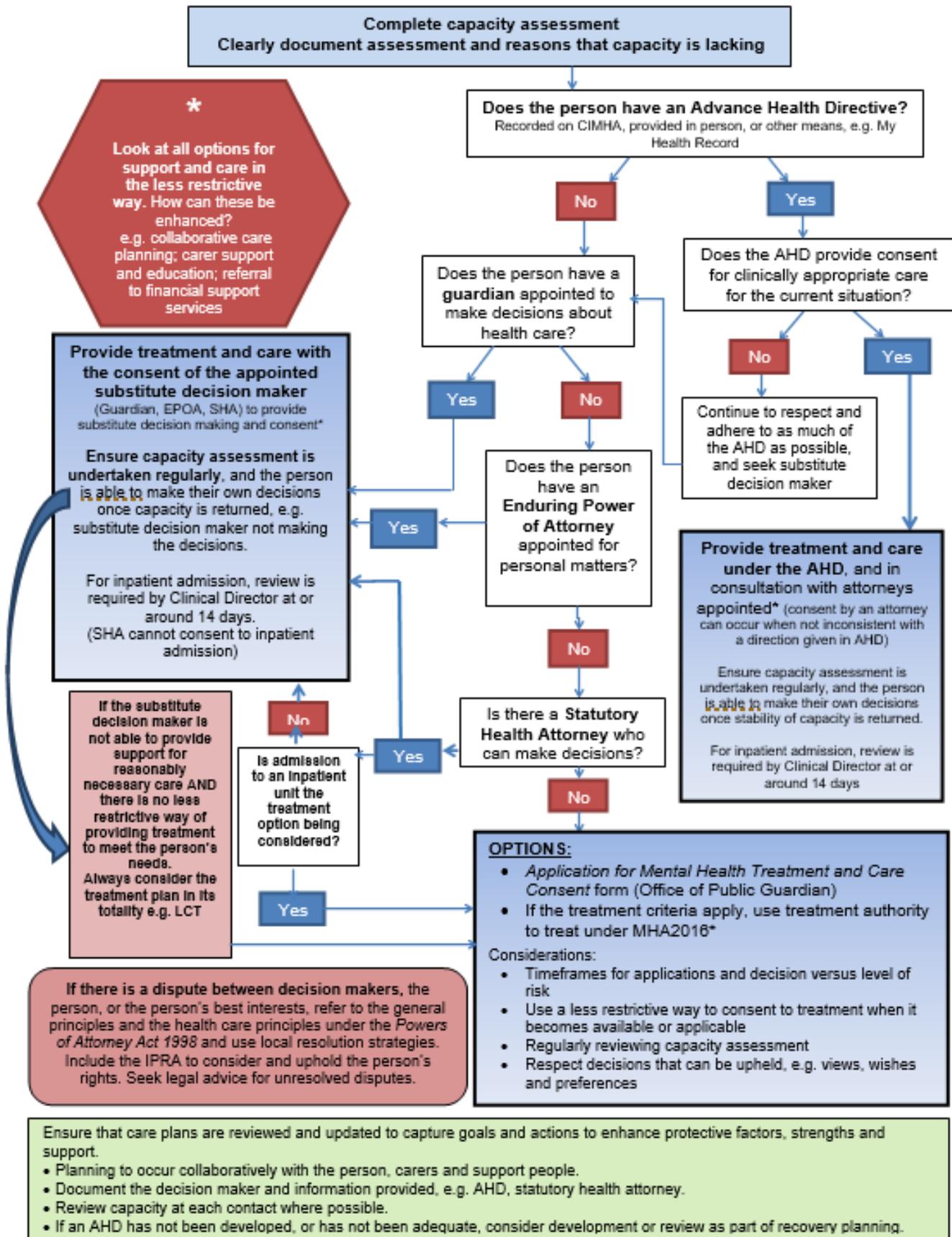
### Less Restrictive Way (section 13 *Mental Health Act 2016*) Decision Making for Adults – Mental Health Treatment and Care

#### When a person has capacity to consent

Capacity is presumed for people over 18 years of age.



# When a person is lacking capacity to consent



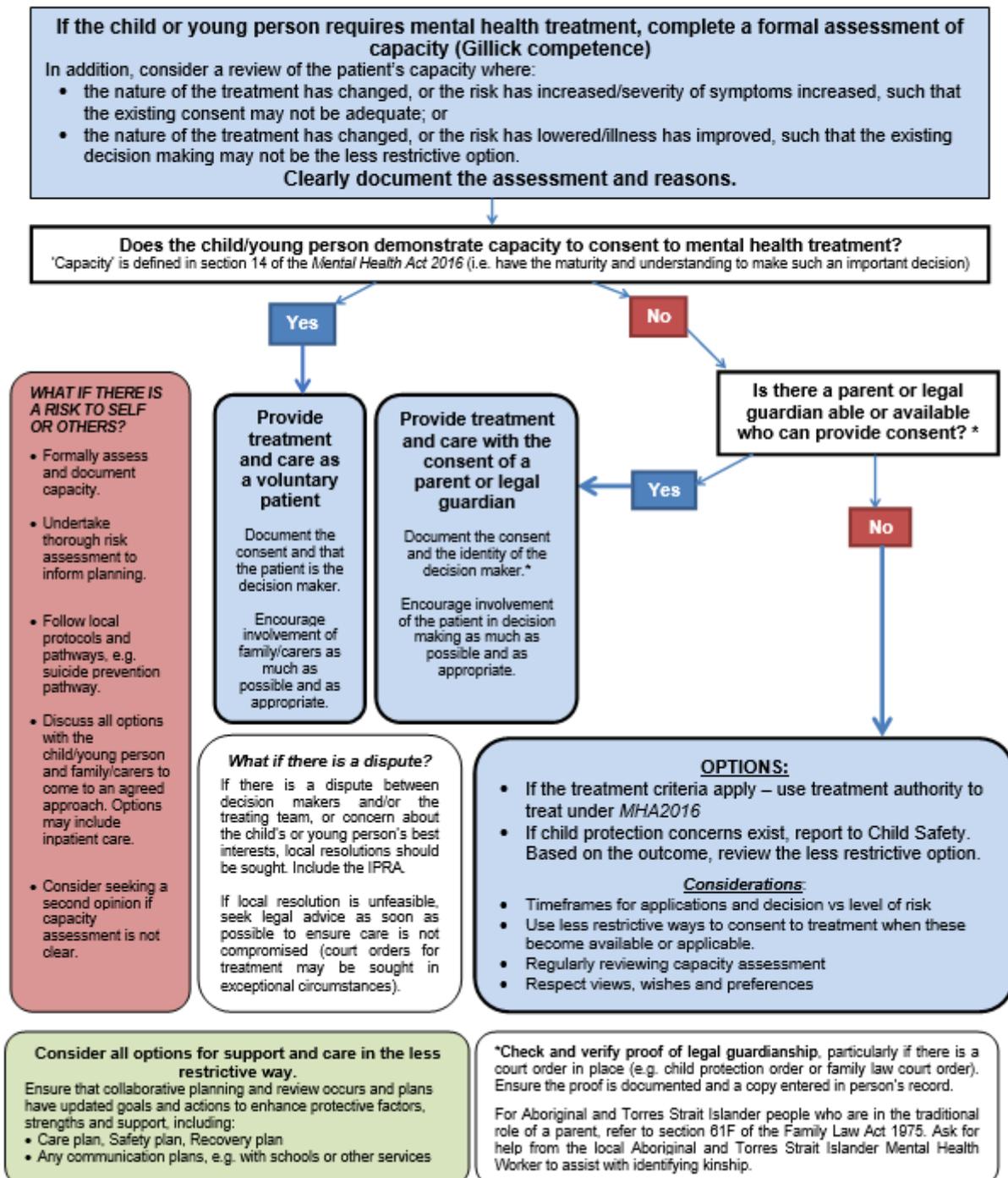
## 9.2 Appendix B: Decision making pathway – child and youth

### Less Restrictive Way (section 13 *Mental Health Act 2016*)

#### Decision Making for Child and Youth Mental Health Treatment and Care

To be read in conjunction with the *Guide to Informed Decision-making in Health Care*

Evidence of capacity for patients to consent to treatment must be established. If evidence of the patient's capacity to consent is not able to be established, the less restrictive way for consent to health care should be sought.



