



Policy

Consent to mental health
treatment and care by the
Public Guardian

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Application	Guardianship	
Related		

1. Relevant Legislation

Mental Health Act 2016
 Guardianship and Administration Act 2000
 Powers of Attorney Act 1998
 Public Guardian Act 2014
 Human Rights Act 2019

2. Purpose

This Policy clarifies the position of the Public Guardian and applies to adults for whom the Public Guardian is providing consent to mental health treatment and care under the *Guardianship and Administration Act 2000* (GAA) and the *Powers of Attorney Act 1998* (PAA) as guardian or attorney for an adult with impaired capacity, and the intersection of this role with the *Mental Health Act 2016* (MHA).

Under the PAA (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 MHA. 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.

As the Public Guardian has the function of educating and advising persons (including all guardians and their attorneys) about the operation of the *Public Guardian Act 2014* (PGA), the GAA and the PAA ¹ this policy also aims to assist guardians and attorneys with their

¹ s 12(j) *Public Guardian Act 2014*

consideration and provision of consent for mental health treatment and care in the performance of their roles.

3. Context

3.1 Role and Function of the Public Guardian

The Public Guardian's role in relation to adults who have impaired capacity for a matter is to protect their rights and interests.²

It is the function of the Public Guardian to act:

- a. as attorney for a personal matter under an enduring power of attorney; and
- b. as guardian if appointed by the Queensland Civil and Administrative Tribunal.³

The Queensland Civil and Administrative Tribunal may appoint the Public Guardian as guardian for a matter only if there is no other appropriate person available for appointment for the matter.⁴

The Public Guardian will advocate for the right of guardianship and attorney clients to:

- a. Make decisions as fundamental to their inherent dignity;
- b. Make decisions with which others may not agree;
- c. Make decisions that are restricted, and interfered with, to the least possible extent; and
- d. Have adequate and appropriate support for decision-making.⁵

The Public Guardian must take into consideration the General Principles (see annexure A) and the Health Care Principle (see annexure B) contained in the GAA, when making healthcare decisions in relation to adults with impaired capacity, including mental health treatment and care.

3.2 Human Rights

All decisions made by Public Entities, including Queensland Health and the Public Guardian, must be compatible with human rights as defined in the *Human Rights Act 2019*. Human rights

² s 10(1) *Public Guardian Act 2014*

³ s 12(1)(e) & s 12(1)(f) *Public Guardian Act 2014*

⁴ s 14(2) *Guardianship and Administration Act 2000*

⁵ s 5 *Guardianship and Administration Act 2000*

must not be limited unless reasonable and demonstrably justifiable. Rights which may be engaged when making mental health treatment decisions include:

- Right to recognition and equality before the law
- Right to protection from torture and cruel or degrading treatment
- Right to freedom of movement
- Right to freedom of expression
- Right to liberty and security of person
- Right to humane treatment when deprived of liberty
- Right to health services.

3.3 Introduction of the *Mental Health Act 2016*

One of the main objectives of the new MHA is to improve and maintain the health and wellbeing of persons who have a mental illness who do not have the capacity to consent to be treated.⁶ The main objectives of the MHA are to be achieved in a way that safeguards the rights and interests of a person; is the least restrictive of the person's rights and liberties, promotes the recovery of a person, and their ability to live in the community without the need for involuntary treatment or care.⁷

The introduction of the MHA represents a significant shift in the provision of mental health treatment and care in Queensland.

The Chief Psychiatrist's policy states that treating a person voluntarily with their own consent is the least restrictive form of health care.⁸ Under the previous *Mental Health Act 2000* (MHA 2000) one of the factors under which a person could receive involuntary treatment and be placed under an involuntary treatment order (ITO) was where a person lacked capacity to provide consent to treatment and satisfied the relevant treatment criteria under the MHA 2000. An ITO would be authorised and confirmed by a psychiatrist and reviewed and confirmed by the Mental Health Review Tribunal within six weeks of the ITO being made and on a six monthly basis after that.

