Decision Making Capacity

Chief Civil Psychiatrist and Chief Forensic Psychiatrist **Clinical Guideline 2**

Provisions to Which this Guideline Relates

Mental Health Act 2013 – sections 3, 6, 7, 8, 9, 12, 15, 24, 25, 32, 35, 37, 40, 62, 88, 91, 108 and Schedule 1.

Preamble

A consumer's right to decide whether or not to have or undergo treatment for an illness is a fundamental expression of individual autonomy[i]; and respecting this right is a vital component of patient centred care[ii].

The increased involvement of consumers in decision making processes is consistent with key national and international frameworks including;

- the Australian Commission on Safety and Quality in Health Care *Australian Safety and Quality Framework for Health Care* action areas;
    - 1.3 partnering with consumers, patients, families and carers to share decision making about their care, and
    - 1.8 promoting healthcare rights, and
- The United Nations *Convention on the Rights of Persons with Disabilities* emphasises respect for the individual autonomy and independence of persons with disability (including persons with mental illness), including the freedom to make one's own choices (Article 3 and item (o) of the Preamble).

The ability for a competent adult to make autonomous decisions about medical treatment is also a legal right that is protected under Common Law[iii]. In particular, a competent adult has the right to refuse medical treatment even if the decision is not sensible, rational or well considered[iv]; or if refusal is reasonably likely to lead to death or serious injury.

Treatment decisions must occur within the relevant legal and legislative context and any interference with a consumer's body outside of the legal and regulatory framework existing in Tasmania may result in criminal or civil action. On this basis, a health carer who provides a person who lacks decision making capacity with treatment may be found to have committed a trespass[v]; while a health carer who provides a patient with treatment in the absence of informed consent may be found negligent[vi].

These principles are reflected in the *Mental Health Act 2013*'s objects, which include promoting voluntary over involuntary assessment and treatment and the making of free and informed assessment and treatment choices.

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This philosophy is also reflected in the Act's principles, which require all persons exercising responsibilities under the legislation to:

- Respect, observe and promote the inherent rights, liberty, dignity, autonomy and self-respect of persons with mental illness
- Interfere with or restrict the rights of persons with mental illness in the least restrictive way and to the least extent consistent with the protection of those persons, the protection of the public and the proper delivery of the relevant service
- Promote the ability of persons with mental illness to make their own choices
- Involve persons receiving services, and where appropriate their families and support persons, in decision-making
- Be sensitive and responsive to individual needs (whether as to culture, language, age, religion, gender or other factors)
- Respect the wishes of persons receiving services, and the wishes of their families and support persons, to the maximum extent consistent with the health and safety of those persons and the safety of others.

The following section of the Guideline draws heavily from a range of sources including in particular the Tasmanian Department of Health and Human Services *Capacity Toolkit*[1].

Purpose

This Clinical Guideline is intended to provide practical assistance to controlling authorities, medical practitioners, nurses, Mental Health Officers and other persons in relation to the assessment of a patient or prospective patient's decision making capacity under the *Mental Health Act 2013,* and related matters.

The Guideline is designed to ensure that the ability for patients and prospective patients to make their own assessment and treatment choices is maximised and that persons receiving services, and where appropriate their families and support persons, are involved in decision making processes where possible and appropriate.

Failure by an individual to comply with this Clinical Guideline may result in professional or occupational disciplinary action being instituted, particularly if the failure leads to unfavourable patient outcomes that might have been avoided if the Guideline had been followed; or if there is a history of failure by the individual to comply with this Guideline, or with similar Guidelines in place at the relevant time.

[1] The Capacity Toolkit has not been updated or reviewed but still provides useful general guidance.

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Guideline

I, Professor Kenneth Clifford Kirkby, being and as the Chief Forensic Psychiatrist, pursuant to sections 151and 153 of the *Mental Health Act 2013* and section 22 of the *Acts Interpretation Act 1931* hereby:

1. Revoke all previous directions (clinical guideline) issued under section 152 of the *Mental Health Act 2013* with respect to the exercise of responsibilities in relation to decision making capacity with effect from 11.59 pm on 30 June 2017; and

2. Issue the following direction (clinical guideline) to controlling authorities (and delegates), authorised persons and other secure mental health unit staff members exercising responsibilities in relation to decision making capacity under the *Mental Health Act 2013*, and related matters, with effect from 12.00 am on 1 July 2017.

What is Capacity?