## 9.3 Appendix C: Capacity Assessment for Mental Health Treatment – Adults Form and Guide for Use



Department of Health Mental Health Act 2016  
**Capacity Assessment for Adults**

© State of Queensland (Queensland Health) 2016  
 Contact: MHA@health.qld.gov.au

**Capacity Assessment for Mental Health Treatment - Adults**  
 This form is an aid to documenting capacity to make decisions related to mental health treatment ONLY. It does not replace any other capacity assessment for other matters or decisions. An assessment for the presence of a mental illness needs to occur prior to this capacity assessment to determine the need for treatment.

A. Person's details			
Surname:		Given name(s):	
Residential address:			
Town / Suburb		State:	Postcode:
Date of birth:	Or age:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Intersex / Indeterminate <input type="checkbox"/> Not stated / unknown	

B. Supported Decision		
A person may have capacity to make decisions about their own mental health treatment, without the assistance of others. However, support from others should be actively encouraged, and capacity may also be achieved with support from others in understanding information relevant to the proposed treatment. (Section 14(3) of the <i>Mental Health Act 2016</i> ). This capacity assessment pertains to the principle decision maker; this can be achieved with supported decision makers, e.g. the person is taken to have capacity to make decisions if they can do so with the assistance of someone else. <b>Who are the persons assisting during this capacity assessment?</b> (please write 'nil' if no-one else present)		
Name of Support:	Relationship to patient:	Contact details:

C. Reason for Capacity Assessment
Capacity is presumed for people over 18 years of age. What is the trigger for this capacity assessment? (e.g. severity of symptoms impacting on cognition, level of risk). Document details:
For each of the following criteria (D, E, F) please provide details including: i) how these were explained to the person; ii) the person's responses indicating understanding or lack thereof. This may include understanding of the cause and effect; consequences for self and others; permanent or long-term outcomes; iii) any written or other materials provided; iv) any factors that were considered important to the person.

D. What is the treatment being proposed?
Document details:
Does stability of capacity need to be demonstrated before consent can be given for this treatment decision?

- Yes – ensure that the 'stability of capacity' section is completed at the end of this document. The capacity decision of this form may not be acted on until stability is demonstrated.
- No – the capacity decision from this assessment can be acted on directly.

**E. Does the person understand, in general terms, that they have a mental illness, or symptoms of a mental illness that affects their mental health and wellbeing?**

Yes  No

Document details:

**F. Is the person capable of understanding in general terms:**

a. The nature and purpose of the treatment proposed?

Yes  No

Document details:

b. The benefits and risks of treatment, and alternatives to the treatment?

Yes  No

Document details:

c. The consequences of not receiving the treatment?

Yes  No

Document details:

**G. Is the person able to make a decision and communicate the decision in some way?** Yes  No

Provide details including how the decision was communicated and the persons reasons for the decision, including any factors that were considered important to the person and/or the support person(s):

**H. If a 'NO' response was documented for any of the above questions (E, F, G) this may indicate that the person lacks capacity to make the decision at this point in time**

Before making this judgement, you should ensure that every effort has been made to encourage and support the person to be able to make their own decision. Consider the following ways to enhance capacity:

- Providing all relevant information for the decision in a way the person understands. This may include written, pictorial, verbal and other means.
- If the choice is between alternatives, do they have the information on the different options? Are the choices clear, or have they been presented in a way that might be confusing? Are the same options being presented each time, or are different options being given?
- Impact of the environment on decision making, e.g. noise, distractions, interruptions, trauma triggers. Can the person be made to feel more at ease?
- Have cultural and religious needs been recognised and taken into account in providing information and choices, e.g. setting, appropriate support people, adapting to beliefs and customs.
- Have communication needs been adequately addressed, e.g. use of interpreters, written information in the person's preferred language, use of plain English, no jargon, use of visual aids?
- Timing – can the person be given time to consider their options? Can the decision be delayed until a time when the person can make a decision? Is there a time of day that is better for the person to take in and retain information?
- Can a family member, friend, carer or advocate help the person to make a choice or express a view?
- Does the person feel that they are able to give their decision freely and voluntarily? Consider the language used, the setting, the influence of others, and other factors that may be perceived as coercive.

Provide any details of these considerations:

**I. Capacity Decision**

At this point in time, I consider the person:

has capacity under section 14 of the *Mental Health Act 2016*  does not have capacity\* → complete section J  
to make this health assessment and or/treatment decision.

\*where an appropriate substitute decision maker exists, they will need to be identified to consent to mental health care. Ensure that where a substitute decision maker makes a decision, the substitute decision maker is identified on any consent forms for treatment.

**Stability of Capacity**

For a person whose capacity appears to be borderline or fluctuating, capacity may need to be established over time to ensure that the person can make a valid decision. To determine that this person's capacity is stable and not fluctuating, I recommend:

- a further capacity assessment on \_\_\_/\_\_\_/\_\_\_ (date)
- a series of further assessments with stability demonstrated by \_\_\_/\_\_\_/\_\_\_ (date)  
(e.g. consistently shows capacity over at least three assessments by a certain date); OR
- this person has consistently demonstrated capacity from \_\_\_/\_\_\_/\_\_\_ (date) to present and has stability of capacity

**Capacity assessed by:**

Name:		Role:	
Signature:	Date:	Time:	
If it is determined that patient does not have capacity, who is the substitute decision maker?			
Name of substitute decision maker:		Relationship to patient:	
Contact details:			

**J. Substitute Decision Maker**

**If it is determined the patient does not have capacity, is there a substitute decision maker?**

You must adhere to the Advance Health Directive (AHD) or the consent obtained from a substitute decision maker.

**i. a) Does the patient have an AHD that is applicable to the treatment?**

- Yes → GO TO i(b)       No → GO TO ii

**b) If yes, has the AHD been sighted and a copy is in the medical record?**

- Yes (the AHD must be adhered to)     No → GO TO ii

**ii. Substitute decision-maker (select one only):**

- Attorney(s) for health matters under an Enduring Power of Attorney or AHD
- Personal guardian appointed by QCAT under the *Guardianship and Administration Act 2000*
- Statutory Health Attorney
- If none of these, the Office of the Public Guardian must provide consent (ph: 1300 653 187)

Name of substitute decision maker

Relationship to patient:

Contact detail

# Capacity Assessment for Mental Health Treatment - Adults

## Guide for use

The *Capacity Assessment for Mental Health Treatment - Adults* form is an optional tool for documenting the outcome of a capacity assessment with a patient. The form is based on the capacity criteria as outlined in the *Mental Health Act 2016*.

This form provides a structured method for obtaining evidence of the patient's capacity to consent to treatment, elicited from the conversations that you have with the person, and helps you to identify which areas of capacity are present or lacking. It also includes the opportunity to recommend and undertake further assessment to demonstrate stability of capacity.

There is no requirement for this form to be used; it is provided as a support for practice.

### How does this form support the less restrictive way under section 13 of the *Mental Health Act 2016*?

Having clear documentation relevant to determining the capacity of a patient to consent to treatment ensures that the most appropriate person consents to the mental health treatment. If a person is lacking capacity, the *Mental Health Act 2016* requires identifying a substitute decision maker where available.

The *Capacity Assessment for Mental Health Treatment - Adults* may support best practice in undertaking a capacity assessment and documenting the assessment, to ensure that decisions for treatment are made with respect to the person's rights and in their best interest.

### When might I use the *Capacity Assessment for Mental Health Treatment – Adult form*?

In circumstances where consent is required, the capacity of the patient to consent to treatment must always be determined before treatment is

contemplated. Capacity assessment may be documented in several ways.