In contrast, the MHA now provides alternative avenues to obtain consent for persons who lack capacity to make their own decisions about mental health treatment and care and this is

⁶ s 3(1)(a) *Mental Health Act 2016*

⁷ s 3(2) *Mental Health Act 2016*

⁸ Section 4, Advance Health Directives and 'Less Restrictive Way' of Treatment, effective date 5 March 2017 ¹⁰

The less restrictive way (s 13 *Mental Health Act 2016*), includes consent provided by a minor's parent; if the person has made an advance health directive; if the person has a personal guardian appointed by the Queensland Civil and Administrative Tribunal; if an attorney has been appointed by the person under an enduring power of attorney; or with the consent of the person's statutory health attorney.

referred to as a 'less restrictive way'¹⁰. A 'less restrictive way' includes doctors being required to seek consent for treatment from appointed guardians and attorneys before considering a treatment authority. Accordingly, appointed guardians and attorneys including the Public Guardian are able to provide consent to mental health treatment and care, for clients that have the Public Guardian appointed as guardian or attorney. Consent provided under the 'less restrictive way' is not reviewed by the Mental Health Review Tribunal.

In relation to matters for which there is no less restrictive way for the person to receive treatment and care for the person's mental illness (including where consent is not given under the less restrictive way, for example, by the Public Guardian)⁹, an authorised doctor may make a treatment authority for the person if the person satisfies the treatment criteria.¹⁰

4. Policy

Requests for consent to mental health treatment and care are to be submitted by way of the OPG mental health treatment and care consent form which is available from the website

The following represents the policy position of the Public Guardian. This policy has been drafted with regard to the suite of policies that have been released by the Chief Psychiatrist to support the operation of the MHA. Please refer to Section 5 of this policy for further information.

4.1 Public Guardian decisions to consent to mental health treatment and care as 'health care'

All requests to provide consent to mental health treatment and care for guardianship or attorney clients as a less restrictive way under the MHA will be considered by the Public Guardian on a case-by-case basis, taking into consideration the appropriateness of providing consent in the person's circumstances. Officers of the OPG will explore the details of the facts relating to the proposed treatment and care in a manner consistent with other health care decisions, and where necessary, request additional information or further medical opinions.

The MHA takes into consideration the safety of others (as well as the wellbeing and safety of the adult) when treating patients in a less restrictive way.¹¹ The Public Guardian can only take into account considerations in relation to the adult. Whilst the safety of others is a

⁹ s 18(2) *Mental Health Act 2016*

¹⁰ s 49 & s 12 *Mental Health Act 2016*

¹¹ s 3(3) *Mental Health Act 2016*

consideration found in the MHA, it is not a consideration found in the General Principles or the Health Care Principle in the GAA.

In accordance with these legislative principles, in making a decision to consent to mental health treatment and care, the Public Guardian will endeavour to:

- place the person at the centre of the decision-making process;
- reflect the person's will and preferences;
- support and protect the person's rights, interests and well-being; and
- make decisions which are compatible with human rights as defined in the *Human Rights Act 2019*.

The Public Guardian will make all reasonable efforts to support the person to exercise their own decision-making capacity with respect to their mental health treatment and care, as far as possible under the Public Guardian's legislative mandate.¹⁴ Also, where the Public Guardian considers that the rights and interests of a client are not being adequately protected, heard or represented, concerns will be escalated to the administrator of the relevant authorised mental health service and, where necessary, the Chief Psychiatrist, and Hospital and Health Service.

Requests for the Public Guardian's consent to mental health treatment and care will be received and considered during general business hours only.

In an emergency, health care of an adult may be carried out under the GAA without consent if the adult's health provider reasonably considers that the adult has impaired capacity for the health care matter concerned; and either the health care should be carried out urgently to meet imminent risk to the adult's life or health; or the health care should be carried out urgently to prevent significant pain or distress to the adult and it is not reasonably practicable to get consent from a person who may lawfully give consent.¹⁵

Consistent with all health care decisions made by the Public Guardian, consent will only be provided upon the receipt of detailed information regarding the client and the proposed treatment and care. The mental health treatment and care consent form requires information to be provided by the treating psychiatrist, including:

- the views, wishes and preferences of the client and their support persons, including objections;
- explanation if the proposed treatment and care is inconsistent with the views, wishes and preferences of the client;
- explanation of assessment finding the client lacks capacity to consent to be treated¹⁶;

¹⁴ National Standards of Public Guardianship (Third Edition 2016)

¹⁵ s 63 *Guardianship and Administration Act 2000*

¹⁶ In accordance with the definition of capacity under s 14 *Mental Health Act 2016*