Broadly speaking, a person's decision making capacity is their ability to:

- Understand the nature and effect of the actual treatment being proposed at the time that the decision is required
- Understand the main choices including the consequences and risks of a proposed treatment
- Weigh up the consequences of the choices including the risks and benefits and the consequences of refusing treatment[vii]
- Communicate their decision.

Capacity is decision-specific and may be present for some types of decisions but not others.

Capacity may also fluctuate over time. It can be lost, and may be increased or regained.

Capacity Assessment Principles

"Capacity is not something that can always be accurately quantified. It is a construct that is based on the complexities of a person's abilities as they interact with their environment. It is also subject to fluctuation. A person's overall capacity to make decisions can be enhanced by personal strengths, good service provision, information and support"[viii].

Decision making capacity may be affected by a person's abilities and what is happening around them. Factors which may impact on a person's decision making capacity include:

- The type of decision that is being made
- When the decision is being made including whether the person is tired
- The nature of the decision and whether it is simple or complicated
- How much information the person has been given and their understanding of the information

- The effectiveness of the communication between the person who is being asked to make the decision, and the person who is asking for the decision to be made
- The physical environment in which the decision is being made including whether it is noisy, busy or stressful
- The person's experience including the person's knowledge of or familiarity with the particular subject
- The person's health and whether the person is under the influence of drugs or alcohol
- Whether the person is dealing with any particular social issues or other stresses which may impact on their decision making.

Enhancing Decision Making Capacity

A person's capacity can be increased or regained, and may fluctuate over time. It can be enhanced or maximised through factors such as:

- Waiting until a person who is intoxicated has had an opportunity to "sober up"
- Treating the person's mental illness and any other conditions which may be affecting the person's capacity
- Waiting until the person is lucid or otherwise more likely to be able to make the decision that he or she is being asked to make. For example consideration could be given to discussing the decision at a time of day and in a location that is more likely to put the person at ease
- Assisting to improve a person's short term memory through therapy, if appropriate
- Removing barriers to communication. This may involve using varied forms of communication including non-verbal communication, visual or hearing aids, or other alternative and augmentative communication systems. Use of an interpreter or advocate should also be considered
- Eliminating factors that may reduce a person's capacity, such as stress, anxiety or insecurity
- Presenting issues sensitively
- Providing the person with time in which to absorb information which has been given, and for the person to seek out additional information and advice
- Involving support persons and representatives where this may be of use
- Not involving support persons and representatives where their presence may cause the person to be anxious and/or where there is potential for the support person or representative to inappropriately influence the person's decision making abilities

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When Capacity Should Be Assessed

There is a range of circumstances, events or behaviour which might prompt the need to conduct a capacity assessment. These include:

- When an Assessment Order is made, affirmed or discharged
- When a Treatment Order is made, renewed or discharged
- Whenever consideration is being given to applying to the Tribunal to authorise treatment for a forensic patient
- Decisions which are considered likely to have a significant impact of the person's decision on their health or safety or the safety of others – "high stakes decisions"
- A decision which is significantly different to a person's usual decisions and/or is out of character
- Repeated decisions that put the person at significant risk of harm or mistreatment
- Being confused about things that were easily understood in the past, or about times and places
- Having difficulty expressing emotions appropriately. This may be demonstrated through inappropriate anger, inappropriate sexual expression, or tears without the presence of actual sadness
- Displaying sudden changes in personality, for example excessive irritability, anxiety, mood swings, aggression, overreaction, impulsivity, depression, paranoia or the onset of repetitive behaviours
- Significant changes in the person's ability to manage themselves, their finances or their home
- Improvements in the person's capacity, and
- Recovery from an episode of mental illness

The presence of mental illness alone is not a reasonable factor.

The refusal of consent to treatment is similarly not a reasonable factor.

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Conducting a Capacity Assessment

Capacity Assessment Principles

Medical practitioners, nurses, Mental Health Officers and staff members of approved hospitals, approved assessment centres and community mental health teams should apply the following principles when assessing a person's decision making capacity:

- An adult's decision making capacity should be presumed. Where this is in doubt, a capacity assessment should be performed
- A child's lack of decision making capacity should be presumed. Where this is in doubt, a capacity assessment should be performed
- Capacity is decision specific: does the person have the capacity to make **this** decision, **now?**
- A person's decision making capacity should be assessed on each occasion that a decision needs to be made
- A person's inability to make a decision in the past should not be taken as an indication that the person cannot make a decision now, or into the future
- Don't assume that the person lacks decision making capacity because of their appearance, age, disability, behaviour, language skills or any other condition or characteristic
- Assess a person's decision making ability, not the decision that they make. The majority of people make poor decisions from time to time; and the right to make a decision includes the right to make a decision that other people do not agree with
- Do not confuse acquiescence with capacity. A person may acquiesce to a request without understanding the decision that they are being asked to make, without retaining the information, without having weighed the decision one way or the other and without being able to communicate the decision
- Use simple, open ended screening questions such as "what is this treatment about?"
- Respect the person's privacy. This includes when collecting information about the person, using information that has been collected, and disclosing that information to another person. Wherever possible a person's consent to each of these processes should be sought
- An Assessment Order or Treatment Order is a last resort and should only be pursued after all reasonable means of maximising a person's capacity have been tried.