This form is not intended to replace current practices, rather it is intended to provide an option for structuring a capacity assessment for mental health treatment when more detailed documentation is needed. You may consider using this form to document capacity in the following circumstances:

- to assist in identifying the less restrictive way for the patient to receive treatment (i.e. if the child or young person has capacity and can consent to treatment themselves)
- when a decision to use involuntary treatment under the *Mental Health Act 2016* is being made
- when a treatment authority is being reviewed, and a decision is being made whether or not to revoke the treatment authority
- when there is uncertainty about the patient's capacity to consent to treatment and several opinions regarding capacity are being sought.
- where concerns exist about fluctuating capacity to consent to treatment, to record recommendations and recurrent assessment for establishing stability of capacity.
- when concerns exist about how is presenting with regards to capacity, to record and clearly document the conversation and measures taken in the capacity assessment.

The form does NOT have to be completed on each of these occasions; it is at the discretion of the clinician, treating team and local health service to determine how the form may be most effectively used. Local health services may develop protocols around the form and times when it is expected to be used.

### When NOT to use this form

The *Capacity Assessment for Mental Health Treatment- Adult form* is only intended to assist in establishing whether a person has capacity to

make decisions related to mental health treatment and care.

Capacity is decision-specific; any other decisions, such as finances or lifestyle choices, need to be assessed separately.

### How do I use the *Capacity Assessment for Mental Health Treatment – Adult form*?

The form provides a structured method for assessing the capacity of a person through assessment conversations. It is not intended to be used as a questionnaire. It provides prompts for all relevant criteria in section 14 of the *Mental Health Act 2016* to clearly document the factors important for capacity assessment.

You may find it useful to read through the form prior to undertaking a capacity assessment, as a reminder of the areas you will need to explore, and the considerations of factors that may enhance or effect decision making at the time.

During the capacity assessment, you may take notes. Use the person's own words (as much as possible), as this provides stronger evidence supporting the assessment and your observations. You complete this form as soon as possible after the assessment.

**Sections A and B** provide context for the capacity assessment, including who is providing support, and what is the reason for the assessment.

**Section C** provides an opportunity to specifically document the reasons for the capacity assessment.

**Sections D to G** are the criteria for capacity under section 14 of the *Mental Health Act 2016*. It is important to provide details under each of these criteria, including:

- i) how these were explained;
- ii) the person's responses indicating understanding or lack thereof;
- iii) any written or other materials provided;

- iv) any factors that were considered important to the person;
- v) how the decision was communicated.

**In section H**, the form assists in identifying any considerations for enhancing capacity. If any environmental, social or other factors may have been present to support or diminish capacity, please note these here. A range of considerations are provided to assist clinicians.

**Section I** documents the capacity decision at the time of the assessment. It requires the assessing clinician to sign. The *Stability of Capacity* subsection gives options to identify further assessment if required to establish capacity, or to document that consistent capacity has been demonstrated.

**Section J: If the person is assessed as not having capacity to consent to treatment**, a substitute decision maker may need to be identified and documented in this section. Refer to the *Less Restrictive Way – Decision Making for Adults - mental health treatment and care* flowchart to assist with this if required.

### Where do I record the *Capacity Assessment for Mental Health Treatment – Adult form*?

The *Capacity Assessment for Mental Health Treatment - Adult form* should be uploaded to the Consumer Integrated Mental Health Application (CIMHA) as a clinical note.

In the CIMHA clinical note, choose the "Assessment" category and an "Attachment summary" template, then record and upload the scanned form.

Be sure to use the attachment naming convention, **<Attachment>\_<date>** to make it easier to search (e.g. **Capacity Assessment\_20180702**). To search for previous capacity assessments, filter for the Assessment category. Refer to the [CIMHA Attachment Description Naming Convention Factsheet](#) for more information.

## **Do I need training to use the Capacity Assessment for Mental Health Treatment – Adults form?**

If you are confident with capacity assessment, you may not need any further training to use this form. If you are not confident, but feel you have the skills and knowledge needed, this form may help you to structure and record your assessment more fully. If you feel that you do not have the skills required to identify factors related to capacity when talking with a person, it is recommended that you undertake training in capacity assessment.

**For more information about Less Restrictive Way and Capacity Assessment, including links to training and education, refer to the ‘Guidelines to Providing Treatment and Care in the Less Restrictive Way’.**

**CIMHA – Attachment Description Naming  
Convention Factsheet link:**

[https://qheps.health.qld.gov.au/data/assets/pdf\\_file/0028/2153683/fact-attachdescrip.pdf](https://qheps.health.qld.gov.au/data/assets/pdf_file/0028/2153683/fact-attachdescrip.pdf)

## 9.4 Appendix D: Capacity Assessment for Mental Health Treatment – Child and Youth Form and Guide for Use



Department of Health Mental Health Act 2016  
Capacity Assessment for Child and Youth

© State of Queensland (Queensland Health) 2016  
Contact: MHA2016@health.qld.gov.au

**Capacity Assessment for Mental Health Treatment (Gillick Competence) Child and Youth**

This form is an aid to documenting capacity to make decisions related to mental health treatment ONLY. It does not replace any other capacity assessment for other matters or decisions. An assessment for the presence of a mental illness needs to occur prior to this capacity assessment to determine the need for treatment.

A. Child/young person's details			
Surname:		Given name(s):	
Residential address:			
Town / Suburb		State:	Postcode:
Date of birth:	Or age:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Intersex / Indeterminate <input type="checkbox"/> Not stated / unknown	

B. Supported Decision		
A child or young person may have capacity to make decisions about their own mental health treatment, without the assistance of others.		
However, support from others should be actively encouraged, and capacity may also be achieved with support from others in understanding information relevant to the proposed treatment. (Section 14(3) of the <i>Mental Health Act 2016</i> ).		
<b>Who are the persons assisting the child or young person during this capacity assessment?</b> (please write 'nil' if no-one else present)		
Support person's Name:	Relationship to young person:	Contact details:

For each of the following criteria (C, D and E) please provide details including:

- i) how these were explained to the child/young person;
- ii) the child/young person's responses indicating understanding or lack thereof. This may include understanding of cause and effect; consequences for self and others; permanent or long-term outcomes;
- iii) any written, visual or other materials provided;
- iv) any factors that were considered important to the person and/or supports.

C. Does the child / young person understand, in general terms, that they have a mental illness, or symptoms of a mental illness that affects their mental health and wellbeing?
<input type="checkbox"/> Yes <input type="checkbox"/> No
Document details:

**D. What is the treatment being proposed?**

Document details:

Does stability of capacity need to be demonstrated before consent can be given for this treatment decision?

- Yes – ensure that the 'stability of capacity' (Section H) is completed. Seek consent from parent or legal guardian until stability is demonstrated.
- No – the capacity decision from this assessment can be acted on directly.

**E. Is the child/young person capable of understanding in general terms:**

a. The nature and purpose of the treatment proposed?

- Yes  No

Document details:

b. The benefits and risks of treatment, and alternatives to the treatment?

- Yes  No

Document details:

c. The consequences of not receiving the treatment?

- Yes  No

Document details:

**F. Is the child/young person able to make a decision and communicate the decision in some way?**

Yes  No

Provide details including how the decision was communicated and the persons reasons for the decision, including any factors that were considered important to the person:

**G. If a 'NO' response was documented for any of the above questions (C, D, E, F) this may indicate that the person lacks capacity to make the decision at this point in time.**

Before forming this view, you should ensure that every effort has been made to encourage and support the child or young person to be able to make their own decision. Consider the following ways to enhance capacity:

- Providing all relevant information for the decision in a way the person understands. This may include written, pictorial, verbal and other means.
- If the choice is between alternatives, do they have the information on the different options? Are the choices clear, or have they been presented in a way that might be confusing? Are the same options being presented each time, or are different options being given?
- Impact of the environment on decision making, e.g. noise, distractions, interruptions, trauma triggers. Can the person be made to feel more at ease?
- Have cultural and religious needs been recognised and taken into account in providing information and choices, e.g. setting, appropriate support people, adapting to beliefs and customs.
- Have communication needs been adequately addressed, e.g. use of interpreters, written information in the person's preferred language, use of plain English, no jargon, use of visual aids?
- Timing – can the person be given time to consider their options? Can the decision be delayed until a time when the person can make a decision? Is there a time of day that is better for the person to take in and retain information?
- Can a family member, friend, carer or advocate help the person to make a choice or express a view?
- Does the person feel that they are able to give their decision freely and voluntarily? Consider the language used, the setting, the influence of others, and other factors that may be perceived as coercive.