Meaning of capacity to consent to be treated

- (1) A person has capacity to consent to be treated if 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.
- (2) A person may have capacity to consent to be treated even though the person decides not to receive treatment.
- (3) A person may be supported by another person in understanding the matters mentioned in subsection (1)(a) and making a decision about the treatment.
 - the diagnosis of mental illness;
 - the client’s relevant circumstances;
 - details of proposed treatment and care, including conditions, location, and duration
 - details of proposed use of physical restraint in providing treatment or care;
 - explanation of alternative available treatments, and why the proposed treatment is recommended, including risks and benefits;
 - a description of the content, manner and mode in which the proposed treatment was explained to the client;
 - a description of how the practitioner ascertained whether the patient objected or not;
 - proposed date of review of the treatment plan;
 - how consideration has been given to providing the treatment and care in the least restrictive way¹²;
 - whether the proposed treatment has been used as a restrictive practice previously; and - details of any nominated support person under the MHA¹³.

Mental health treatment and care decisions will be made based upon information provided in the mental health treatment and care consent form, medical assessments provided, through discussion with the treating psychiatrist, and in consultation with the client. Consistent with health care decision-making practice, further information will be sought from the treating psychiatrist, or a second opinion may be requested, where there is insufficient or inadequate information provided in the consent form.

¹² Chief Psychiatrist Policy, *Treatment and Care of Patients* – section 5.4

¹³ s 223 *Mental Health Act 2016*

While the Public Guardian will consider all requests on a case by case basis, there may be a range of circumstances or factors that, if present, may lead the Public Guardian to place conditions upon consent, or not provide consent under the 'less restrictive way' on the basis that a treatment authority might be more appropriate in the circumstances. For example:

- where the request is for consent to administer off-label medication, anti-libidinal medication, or medications with known serious or significant side-effects;
- where the treatment and care plan is lengthy (e.g. more than 6 months) and requires regular review or where repeat requests for consent for the same treatment and care are made;
- where treatment is in a locked inpatient unit for a significant period of time (i.e. more than 14 days)¹⁴;
- where the client has a history of trauma, including the ongoing/regular physical or mechanical restraint or force, or use of seclusion in the administration of treatment and care.

4.2 Where a client objects to mental health treatment and care & section 67 of the Guardianship and Administration Act 2000

The mental health treatment and care consent form will require the treating psychiatrist to confirm that the client does not object, or does not have a history of objecting to the treatment requested, and confirm the client's will and preferences regarding the proposed mental health treatment and care.

If the client objects to the proposed mental health treatment and care, it is the responsibility of the treating psychiatrist to determine whether or not the objection can be overridden by a guardian or attorney in accordance with section 67 of the GAA.

Section 67 of the GAA states that the Public Guardian's power to consent will be ineffective where there is evidence, either expressed or demonstrated, that the client objects to the proposed treatment. The exception to this is where the adult has minimal or no understanding of either what the health care involves, or why the health care is required, and the health care is likely to cause the adult no distress, or temporary distress that is outweighed by the benefit to the adult of the proposed health care.

The Public Guardian will consider consenting to treatment where a client objects to the treatment on a case by case basis in accordance with section 67 of the GAA. However, where

¹⁴ This accords with the Chief Psychiatrist policy 'Advance Health Directives and Less Restrictive Way of Treatment' section 5.5 where a person who is an inpatient under an advance health directive or with the consent of an attorney of guardian for 14 days or more must have their treatment and care reviewed at or around 14 days after admission.

a client objects to treatment, the more appropriate mechanism for providing treatment and care will be under a Treatment Authority so that the client has access to statutory safeguards and oversight mechanisms, such as regular review by the Mental Health Review Tribunal. **4.3 Physical restraint and use of force in providing mental health treatment and care**

Where the Public Guardian's consent to mental health treatment and care is provided, section 270 of the MHA authorises the use of physical restraint on a patient for a number of purposes, including providing treatment and care to the patient. In addition to provisions within the MHA enabling the use of physical restraint, section 75 of the GAA also authorises the use of the minimum force necessary and reasonable to carry out health care authorised under the GAA.

Section 5.3 of the Chief Psychiatrist's Policy, *Physical Restraint*, provides that data to monitor the use of physical restraint will be collected by authorised mental health services on the types of events that result in physical restraint, the types of physical restraint used and any adverse events.¹⁵ As this data is already being collected, the Public Guardian will require as a condition of consent to mental health treatment and care, that each instance of the use of physical restraint on a client of the Public Guardian, which is recorded in accordance with Section 5.1 of the Chief Psychiatrist's Policy,¹⁶ be reported back to the Office of the Public Guardian on a monthly basis.