Prior to a capacity assessment being performed the person should be advised of why the assessment is being conducted, what it will involve and possible outcomes.

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Consideration should be given to the person's individual communication needs and an interpreter organised if needed. Consideration should also be given to the person's cultural and ethnic background and religious beliefs so that the impact of the person's decision on the person's relationships with their cultural or religious community can be taken into account.

Open ended questions should be asked wherever possible, and leading questions should be avoided. Rather efforts should be made to engage the person in discussion with a view to identifying why the person has reached their decision, what factors they took into account when making their decision, and how they balanced those factors in reaching the conclusion that they have reached.

Where there are concerns about the extent to which a person has been influenced by others in reaching their decision, it may be useful to ask the person who else was involved in their decision making process. It may also help to identify the type and extent of support that may have been provided to the person in reaching a decision.

In cases where there are doubts about a person's decision making capacity which are not resolved through the performance of a capacity assessment, consideration should be given to seeking a second opinion from a senior psychiatrist.

Determining Whether the Criteria are Met

For the presumption that an adult has decision making capacity in respect of his or her own assessment or treatment to be rebutted it is necessary to show:

- That the person is unable to make the decision because of an impairment of, or disturbance in, the functioning of the mind or brain rather than for another reason such as duress or pressure from others, and
- That the person is unable to:
    - Understand information relevant to the decision, including information on making the decision one way or the other, deferring the making of the decision or failing to make the decision, or
    - Retain information relevant to the decision, including information on making the decision one way or the other, deferring the making of the decision or failing to make the decision, or
    - Use or weigh information relevant to the decision, including information on making the decision one way or the other, deferring the making of the decision or failing to make the decision, or
    - Communicate the decision.

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For the presumption that a child *does not* have decision making capacity in respect of his or her own assessment or treatment to be rebutted it is necessary to show:

- That the child is sufficiently mature to make the decision, and
- That notwithstanding any impairment of, or disturbance in, the functioning of the mind or brain, the child is able to:
    - Understand information relevant to the decision, including information on making the decision one way or the other, deferring the making of the decision or failing to make the decision, or
    - Retain information relevant to the decision, including information on making the decision one way or the other, deferring the making of the decision or failing to make the decision, for long enough to enable the person to use the information to make their decision, or
    - Use or weigh information relevant to the decision, including information on making the decision one way or the other, deferring the making of the decision or failing to make the decision, or
    - Communicate the decision.

A determination may be made that a person has decision making capacity if it reasonably appears to the person who is assessing the person's decision making capacity, that the person is able to understand an explanation of the nature and consequences of the decision in a way that is appropriate to his or her circumstances (whether by words, signs or other means).

Documenting the Outcome of a Capacity Assessment

The outcome of any capacity assessment conducted should be documented either through completing relevant sections of Chief Civil Psychiatrist Approved Form 6: Assessment Order or the Mental Health Tribunal Application for Treatment Order Form (or other relevant Mental Health Tribunal Form) or by completing Chief Civil Psychiatrist Approved Form 2A: Capacity (Adults) if the patient is an adult or Chief Civil Psychiatrist Approved Form 2B: Capacity (Children) if the patient is a child. Any additional information including a summary of the questions asked and the answers given should be documented in the patient's clinical notes.

Special Considerations

Children and Adolescents

Consideration should be given to seeking advice and/or assistance from a child and adolescent psychiatrist when assessing the decision making capacity of a child.

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Young People of Unknown Age

There may be occasions when it is not possible to determine whether a young person is above, or below, the age of 18. This may be because the person does not have with them any identification which may confirm the person's age, or because the person refuses to communicate this information to staff.

Young persons whose age is unknown should be taken to be children – that is, under the age of 18 - until such time as evidence of their adult status is provided.

This does not prevent a young person from being found to have decision making capacity; rather it requires the young person to have his or her capacity assessed in accordance with the test set out in the Act, before such a determination is made.

