Application for Mental Health Treatment Consent
(Mental Health Act 2016, s13)

public guardian

This application form is to be completed when requesting a Mental Health Treatment Consent from the Public Guardian.
Please complete this form in **conjunction with the Guide attached** to this consent form.
Applications for Mental Health Treatment Consent are to be emailed to MHA@publicguardian.qld.gov.au
Applications will only be accepted via email and will only be considered during business hours. A decision will be made within 10 business days of receipt of the consent form.

Section 1: Details of the 'Authorised Doctor', 'Authorised Psychiatrist' or 'Authorised Mental Health Practitioner' applying for mental health treatment consent for an Adult living with impaired capacity
Name:
Position:
Hospital/Clinic:
Phone:
Email:
Section 2: Authorised Mental Health Service details
Authorised Mental Health Service Address:
Treating Doctor/Psychiatrist:
Mental Health Case Manager:
Phone:
Email:
Section 3: Details of the Adult who the application is about
Name:
Address:
Date of Birth:
Does the Adult identify as: ☐ Male ☐ Female ☐ Other
Does the Adult identify as Aboriginal and/or Torres Strait Islander? ☐ Yes ☐ No If yes, please provide details:

If the Adult identifies as Aboriginal and/or Torres Strait Islander, has the Indigenous Mental Health Worker consulted with the Adult? If yes, please provide details: ☐ Yes ☐ No

Does the Adult experience communication/language barriers, visual impairment, speech impairment or any other special need? If yes, please provide details (interpreter required / type e.g. Auslan):

Section 4: Details of Carer/Support Person/ Service Provider 1

Name:

Address:

Phone:

Email:

Relationship to Adult (e.g. relative, friend, carer, service provider):

Details of Carer/Support Person/ Service Provider 2

Name:

Address:

Phone:

Email:

Relationship to Adult (e.g. relative, friend, carer, service provider):

Section 5: Details of the Adult's impaired capacity
Please provide detailed evidence that the Adult has impaired capacity to make decisions about their mental health treatment and provide supporting documentation where relevant:
Please detail the level of understanding that the Adult has regarding the nature and effect of the mental health treatment:
Section 6: Background information of the Adult
Cultural/religious considerations - has the Transcultural/Bilingual Mental Health Worker consulted with the Adult? If yes, please provide details (including cultural/religious networks and/or community support, cultural/religious issues impacting on treatment, need for interpreter and cultural/religious support being provided):

Does the Adult have an involuntary treatment/ forensic and/or legal history? If yes, please provide details:
☐ Yes ☐ No

Current circumstances (please provide details including living arrangements, family/social relations, employment/education, activities of daily living (ADL's) etc.):

Does the Adult have any medical/surgical history? If yes, please provide details: ☐ Yes ☐ No

Does the Adult have a history of medication and other treatments for mental illness? If yes, please provide details including past referrals, effectiveness of previous treatments, side-effects and complications associated with previous treatments and Adult's preference for medications: ☐ Yes ☐ No

Does the Adult have any other condition and/or treatment that may impact on their mental health? If yes, please provide details including substance abuse, developmental disability, psychosocial issues:

☐ Yes ☐ No

Section 7: Clinical information of the Adult
Diagnosis of mental illness/provisional/differential diagnosis. Please provide details, including diagnosis, date of diagnosis, symptomology and predisposing/precipitating/perpetuating factors. Please provide supporting documentation where relevant:
Details of current mental health treatment plan including details of medications (please include dosage, frequency of administration, date of commencement, date of change in dosage, reason for the prescription, issues with compliance or misuse, review dates of treatment plan, identified issues, goals of treatment, treatment/interventions, referrals and role of carer/support person(s):
Please provide details of the Mental State Examination (MSE) (including when the MSE was conducted, who conducted the MSE, presenting problem and current functioning):

Please provide details of any Risk Assessments conducted (including when and who completed the risk assessment, nature of risks, relevant dates, past instances, reasons for concern including imminent risk to the Adult, any risk mitigation strategies and protective factors):
Please provide details of the Adult's mental health intervention/relapse prevention plan (including identified warning signs from past experiences, arrangements for intervention in case of relapse or crisis, support services currently in place and past effective strategies):
Please provide details of any psycho-education provided to the Adult:
Should the Adult not be compliant to the proposed mental health treatment, what could be the potential consequences?

Does the proposed mental health treatment include any form of restraint or treatment in a locked inpatient unit? If yes, provide details of the restrictive practices implemented and conditions for free entry and exit from the locked inpatient unit: ☐ Yes ☐ No

Please provide details of any alternative treatment and therapies available for the mental illness:

Is the proposed mental health treatment consistent with 'good medical practice'? If yes, state the reasons why and provide supporting documentation where relevant: ☐ Yes ☐ No

Is the proposed mental health treatment in the Adult's best interest? If yes, state the reasons why and provide supporting documentation where relevant: ☐ Yes ☐ No

Is the proposed mental health treatment necessary and appropriate to maintain or promote the Adult's health and wellbeing? If yes, state the reasons why and provide supporting documentation where relevant: ☐ Yes ☐ No

Is the proposed mental health treatment the least restrictive on the adult's rights? (Least restrictive option refers to Schedule 1 Part 2 section 12 of the *Guardianship and Administration Act 2000*, Health Care Principle. *Example of exercising power in the way lease restrictive of the adult's rights- if there is a choice between a more or less intrusive way of meeting an identified need, the less intrusive way should be adopted*).

If yes, state the reasons why and provide supporting documentation where relevant: ☐ Yes ☐ No

Section 8: Consultation with the Adult and their support network

Has the Adult been provided a reasonable period of time to consider the proposed mental health treatment and has the information regarding the proposed mental health treatment been presented to them in a way that is appropriate to the communication needs and understanding? If yes, please provide details: ☐ Yes ☐ No

Has the Adult been provided the opportunity to discuss the proposed mental health treatment with an 'authorised doctor', 'authorised psychiatrist' or 'authorised mental health practitioner'? If yes, please provide details: ☐ Yes ☐ No

Has the Adult been provided the opportunity to seek advice, support, assistance, and adequate information on the treatment, alternatives, advantages, disadvantages and beneficial alternative treatments? If yes, please provide details: ☐ Yes ☐ No

What are the Adult's views, wishes and preferences regarding the proposed mental health treatment? Please provide details:

What are the views, wishes and preferences of the Adult's support network regarding the proposed mental health treatment? Please provide details:

Does the adult object to the proposed mental health treatment? ☐ Yes ☐ No

If yes, please provide the details of the objection:

Does the adult have minimal or no understanding of:

What the proposed mental health treatment involves; and

1) Why the proposed mental health treatment is required

If the Adult objects to the proposed mental health treatment, and that objection is overridden, will it cause the Adult;

☐ 1 - No distress; or ☐ 2 - Temporary distress that is outweighed by the benefit

Provide details of how 1) or 2) has been determined:

Can the objection be overridden? ☐ Yes ☐ No

If yes, please provide the details of overriding the Adult's consent:

Section 9: Signature of the 'Authorised Doctor', 'Authorised Psychiatrist' or 'Authorised Mental Health Practitioner' completing the application for mental health treatment
The information in this application is true to the best of my knowledge. Signature of applicant: Date: / /

Please be advised the consent for mental health treatment will be considered on a case-by-case basis and on the information provided in this application form.

The Public Guardian will discuss the application with the Adult and may also discuss the application with the treating psychiatrist/team, key parties, carer and other support persons.

Where insufficient information is provided, further information will be sought from the 'authorised doctor', 'authorised psychiatrist' or 'authorised mental health practitioner', and a second opinion may be requested.