

Treatment Criteria and Assessment of Capacity

1. Purpose

This Policy outlines the relevant provisions of the *Mental Health Act 2016*, and the Chief Psychiatrist Policy, regarding the application of the treatment criteria and the assessment of capacity of patients to consent to being treated.

2. Scope

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

This Policy must be implemented in a way that is consistent with the Objects and Principles of the Act.

3. Authorising Legislation

Section 305(1)(a) of the *Mental Health Act 2016*.

4. Background

An authorised doctor may make a treatment authority for a person (section 48) if:

- the 'treatment criteria' apply to the person, and
- there is no 'less restrictive way' for the person to receive treatment and care for the person's mental illness (section 13).

The treatment criteria for a person are all of the following (section 12):

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

The Act defines 'mental illness' as a condition characterised by a clinically significant disturbance of thought, mood, perception or memory (section 10). The Act states matters that do not indicate a person has a mental illness, such as holding a particular religious, cultural, philosophical or political beliefs or having a particular sexual preference or sexual orientation. A decision that a person has a mental illness must be made in accordance with internationally accepted medical standards.

A person has capacity to consent to be treated if the person is capable of understanding, in general terms (section 14):

- that the person has an illness, or symptoms of an illness, that affects the person's mental health and wellbeing
- the nature and purpose of the treatment for the illness
- the benefits and risks of the treatment, and alternatives to the treatment, and
- the consequences of not receiving the treatment.

The person must also be capable of making a decision about the treatment and communicating the decision in some way.

The Act also recognises the importance of supported decision making, in that a person may have the capacity with the support of another person

Treating a person in a 'less restrictive way' is outlined in the *Chief Psychiatrist Policy: Advance Health Directives and 'Less Restrictive Way' of Treatment*.

The Act highlights certain principles to be considered in relation to making decisions in this area.

The principles include the following:

- as far as possible a person is to take part in making decisions affecting the person's life, especially in relation to treatment and care
- the person's views, wishes and preferences are to be taken into account
- a person is presumed to have capacity to make decisions about the person's treatment and care, and other matters under the Act, regardless of their age, circumstances, condition, behaviour or legal status
- the involvement of family, carers and other support persons is encouraged subject to the patient's right to privacy, and
- a person is to be helped to achieve maximum potential, quality of life and self-reliance.

The Act promotes treatment for persons with a mental illness in a way that is the least restrictive of the patient's rights and liberties of the person by requiring involuntary treatment only to the extent required to protect the person's safety and welfare or the safety of others.

It is essential that all clinicians working within AMHSs fully understand the treatment criteria and the underlying principles in the Act.

5. Policy

This Policy applies if, at the time of making an assessment of a person for the presence of a mental illness, a decision is made that the person has a mental illness and that treatment is indicated for that illness.

A clinician needs to decide whether the treatment criteria apply in all mental health assessments. Clinicians must ensure that this assessment is clearly documented in the patient's health records with an opinion in relation to the application of the treatment criteria evident. The patient, and a support person for the patient, must be kept informed of the outcome of this assessment.

The treatment criteria are clearly defined in the legislation and form the basis for a person being placed on a treatment authority. Clinicians need to be aware that all criteria must be present, and if one criterion is not fully met then the person cannot be placed under a treatment authority

5.1 The presence of a mental illness

A comprehensive mental health assessment will involve a clinical assessment and information gathering across a number of areas, including presenting problems, current functioning, background medical, family, psychiatric and developmental history, forensic and legal history, and substance use. Relevant cultural issues must always be addressed.

A mental state examination must also be conducted.

A risk assessment forms a necessary part of all assessments (see below).

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

The clinical formulation, an essential component of the mental health assessment, must adopt a multimodal approach and be clearly documented, along with the assessment, in the patient's health records. This must be communicated with the patient and relevant support persons.

5.2 The assessment of capacity of patients to consent to being treated

Having established that the person has a mental illness requiring treatment, a judgement needs to be made in relation to the person's capacity to consent to being treated for that illness.

Before treatment can be administered to a person, a clinician must seek the informed consent of the person. Capacity is the ability of that person to give informed consent to a particular treatment at a particular time.

The clinician must presume that the patient has capacity to give informed consent to treatment. This presumption of capacity can be rebutted if it can be shown that the patient does not have capacity to give informed consent at the time a particular treatment decision needs to be made.

Assessment of capacity is a complex matter. The Act outlines the many different aspects of the person's understanding and appreciation of their illness and treatment that encompasses a full assessment of capacity. All of these elements must be addressed in a capacity assessment.