Provide any details of these considerations:

### H. Capacity Decision

At this point in time, I consider the child/young person:

- has capacity (is Gillick Competent) under section 14 of the *Mental Health Act 2016*; OR  
 does **not** have capacity\* → **COMPLETE** section I

to make this mental health assessment and or/treatment decision.

\*a parent or legal guardian will need to be identified to decide upon consent to mental health care. Ensure that the parent or legal guardian is identified on any consent forms for treatment.

#### Stability of Capacity

For a child/young person whose capacity appears to be emerging, borderline or fluctuating, capacity may need to be established over time to ensure that the person can make a valid decision. To determine that this child/young person's capacity is stable and not fluctuating, I recommend:

- a further capacity assessment on \_\_\_/\_\_\_/\_\_\_ (date)  
 a series of further assessments with stability demonstrated by \_\_\_/\_\_\_/\_\_\_ (date)  
 (e.g. consistently shows capacity over at least three assessments by a certain date); OR  
 this person has consistently demonstrated capacity from  
 \_\_\_/\_\_\_/\_\_\_ (date) to present and has stability of capacity

#### Capacity assessed by:

Name:		Role:	
Signature:	Date:	Time:	
If it is determined that patient does not have capacity, who is the substitute decision maker?			
Name of substitute decision maker:			
Relationship to patient:			
Contact details:			

### I. Parent or legal guardian

Who is the parent/legal guardian\* with parental rights and responsibilities to provide consent for treatment?

If applicable, source of decision-making authority (*tick one*):

- Court order →  Court order verified  
 Legal guardian →  Documentation verified  
 Other person →  Documentation verified

Name of Parent/legal guardian/other person\*

Relationship to child/young person

\*Formal arrangements such as parenting/custody orders, adoption, or other formally recognised carer/guardianship arrangements. Refer to the Queensland Health 'Guide to Informed Decision-making in Health Care' and local policy and procedures.

## Capacity Assessment for Mental Health Treatment (Gillick Competence) – Child and Youth

### Guide for use

The *Capacity Assessment for Mental Health Treatment (Gillick Competence) Child and Youth* form is an optional tool for documenting the outcome of a capacity assessment with a patient. The form is based on the meaning of 'capacity' in section 14 of the *Mental Health Act 2016*.

This form provides a structured method for obtaining evidence of the patient's capacity to consent to treatment, during conversations you have with relevant persons, and helps you to identify which areas of capacity are present or lacking. It also includes the opportunity to recommend and undertake further assessment to demonstrate stability of capacity.

There is no requirement for this form to be used; it is provided as a support for practice.

### How does this form support the less restrictive way under section 13 of the *Mental Health Act 2016*?

Having clear documentation relevant to determining the capacity of a patient to consent to treatment ensures that the most appropriate person consents to the mental health treatment of a child or young person. In most instances, this person is a parent/legal guardian, if the young person does not have capacity.

If the child or young person does have the requisite capacity, they can consent to the treatment.

The *Capacity Assessment for Mental Health Treatment (Gillick Competence) Child and Youth* form may support best practice in undertaking a capacity assessment, and documenting the assessment, to ensure that decisions for treatment are made with respect to the child or young person's rights and in their best interest.

### When might I use the *Capacity Assessment for Mental Health*

### *Treatment (Gillick Competence) Child and Youth form?*

In circumstances where consent is required, the capacity of the patient to consent to treatment must always be determined before treatment is contemplated. Capacity assessment may be documented in a number of ways.

This form is not intended to replace current practices, rather it is intended to provide an option for structuring a capacity assessment for mental health treatment when more detailed documentation is needed. You may consider using this form to document capacity in the following circumstances:

- to assist in identifying the less restrictive way for the patient to receive treatment (i.e. if the child or young person has capacity and can consent to treatment themselves)
- when a decision to use involuntary treatment under the *Mental Health Act 2016* is being made
- when a decision is being made to revoke a treatment authority – to determine if the child or young person has capacity, or if consent is required from a parent or legal guardian
- when there is uncertainty about the patient's capacity to consent to treatment, and a number of opinions on capacity to consent are being sought
- where concerns exist about fluctuating or emerging capacity to consent to treatment, to record recommendations and recurrent assessment in order to establish stability of capacity
- when concerns exist about how a child or young person is presenting with regards to capacity, to record and clearly document the conversation and measures taken in the capacity assessment.

The form does NOT have to be completed on each of these occasions; it is at the discretion of the clinician, treating team and local health service to

determine how the form may be most effectively used. Local health services may develop protocols around the use of the form.

### When NOT to use this form

The *Capacity Assessment for Mental Health Treatment (Gillick Competence) Child and Youth* form is only intended to assist in establishing whether the child or young person has capacity to make decisions related to mental health treatment and care.

Capacity is decision-specific; any other decisions, such as managing finances, schooling or lifestyle choices, need to be assessed separately.

### How do I use the *Capacity Assessment for Mental Health Treatment (Gillick Competence) Child and Youth* form?

The form provides a structured method for assessing the capacity of a child or young person, through assessment conversations. It is not intended to be used as a questionnaire. It provides prompts for all the relevant criteria in section 14 of the *Mental Health Act 2016*, to clearly document the factors important for capacity assessment.

You may find it useful to read through the form prior to undertaking a capacity assessment, as a reminder of the areas you will need to explore, and the considerations of factors that may enhance or effect decision making at the time.

During the capacity assessment, you may take notes. Use the child's or young person's own words (as much as possible), as this provides stronger evidence supporting the assessment and your observations. You should complete this form as soon as possible after the assessment.

**Section A** records the child/young person's details.

**Section B** provides context for the capacity assessment by identifying who is included in the discussion as a supported decision maker. This acknowledges that parents, carers, cultural

supports and others may assist a child or young person in weighing up and making a decision.

**Sections C to F** are the criteria for capacity under section 14 of the *Mental Health Act 2016*. It is important to provide details under each of these criteria, including:

- i) how these were explained;
- ii) the child's or young person's responses indicating understanding or lack thereof;
- iii) any written or other materials provided;
- iv) any factors that were considered important to the child or young person;
- v) how the decision was communicated by the child or young person.

**In section G**, the form assists in identifying any considerations for enhancing capacity. If any environmental, social or other factors may have been present to support or diminish capacity, please note these here. A range of considerations are provided to assist clinicians.

**Section H** documents the decision by the clinician regarding the child or young person's capacity to consent to treatment at the time of the assessment. It requires the signature of the assessing clinician, by way of showing that this assessment was undertaken by that clinician.

The 'Stability of Capacity' subsection gives options to identify further assessment if required to establish capacity, or to document that consistent capacity has been demonstrated. This may be relevant if the child or young person has shown fluctuating or emerging capacity.

**Section I:** If the child or young person is assessed as not having capacity to consent to treatment, a parent or legal guardian needs to be identified and documented in this section. Refer to the *Less Restrictive Way – Decision Making for Child and Youth Mental Health Treatment and Care* flowchart to assist with this if required.

## **Where do I record the Capacity Assessment for Mental Health Treatment (Gillick Competence) Child and Youth form?**

The *Capacity Assessment for Mental Health Treatment (Gillick Competence) Child and Youth* form can be uploaded to the Consumer Integrated Mental Health Application (CIMHA) as a clinical note.