The Public Guardian will not provide consent to mental health treatment or care where in the individual circumstances of the case the Public Guardian considers that physical restraint is, or will be too frequently used. Where physical restraint is proposed, it must be the minimum necessary in the circumstances.¹⁷ In these circumstances, the Public Guardian considers that the rights and interests of the client may be better protected by being placed under a Treatment Authority and subject to appropriate procedural safeguards and review mechanisms under the MHA.

Further, in accordance with the Chief Psychiatrist's Policy, *Physical Restraint*, the Public Guardian strongly supports that physical restraint must never be used:

- as a substitute for other less restrictive interventions; or
- as a form of discipline or punishment; or
- as a substitute for adequate staffing levels; or

¹⁵ Chief Psychiatrist Policy, *Physical Restraint* – section 5.3.

¹⁶ *Physical Restraint*

¹⁷ Chief Psychiatrist Policy, *Advance Health Directives and 'Less Restrictive Way' of Treatment* - section 5.3.

²³ Section 5 of the Chief Psychiatrist Policy, *Physical Restraint* outlines a number of situations where physical restraint must not be used.

- as a substitute for staff training in crisis prevention and intervention to manage aggressive, harmful behaviours.²³

Where a client of the Public Guardian is subjected to physical restraint and the use of force, the Public Guardian will advocate for:

- the protection and advancement of the rights and interests of clients;
- the measures apply for the shortest time possible; and
- the use of any practice to be reviewed by the treating psychiatrist.

Where the Public Guardian has advocated for a review of the use of physical restraint of a client, the outcome of the review will be required to be communicated to the Public Guardian within 3 days.

4.4 Consent to mental health treatment and care in a locked inpatient unit

Under the MHA, treatment and care must be provided in the least restrictive way and therefore should be provided in the community wherever possible. However, there may be occasions when the Public Guardian's consent for inpatient treatment and care in a locked unit is sought for a client.

A locked inpatient unit is where a patient is restricted from freely entering or exiting the unit of their own accord, or leaving unaccompanied. In Queensland public hospitals, voluntary and involuntary patients may be accommodated in the same wards and all are locked. Arrangements are made at a local level for voluntary patients to enter and leave at will.

The Public Guardian will consider consenting to mental health treatment and care in a locked inpatient unit on a case by case basis. However, the Public Guardian's general position is that if a treating doctor has assessed that being detained in a locked inpatient unit from which exit is prevented is necessary to manage non-health care related risk or the safety of others, then consent may not be provided by the Public Guardian. This is on the basis that the rights and interests of the client may be better protected by being placed under a Treatment Authority and therefore subject to appropriate legislative procedural safeguards and review mechanisms under the MHA.

As outlined in section 4.1 above, the Public Guardian is unable to provide consent if the proposed treatment and care in a locked inpatient unit is predominantly required to protect the safety of others pursuant to the MHA, as the safety of others is not a consideration found in the General Principles or the Health Care Principle in the GAA.

4.5 Public Guardian may require further information

Where the Public Guardian is concerned with certain requests for consent to mental health treatment and care, for example if the proposed treatment includes medication that is known to have potentially significant side-effects, the Public Guardian may request a second medical opinion, or seek advice from an independent psychiatrist or the treating team. Where consent to mental health treatment and care is provided, regular updates on the general, and mental health and well-being of the client will be required to be provided to the Public Guardian by the treating psychiatrist, in accordance with the Public Guardian's request for information.

4.6 Public Guardian's consent to mental health treatment and care may be time limited

The Public Guardian will consider providing a time limited consent to mental health treatment and care on a case by case basis. Limiting the consent to a specific period of time provides the Public Guardian with the opportunity to regularly review the treatment and care of the client. Consent will therefore be for the minimum time necessary in accordance with the treatment needs of the client.

5. Related documents

Chief Psychiatrist Policy – Treatment and Care of Patients

Chief Psychiatrist Policy – Treatment Criteria and Assessment of Capacity

Chief Psychiatrist Policy — Advance Health Directives and 'Less Restrictive Way' of Treatment

Chief Psychiatrist Policy – Physical Restraint