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

Clinicians must provide patients with all of the relevant information in making treatment decisions, and must support persons in making all treatment decisions - with the use of interpreters, visual aids, simple language or any other means necessary.

Clinicians must ensure the patient has been given a reasonable period of time to consider matters involved in the decision, reasonable opportunity to discuss the decision with the health practitioner, opportunity to seek advice, support and assistance, adequate information on the treatment, alternatives, advantages, disadvantages and beneficial alternative treatments.

Clinicians must be aware that a person's capacity to make treatment decisions can fluctuate over time. It is not uncommon for persons with a mental illness to show a fluctuation of mental state throughout the day or over the course of many days. Capacity assessments that are conducted merely on a one-off cross-sectional basis for such patients may not accurately reflect their status. It is important that clinicians recognise persons who have a fluctuating mental state and ensure that, where this applies, capacity assessments are conducted across a number of examinations to ensure that there is stability to the opinion. However, as indicated above, decisions under the Act that relate to capacity must be undertaken at a point in time. The only exception to this is where a clinician is considering revoking a treatment authority (see section 5.4).

Clinicians must try to obtain consent in a manner, and at a time, where the person is most likely to give it. For example, while a busy emergency department late at night at the time of a crisis presentation might be the necessary setting for immediate decisions about treatment setting and acute treatment, it may not be the most desirable timing or location to make an assessment on the patient's capacity for more subacute or longer term treatment decisions, which might best be re-assessed in the days following an acute presentation.

Clinicians must be aware that not consenting to treatment does not necessarily imply a lack of capacity. A patient may have capacity to make a decision about treatment but still not consent to it. Although this may not be in their best interest and despite the inherent risks, if the person demonstrates capacity, the treatment criteria do not apply.

Similarly, clinicians must appreciate that a 'high risk' patient can still receive treatment as a voluntary patient if the patient is able to demonstrate capacity.

Clinicians must always consider a patient's views and preferences, including any that might have been formally expressed in advance health directives or in an informal way to treating teams.

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

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

At times a patient may lack capacity but not meet any of the other criteria for involuntary status, such as those related to risk. Therefore, even though the patient may be impaired in many aspects of their functioning, there may be insufficient grounds to make a treatment authority.

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

5.3 The assessment of risk

Clinicians must also make an assessment on whether, because of the mental illness, the absence of involuntary treatment is likely to result in harm to the person or someone else, or a deterioration of the person's physical or mental health.

In this regard, the clinician needs standardised contemporary risk assessment processes, tools and guides, appropriate to age and context, to support clinical judgement and clinical decision making. Relevant information must be gathered and analysed for this purpose. Historical information may be linked to current circumstances.

Clinicians must acknowledge that, even if a person has a mental illness requiring treatment and is deemed to lack capacity in this regard, the treatment criteria are not met unless the risk criteria are met.

Conversely, even though a person may be assessed as a high risk, a treatment authority can only be made if all of the remaining treatment criteria are met and there is no 'less restrictive way' to treat the person.

The clinician must be satisfied that the risk is imminent and results from the patient's mental illness.

Risk of harm is not necessarily limited to risk of physical injury or deterioration in physical health. Clinicians should take account of psychological and emotional harm, as well as adverse financial or social impacts, particularly where these are of a significant nature.

The clinician should ensure that documentation takes place in relation to the nature of the risk of harm, how this is attributed to the patient's illness, and the basis for the view that the risk of harm is imminent.

The clinician must also assess if serious mental or physical deterioration is 'likely' in the absence of treatment. In addressing this, the clinician should document the basis for this opinion including, for example, the nature and course of the illness and the patient's clinical history.

5.4 Regular assessments and revocation of treatment authorities

To monitor whether a treatment authority should continue, authorised doctors must undertake regular assessments of the patient. These must occur at least three monthly. In addition, an authorised doctor must assess a patient if, at any time, it appears that the treatment criteria no longer apply to the patient or there may be a 'less restrictive way' for the patient to receive treatment and care.

After an assessment, an authorised doctor must revoke the treatment authority if the treatment criteria no longer apply or there is a less restrictive way for the patient to receive treatment and care for the patient's mental illness.

The only exception to this is if a patient regains capacity but the capacity is not stable. To avoid a person with fluctuating capacity 'cycling' on and off treatment authorities, a patient may remain on a treatment authority until their capacity becomes stable. It is intended that this would apply over a relatively short period of time.

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

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

6. Supporting Documents

- Attachment 1: Process for the making of a treatment authority

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



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Process for the making of a treatment authority