In the CIMHA clinical note, choose the "Assessment" category and an "Attachment summary" template, then record and upload the scanned form.

Be sure to use the attachment naming convention, **<Attachment>\_<date>** to make it easier to search (e.g. **Capacity Assessment\_20180702**). To search for previous capacity assessments, filter for the Assessment category. Refer to the [CIMHA Attachment Description Naming Convention Factsheet](#) for more information.

## **Do I need training to use the Capacity Assessment for Mental Health Treatment?**

If you are confident with capacity assessment, you may not need any further training to use this form. If you are not confident, but feel you have the skills and knowledge needed, this form may help you to structure and record your assessment more fully. If you feel that you do not have the skills required to identify factors related to capacity when talking with a person, it is recommended that you undertake training in capacity assessment.

**For more information about Less Restrictive Way and Capacity Assessment, refer to the 'Guidelines to Providing Treatment and Care in the Less Restrictive Way'.**

CIMHA Attachment Description Naming Convention Factsheet link:  
[https://qheps.health.qld.gov.au/\\_data/assets/pdf\\_file/0028/2153683/fact-attachdescrip.pdf](https://qheps.health.qld.gov.au/_data/assets/pdf_file/0028/2153683/fact-attachdescrip.pdf)

## 9.5 Appendix E: Decision Maker Information Checklist (Child and Youth) and Guide for Use



Queensland  
Government

Department of Health Mental Health Act 2016

Decision Maker Information Checklist for CYMHS

© State of Queensland (Queensland Health) 2016  
Contract: <http://www.health.qld.gov.au>

### Decision Maker Information for Child and Youth Mental Health Services

Refer to Decision Maker Information Checklist - Guide for Use.

#### A. Does the child/young person have capacity?

Yes Gillick competency/capacity to consent was assessed on: \_\_\_/\_\_\_/\_\_\_ (date) and is documented in:  
Provide details of location on CIMHA:

The child/young person is to actively participate in the discussions outlined in this checklist.

No Parent/legal guardian/other person\* with parental rights and responsibilities to participate in the discussions outlined in this checklist.

If applicable, source of decision-making authority (tick one):

Court order →  Court order verified

Legal guardian →  Documentation verified

Name of parent/legal guardian\*

Relationship to child/young person

\*Formal arrangements such as parenting/custody orders, adoption, or other formally recognised carer/guardianship arrangements. Refer to the Queensland Health 'Guide to Informed Decision-making in Health Care' and local policy and procedures. Complete the source of decision-making authority as applicable below.

#### B. Understanding Informed Consent

The clinician is to talk with the child/young person and/or parent/guardian about informed consent, including:

- what is meant by 'informed consent'.
- the treatment and care provided by the service.
- engaging in developing a care plan.
- providing consent for any treatment or care proposed in the care plan.
- provide the opportunity for questions to be asked and answered.

Additional notes:

#### C. Restrictive practices

The clinician should explain the following to the child/young person and/or parent/guardian:

- The service has a duty of care to keep people safe. If the child/young person is at risk of harm to self or others, and no other less restrictive method is able to maintain safe care, as a last resort restrictive practices might be used. Every effort will be made to include safe ways of managing behaviours in the care plan to prevent resorting to these practices.
- the inpatient unit is a locked unit. This means that the child/young person will not be able to leave without permission.
- the use of restrictive practices (physical restraint, sedation and seclusion) as a last resort of treatment the child/young person is a risk of harming self, others or property. Providing written information about how these practices might be used, including the risks involved.

Page 1 of 3

is suggested best practice.

consent cannot be given for seclusion; this can only be authorised by clinicians under the Mental Health Act 2016.

provide the opportunity for questions to be asked and answered.

Additional notes:

#### D. Withdrawal of consent

The clinician should explain the following to the child/young person and/or parent/guardian:

Consent to treatment may be withdrawn at any time by telling the clinician (or another staff member) at the Child and Youth Mental Health Service. Such a decision will be discussed and clearly written in the child's/young person's medical record.

The decision will be acted upon unless there are concerns that the condition will get significantly worse, or there is serious risk of harm to self or others. The treating team will discuss any concerns with me to work out options.

If treatment and care is necessary to prevent harm and there is no less restrictive way to provide it, the treating team may need to consider involuntary treatment under the *Mental Health Act 2016*.

If consent is withdrawn consent, the treating team may have concerns about my/my child's best interests and need for ongoing care. In these circumstances the team will further discuss options to meet the child's/young person's needs, including the option of involuntary treatment under the *Mental Health Act 2016* if required.

Additional notes:

#### E. Doctor/Clinicians statement

I have explained all the ticked content in this form to the patient/parent/legal guardian\* and I am of the opinion that they have understood this information.

Clinician Name:

Clinician Signature: Date

#### F. Does the patient/parent/legal guardian \* need interpreter/cultural services?

i. a) Is a language interpretation service required?  Yes  No → GO TO ii

b) If yes, is a qualified Interpreter present?  Yes (complete section H)  No

If no, please state reason:

ii. a) Is a cultural support person required?  Yes  No

b) If yes, is a cultural support person present?  Yes  No

If no, please state reason:

G. Interpreters Statement	
I have:	
<input type="checkbox"/> provided a sight translation	
<input type="checkbox"/> translated as per doctor/clinician explanation in:	
Language:	
<small>(state patient's/parent's/legal guardian's * language) of the information and assisted in the provision of any verbal and written information given to the patient/parent/legal guardian by the doctor/clinician.</small>	
Name of child/young person (patient):	
Language of patient/parent/legal guardian*	
Name of Interpreter service:	
Name of Interpreter:	
Signature of Interpreter:	Date:

# Decision Maker Information Checklist:

## Child and Youth Mental Health

**Guide for use**

The *Decision Maker Information* checklist is an optional tool for documenting the decision maker for a young person's mental health treatment and care. It provides a prompt and record of the important discussions that occur between the clinician, young person and/or parent/guardian about informed consent for inpatient services.

### How does this checklist support the less restrictive way under the *Mental Health Act 2016*?

Making informed decisions about mental health treatment for a child or young person involves the decision maker having adequate information of the service and the treatments being proposed. This includes treatments that are more restrictive in nature, such as inpatient treatment and physical restraint. Informed decision making ensures that all parties have discussed options and have identified the less restrictive alternatives.

### When might I use the *Decision Maker Information Checklist* with children and young people?

This checklist is intended to support current documentation practices. It can be used in a range of ways, including:

- As part of the admission or orientation process
- to assist the care planning process
- to assist with discussing restrictive practices as a last resort
- to document the discussion about withdrawal of consent to treatment
- to document a change in decision maker (e.g. change to guardianship or if the young person

has been determined to have capacity and is making his/her own healthcare decisions).

The checklist does NOT have to be completed on each of these occasions; it is at the discretion of the clinician, treating team and local service to determine how the checklist may be most effectively used. Local services may develop protocols around the checklist and times when or if it is expected to be used.

### What this checklist does NOT do

The Decision Maker Information Checklist is NOT an informed consent form. It does not provide blanket consent to treatment. Rather, it records that the conversation around informed consent has taken place. It is important that consent, and withdrawal of consent, to various treatments and therapy is discussed and recorded in the clinical record.

### How do I use the *Decision Maker Information* checklist?

A decision maker needs to be identified at the start of the checklist. A capacity assessment should occur prior to the young person being recorded as being the decision maker. For court orders and legal guardians, ensure that documentation is verified. For instance, foster carers are not able to consent to some treatments, and the legal guardian needs to be recorded.

You may find it useful to read through the checklist prior to discussing the decision-making process with the young person, parent or legal guardian, as a reminder of the areas you will need to explore.

If an interpreter or cultural support person is required, please coordinate this prior to the

discussion with the decision maker and/or young person. This is recorded in sections F and G of the checklist.

The checklist provides prompts for topics of discussion about informed consent, restrictive practices, and withdrawal of consent. The clinician ticks which topics were covered. Space is provided for additional notes if required, in which the clinician may record information such as:

- the questions that were asked and clarified
- additional information that was provided
- issues of concern for the decision maker

and any other relevant information.

You may use other written resources to assist with the conversation, including information about the inpatient service and treatments, and information about restrictive practices. The *Physical Restraint Information Sheet* may help with the discussion for completion of section C.

## Where do I record this checklist?

This checklist should be signed and uploaded to CIMHA. Although it is not a consent form, it documents the decision maker who will provide consent, and the discussion of informed consent. Select 'Consent Record' under the clinical note category, and choose an attachment summary for completed checklist to be uploaded.

Follow the naming convention for attachments to ensure that they are easy to find in searches, with *<Attachment>\_<date>* in the Description field, e.g. *Consent for Services\_20180604*.

Refer to the *CIMHA Attachment Description Naming Convention Factsheet* for more information.

**For more information about Less Restrictive Way, informed consent and decision making in mental health, refer to the *Guidelines to***

## ***Providing Treatment and Care in the Less Restrictive Way.***

## 9.6 Appendix F: Physical Restraint Information Sheet – Adults

# Physical Restraint

Adult Mental Health Information sheet

### What is physical restraint?

Physical restraint is defined in the *Mental Health Act 2016* to mean the use by a person of his or her body to restrict the patient's movement. This may mean holding a part of the person's body (like arms or legs), or holding the person so that they can't get up. Physical restraint may be authorised under the *Mental Health Act 2016* to prevent harm to the person, other people or property.

Physical restraint **does not** include giving support for a person to carry out daily activities, or to redirect a disoriented person, e.g. holding a person's hand to help them step down safely; using a hand on a shoulder to move the person towards a group activity.

### When might physical restraint be used?

Physical restraint must not be used unless it is used in accordance with the *Mental Health Act 2016*.

Physical restraint can only be used if there is no other reasonably practicable way:

- to protect the person or others from physical harm
- to provide treatment and care to the person
- to prevent the person from causing serious damage to property, or
- to prevent the person from leaving the service when they are detained as an inpatient.

### How do you know when it is appropriate to use physical restraint?

Mental health staff will try as many ways as they can to keep people safe and help control or prevent behaviours that may ultimately require the use of physical restraint. This may include talking approaches, calming techniques, giving the person safe space, and sensory modulation.

Ask your mental health team what strategies they use, and what is included in the care plan. You might know what has worked in the past to calm down unsafe behaviours. Talk with the team about what might help to avoid the use of physical restraint.

### Who can authorise physical restraint?

An authorised doctor, or a health practitioner in charge of an inpatient or other unit within an authorised mental health service, may authorise the use of physical restraint.

### What are the risks?

Being held down or prevented from moving has risks of physical and psychological harm to the person and others. Because of the risk of harm, all staff who use physical restraint **have to** be trained and regularly updated on the safest ways to restrain a person.

Physical restraint is only used for the minimum time, and with the minimum force necessary in each individual circumstance.

Anything that may increase the risk of harm to the patient, or others, is considered, wherever possible, and whenever known, by the mental health team, before, during and after, the use of physical restraint (e.g. physical health issues).

### How is the physical restraint checked and monitored?

Whenever physical restraint is used, it is recorded on a form in the patient's clinical record. Staff must write in the clinical record details about:

- when and how physical restraint was used;
- for how long;
- the outcome; and
- why there was no other reasonably practicable way to maintain safety or provide treatment.

Under the *Public Guardian Act 2014*, the Community Visitor(adult) can ask for information about a person, and this may include information about the use of physical restraint.

### How is the person supported?

The mental health team will make sure that someone talks with the person as early as possible about what



happened. This will include finding out what the person needs, any concerns they have, and ways to cope with feelings. They will want to make sure that the person is feeling as safe and comfortable as possible.

The Independent Patient Rights Adviser can be contacted to talk with the person or their decision maker about any concerns.

**For more information, contact your service.**

### **Useful Links:**

#### **Mental Health Act 2016**

<https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/clinical-staff/mental-health/act>

#### **Public Guardian and Community Visitors**

<http://www.publicguardian.qld.gov.au/adult-guardian/adult-community-visitors>

## 9.7 Appendix G: Physical Restraint Information Sheet – CYMHS

# Physical Restraint

### Child and Youth Information sheet

#### What is physical restraint?

Physical restraint is defined in the *Mental Health Act 2016* to mean the use by a person of his or her body to restrict the patient's movement. This may mean holding a part of the person's body (like arms or legs), or holding the person so that they can't get up. Physical restraint may be authorised under the *Mental Health Act 2016* to prevent harm to the person, other people or property.

Physical restraint **does not** include giving support for a person to carry out daily activities, or to redirect a disoriented person, e.g. holding a child's hand to help them step down safely; using a hand on a shoulder to move the young person towards a group activity.

#### When might physical restraint be used?

Physical restraint must not be used unless it is used in accordance with the *Mental Health Act 2016*.

Physical restraint can only be used if there is no other reasonably practicable way:

- to protect the child/young person or others from physical harm
- to provide treatment and care to the child/young person
- to prevent the child/young person from causing serious damage to property, or
- to prevent the child/young person from leaving the service when they are detained as an inpatient.

#### How do you know when it is appropriate to use physical restraint?

Mental health staff will try as many strategies as they can to keep people safe and help control or prevent behaviours that may ultimately require the use of physical restraint. This may include talking approaches, calming techniques, giving the child or young person safe space, and sensory modulation.

Ask your mental health team what strategies they use, and what is included in the care plan. You might know what has worked in the past to calm down unsafe

behaviours. Talk with the team about what might help to avoid the use of physical restraint.

#### Who can authorise physical restraint?

An authorised doctor, or a health practitioner in charge of an inpatient or other unit within an authorised mental health service, may authorise the use of physical restraint.

#### What are the risks?

Being held down or prevented from moving has risks of physical and psychological harm to the person and others. Because of the risk of harm, all staff who use physical restraint have to be trained and regularly updated on the safest ways to restrain a child/young person.

Physical restraint is only used for the minimum time, and with the minimum force, necessary in each individual circumstance.

Anything that may increase the risk of harm to the patient, or others, is considered, wherever possible, and whenever known, by the mental health team, before, during, and after, the use of physical restraint (e.g. physical health issues).

#### How is the physical restraint of a child or young person checked and monitored?

Whenever physical restraint is used on a child or young person, it is recorded on a form in the patient's clinical record.

Information recorded in the Mental Health Services Physical Restraint form is used to notify the Public Guardian (section 274 of the *Mental Health Act 2016*) and the Chief Psychiatrist. Staff must write in the clinical record details about:

- when and how physical restraint was used;
- for how long;
- the outcome; and
- why there was no other reasonably practicable way to maintain safety.
- or provide treatment.



Under the *Public Guardian Act 2014*, the Community Visitor (child) may ask for information about a child or young person, and this may include information about the use of physical restraint.

### **How is the child or young person supported?**

The mental health team will make sure that someone talks with the child/young person as early as possible

about what happened. This will include finding out what the child/young person needs, any concerns they have, and ways to cope with feelings. They will want to make sure that the child/young person is feeling as safe and comfortable as possible.

The Independent Patient Rights Adviser can be contacted to talk with the child/young person or parent/legal guardian about any concerns.

### **For more information, contact your service at:**

#### **Useful Links:**

##### **Mental Health Act 2016**

<https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/clinical-staff/mental-health/act>

##### **Public Guardian and Community Visitors**

<http://www.publicguardian.qld.gov.au/child-advocate/child-community-visiting>

## 9.8 Appendix H: Acute Sedation Information Sheet - Adults

# Acute Sedation: Using medicine to calm

Adult Mental Health Information sheet

### Using medicine to keep calm?

Medicines can slow you down and make you sleepy. People who are very upset or angry sometimes need medicine to help keep them or others safe.

### When do we use it?

Your team will try their best to help you and other people stay safe. People who are upset, angry or afraid sometimes do things that hurt themselves or others. Our team will try to help in lots of ways; things like giving you extra time, space, quiet, favourite things or people. But sometimes this isn't enough to keep people safe. When it's possible your team will talk about using medicine with you, your family or carers.

Acute sedation is often given as an injection (needle). People getting needles may need to stay very still. Staff might need to hold you for a short time so it's safe to give the medicine. Please read the 'Physical Restraint' information sheet.

### Planning can make a difference

We want to help you feel supported and cared for in the health service. Right at the start we will talk with you about ways to help you feel safe and in control, and what makes you upset. We want to know what works for you. Staff will try as many ways as they can to keep people safe and/or stop situations becoming dangerous.

Talk with your team about the use of medicine and when it might be helpful.

Medicine cannot be used to punish someone, or because the team is tired or its time to change over staff.

### Who can give acute sedation?

Like other medicine, a doctor needs to decide that the medicine is safe to give. The medicine can only be given by a doctor or nurse.

### Is there a risk?

All medicines need to be used properly to be safe. All medicines have benefits and risks. Not using the medicine may also have risks.

The medicines for making you calm and sleepy are called sedatives. Doctors need to carefully choose the right one for you. It will depend on your age, body shape, size and health.

Remember to ask your doctor about:

- What medicine could be helpful for you.
- If there can be problems using the medicine
- What to look out for (side effects)
- Anything that might need urgent attention.

### Staying safe with medicines

All Queensland Health staff need to follow clear guidelines for using medicines in this situation, especially sedatives. The guidelines tell us about important clinical checks and observations of the person. We need to write these checks in your medical record.

### How do we help you be safe with acute sedation?

We want to help you feel as safe as possible. A member of the team will talk with you as soon as possible about what happened. We want to check out any worries, and help you to cope with your feelings.

The team will keep checking on your health.

The *Independent Patient Rights Adviser* can talk with you or your family/ carer about any concerns.

### Useful Links:

#### Mental Health Act 2016

<https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/clinical-staff/mental-health/act>

#### Acute behavioural disturbance management (including acute sedation in Queensland Health Authorised Mental Health Services) (adults)

[https://www.health.qld.gov.au/\\_data/assets/pdf\\_file/0026/665306/qh-gdl-451.pdf](https://www.health.qld.gov.au/_data/assets/pdf_file/0026/665306/qh-gdl-451.pdf)



## 9.9 Appendix I: Acute Sedation Information Sheet – CYMHS

# Acute Sedation: Using medicine to calm

Child and Youth Information sheet – for patients and carers

### Using medicine to keep calm?

People who are very upset or angry sometimes need to take medicine to help keep them or others safe.

### When do we use it?

Your team will try their best to help you/your child and other people stay safe. People who are upset, angry or afraid sometimes do things that hurt themselves or others. Our team will try to help in lots of ways; things like giving you extra time, space, quiet, favourite things or people. But sometimes this isn't enough to keep people safe. When it's possible your team will talk about using medicine with your family or carers.

People getting medicine may need to stay very still. Staff might need to hold you for a short time so it's safe to give the medicine. Please read the 'Physical Restraint' information sheet.

### Planning can make a difference

We want to help you feel supported and cared for in the health service. We will talk with you about ways to help you/your child feel safe and in control, and what makes you/your child upset. We want to know what works for you/your child. Staff will try as many ways as they can to keep people safe and/or stop situations becoming dangerous.

Talk with your team about the use of medicine and when it might be helpful.

Medicine cannot be used to punish someone, or because the team is tired or its time to change over staff.

### Who can give the medicine (acute sedation)?

Like other medicine, a doctor needs to decide that the medicine is safe to give. The medicine can only be given by a doctor or nurse.

### Is there a risk?

All medicines need to be used properly to be safe. All medicines have benefits and risks. Not using the medicine may also have risks.

The medicines for making you calm and sleepy are called sedatives. Doctors need to carefully choose the right one for you. It will depend on your/your child's age, body shape, size and health.

Remember to ask your doctor about:

- What medicine could be helpful for you/your child
- If there can be problems using the medicine
- What to look out for (side effects)
- Anything that might need urgent attention.

### Staying safe with medicines

All Queensland Health staff need to follow clear guidelines for using medicines, especially sedatives. The guidelines tell us about important clinical checks and observations of the child/young person. We need to write these checks in your/your child's medical record.

### How do we help keep you/your child safe?

We want to help you/your child feel as safe as possible. A member of the team will talk with you/your child as soon as possible about what happened. We want to check out any worries, and help you/them to cope with feelings.

The team will keep checking on the child/young person's health.

### Who else can you talk to?

The *Independent Patient Rights Adviser* can be contacted. They can talk with you/your child about any worries.

You can ask the team to contact a Community Visitor while in hospital who can meet with you and talk about your worries or concerns.



## Useful Links:

### **Mental Health Act 2016**

<https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/clinical-staff/mental-health/act>

### **Guideline: Acute behavioural disturbance management in Queensland Health Authorised Mental Health Services (children and adolescents)**

[https://www.health.qld.gov.au/\\_\\_data/assets/pdf\\_file/0026/665306/qh-gdl-451.pdf](https://www.health.qld.gov.au/__data/assets/pdf_file/0026/665306/qh-gdl-451.pdf)

### **Public Guardian and Community Visitors**

<http://www.publicguardian.qld.gov.au/child-advocate/child-community-visiting>

## 9.10 Appendix J: Definitions of supports for decision making in mental health

Support Title	Definition	Roles / functions
<a href="#"><u>Nominated Support Person</u></a>	<p>A nominated support person provides assistance and support to the person if they become unwell and become an involuntary patient.</p> <p>A person may appoint a family member, carer or other support person to be their nominated support person.</p>	<p>Nominated support persons:</p> <ul style="list-style-type: none"> <li>• must be given all notices about the patient that are required under the Act</li> <li>• may discuss confidential information about the patient's treatment and care</li> <li>• may represent, or support the person, in any hearings of the Mental Health Review Tribunal, and</li> <li>• may request a psychiatrist report if the person is charged with a serious offence.</li> </ul>
<b>Supported decision making</b>	<p>Section 14(3) of the MHA2016 provides that a person may still have capacity, while being supported by another person in understanding matters about the proposed treatment and deciding about the proposed treatment.</p>	<p>In supported decision making, the patient has capacity and still makes the final decision.</p> <p>The support person/people helping the person to understand the treatment and the decision may have a good understanding of the person's values and beliefs, lifestyle needs, cultural needs, language, communication style/approach and various other aspects of their personhood that can help in receiving and interpreting information, weighing up options, and making sense in relation to the person's needs.</p> <p>A person providing support does not have to be the Nominated Support Person.</p>
<a href="#"><u>Substitute Decision Maker</u></a>	<p>A substitute decision-maker is a person permitted under the law to make decisions on behalf of someone who does not have capacity. A person can have more than one substitute decision-maker.</p> <p>A substitute decision-maker may be:</p> <ul style="list-style-type: none"> <li>• An Advance Health Directive or attorney appointed under an Advance Health Directive</li> <li>• A guardian appointed to make the decision</li> <li>• An attorney under an Enduring Power of Attorney</li> <li>• A Statutory Health Attorney</li> <li>• A parent or guardian.</li> </ul>	<p>The substitute decision-maker for someone who has lost capacity must:</p> <ul style="list-style-type: none"> <li>• act in their best interests</li> <li>• make decisions they believe the person would have made for themselves</li> <li>• gain an understanding of their medical condition and potential future complications</li> <li>• gain an understanding of future medical care options, particularly the benefits and risks of current and future treatments</li> <li>• give careful consideration to their choices for end of life care if they have expressed them to you, as well as their goals, values and personal and spiritual beliefs</li> <li>• discuss available choices with family/trusted others and document these choices</li> <li>• talk to them about recording their wishes while they have capacity, or regain capacity for decision-making.</li> </ul>
<b>Cultural support person</b> (for the Mental Health Review Tribunal).	<p>For Aboriginal and Torres Strait Islander consumers, the cultural support person is any person from their support network that can provide cultural information to the Mental Health Review</p>	<p>The cultural support person can provide cultural information and support by:</p> <ul style="list-style-type: none"> <li>• completing the cultural information section of the MHRT clinical report.</li> <li>• attending the MHRT hearing to provide cultural support.</li> </ul>

Support Title	Definition	Roles / functions
	<p>Tribunal. They could be a family member or relative, an Uncle or Aunt or the traditional people of a consumer's community, or any other person providing cultural information that is a support person of the consumer.</p> <p>They may be different from the Nominated Support Person.</p>	<p>For further understanding of the role and function of the cultural support person, talk with an Aboriginal and Torres Strait Islander Mental Health Worker in your service.</p>

## 9.11 Videoconferencing

Refer to: [8.12 Telehealth resources](#)

In rural and remote areas, consultations often occur via videoconferencing or telehealth. It provides an efficient, time-saving and cost saving means of delivering services and can greatly reduce travel and disruptions to care. However, videoconferencing can create some challenges with communication and rapport, for example, reading body language, hearing issues, communication and language difficulties resulting in increased frustration, and difficulty providing written information. People may also have a level of uncertainty or distrust with using videoconference to communicate with a health professional. In situations which are unfamiliar for the person, it is even more important for clinicians to take some time to develop the therapeutic alliance and put the person at ease as much as possible. If possible, spend a few minutes at the start of a telehealth session allowing the person to become familiar with the form of communication, and introduce everyone who is involved in the discussion.

The technical aspects, such as audio-visual quality, sound volume, and size of the person on the screen can all create potential barriers. Some tips for improving these to enhance capacity assessment include:

- Book the telehealth session for longer than needed, to allow time beforehand to set up and test the equipment and connection; and enough time afterwards in case the session runs overtime.
- Ensure your environment is suitable for telehealth – close any doors or windows to reduce background noise, avoid any natural light in the background of your camera, and make sure your microphone is close to the speaker.
- Zoom in the image of the people/person on the screen (at each location) as part of the set-up. A person who appears more 'life-sized' on the screen allows more personable contact and reading of body language; a person who appears distant or in the corner will be challenging to talk to naturally.
- Give the person the opportunity at the start to be made comfortable with the technology, including location of speakers and screen, and to indicate their preferences, e.g. for the volume.
- If technology issues arise, or the videoconference gets cut off before the session is completed, telephone the other party (where possible) to allow the opportunity to complete the conversation/assessment by phone, or to reschedule the session.

During the assessment, health professionals may need to allow more opportunities for questions from the person, and break down information into small chunks to ensure that it is being understood. Having a parent, carer or support person present who is familiar with the person's communication style or needs, may be helpful.

It is important for all people present to end the session knowing what the planned actions and goals are. When the session is ended, the clinician(s) present with the person should provide the opportunity to debrief, and to check if there were any other questions or concerns that they had that they weren't comfortable bringing up in the videoconference.

For further information and tips about videoconferencing, access the telehealth guidelines listed in the [Resources](#).

## 10. FURTHER READING

In addition to the resources listed above, the following articles assisted in developing the content of these guidelines, and may be useful further reading for clinicians.

Bellesheim, K. R. (2016). Ethical challenges and legal issues for mental health professionals working with family caregivers of individuals with serious mental illness. *Ethics & Behaviour*, 26(7), 607-620.

Davidson, G., Brophy, L., Campbell, J., Farrell, S. J., Gooding, P. and O'Brien, A. (2016). An international comparison of legal frameworks for supported and substitute decision-making in mental health services. *International Journal of Law and Psychiatry*, 44, 30-40.

Davidson, G., Kelly, B., MacDonald, G., Rizzo, M., Lombard, L., Abogunrin, O., Clift-Matthews, V. and Martin, A. (2015). Supported decision making: A review of international literature. *International Journal of Law and Psychiatry*, 38, 61-67.

Devi, N., Bickenbach, J. and Stucki, G. (2011). Moving towards substituted or supported decision-making? Article 12 of the Convention on the Rights of Persons with Disabilities. *ALTER, European Journal of Disability Research*, 5, 249-264.

Fields, L. M. & Calvert, J. D. (2015). Informed consent procedures with cognitively impaired patients, A review of ethics and best practices. *Psychiatry and Clinical Neurosciences*, 69, 462-471.

Germain, V., Marchand, A., Bouchard, S., Guay, S. and Drouin, M. (2010). Assessment of the Therapeutic Alliance in Face-to-Face or Videoconference Treatment for Post-Traumatic Stress Disorder. *Cyberpsychology, Behaviour, and Social Networking*, 13(1), 29-35.

Johansson, A. M., Söderberg, S. and Lindberg, I. (2014). Views of residents of rural areas on accessibility to specialist care through videoconference. *Technology and Health Care*, 22, 147-155.

Kim, M., Van Dorn, R. A., Scheyett, A. M., Elbogen, E. E., Swanson, J. W., Swartz, M. S. & McDaniel, L. A. (2007). Understanding the personal and clinical utility of psychiatric advance directives, A qualitative perspective. *Psychiatry, Interpersonal & Biological Processes*, 70(1), 19-29.

Mohr, W. K. and Nunno, M. A. (2011). Black boxing restraints: The need for full disclosure and consent. *Journal of Child and Family Studies*, 20, 38-47.

Morrissey, F. (2010). Advance directives in mental health care: Hearing the voice of the mentally ill. *Medico Legal Journal of Ireland*, 16 (1). Downloaded 2018-04-16T00:35:06Z. <http://hdl.handle.net/10379/1146>

Nicaise, P., Lorant, V. & Dubois, V. (2013). Psychiatric Advance Directives as a complex and multistage intervention, a realistic systematic review. *Health and Social Care in the Community*, 21(1), 1-14.

Ouliaris, C. and Kealy-Bateman, W. (2017). Psychiatric advance directives in Australian mental-health legislation. *Australasian Psychiatry*, 25(6), 574-577.

Parsons, B. and Kennedy, M. (2007). A review of recorded information given to patients starting to take clozapine and the development of guidelines on disclosure, a key component of informed consent. *Journal of Medical Ethics*, 33, 564-567.

Paul, M., Berriman, J. and Evans, J. (2008). Would I attend a Child and Adolescent Mental Health Services (CAMHS)? Fourteen to sixteen year olds decide. *Child and Adolescent Mental Health*, 13(1), 19-28.

Sheldon, C. T. (2017). Proof in the pudding: The value of a rights based approach to understanding the covert administration of psychotropic medication to adult inpatients determined to be decisionally-incapable in Ontario's psychiatric settings. *Journal of Law, Medicine & Ethics*, 45, 170-181.

Srebnik, D. S., Rutherford, L. T., Peto, T., Russo, J., Zick, E, Jaffe, C. & Holtheimer, P. (2005). The content and clinical utility of psychiatric advance directives. *Psychiatric Services*, 56(2), 592-598.

Swanson, J. W., Swartz, M. S., Elbogen, E. B., Van Dorn, R. A., Ferron, J., Wagner, H. R., McCauley, B. J. & Kim, M. (2006). Facilitated Psychiatric Advance Directives, A randomized trial of an intervention to foster advance treatment planning among persons with severe mental illness. *American Journal of Psychiatry*, 163, 1943-1951.

Thomas, J. F., Novins, D.K., Hosokawa, P.W., Olson, C. A., Hunter, D., Brent, A.S., Frunzi, G., and Libby, A.M. (2018). The Use of Telepsychiatry to Provide Cost-Efficient Care During Pediatric Mental Health Emergencies. *Psychiatric Services*, 69 (2), 161-168.

Weger, E. D., MacInnes, D., Enser, J., Francis, S. J. & Jones, F. W. (2013). Implementing video conferencing in mental health practice. *Journal of Psychiatric and Mental Health Nursing*, 20, 448-454.