Culture, Language, Ethnicity and Religious Impacts

Medical practitioners, nurses, Mental Health Officers and other staff members of approved hospitals, approved assessment centres and community mental health teams should consider how a person's ethnicity, culture, language or religion may impact on their decision making. For example, in some communities and in some families it is usual for the head of a household, a parent or a community elder to make critical decisions; while in some indigenous communities, community decision making processes may be preferred.

A person's religion may also impact on the decisions that they are likely to make.

Intoxication

Assessing the decision making capacity of a person who is intoxicated may be particularly challenging. In particular it may be difficult to know whether the person lacks decision making capacity because of, or in spite of, the intoxication.

While intoxication is not, in and of itself, a bar to assessing a person's capacity, consideration should be given to providing the person with an opportunity to "sober up" before the capacity assessment process is commenced or completed.

Where there is genuine doubt about whether a person lacks decision making capacity because of a mental illness because of the person's intoxication and there are concerns about the person's health or safety or the safety of others consideration should be given to invoking the protective custody criteria and/or placing the person on an Assessment Order requiring his or her detention in an approved facility with a view to assessing the person's capacity once they are no longer under the influence of drugs, or alcohol.

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Guidance for Controlling Authorities

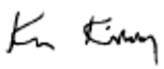
Controlling authorities of approved assessment centres and approved hospitals should consider the requirements of the *Mental Health Act 2013* when developing policies and protocols around the assessment of a person's decision making capacity.

Controlling authorities should also ensure that staff members who are required, or potentially required, to assess a person's decision making capacity under the Act are educated and trained in the requirements of the Act as they relate to the assessment of a person's decision making capacity, including in how to access interpreter services and alternative or augmentative communication systems.

Guidance for Clinical Staff

Staff members working with people with serious mental illness should ensure that they have a sound knowledge of the *Mental Health Act 2013*, this Guideline, relevant Chief Civil and Chief Forensic Psychiatrist Standing Orders and of any local policies and procedures relating to the assessment of a person's decision making capacity with respect to assessment or treatment which may be in place from time to time.

Staff members who are directly involved in the provision of patient care should ensure that they receive specific training in how to identify whether or not a capacity assessment may be required and in how to conduct a capacity assessment should this be required.



Professor Kenneth Clifford Kirkby

Chief Civil Psychiatrist/Chief Forensic Psychiatrist

Date: 1 July 2017

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Appendix 1: Relevant Legislative Provisions

3. Interpretation

adult *means a person who has attained the age of 18 years*

approved assessment centre *means an assessment centre that is approved under section 140 of the Act*

approved hospital *means a hospital approved under section 140 of the Act*

Chief Civil Psychiatrist *means the person for the time being holding or acting in the office referred to in section 143 of the Act. The Chief Civil Psychiatrist has responsibility for ensuring that the objects of the Act are met in respect of patients other than forensic patients or persons who are subject to supervision orders, and for the running of approved facilities other than secure mental health units*

Chief Forensic Psychiatrist *means the person for the time being holding or acting in the office referred to in section 144 of the Act. The Chief Forensic Psychiatrist has responsibility for ensuring that the objects of the Act are met in respect of forensic patients and persons admitted to a secure mental health unit under the Act, persons who are subject to supervision orders and for the running of secure mental health units*

child *means a person who has not attained the age of 18 years*

controlling authority *means –*

> *(a) for an approved facility run by or on behalf of the State, the Secretary, Department of Health and Human Services; and*
>
> *(b) for any other approved facility, the person for the time being in overall charge of the day-to-day clinical management of that facility*

forensic patient *means a person admitted to a secure mental health unit under section 68 of the Act and not discharged from a secure mental health unit*

guardian *has the same meaning as in the Guardianship and Administration Act 1995, that is, a person named as a guardian in a guardianship order or as an enduring guardian in an instrument of appointment as such.*

involuntary patient *means a person who is subject to an assessment order or treatment order*

parent*, of a child, means a person having, for the child, all of the responsibilities which, by law, a parent has in relation to his or her children*

patient *means, according to the context, a voluntary inpatient, involuntary patient or forensic patient and, in relation to in special psychiatric treatment, includes a voluntary patient*

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***representative**, of a patient or prospective patient, means –*

(a) the patient's guardian; or

(b) the patient's Australian lawyer; or

(c) if the patient is a child and raises no objection, a parent of the patient; or

(d) any other person nominated by the patient to represent his or her interests

***support person**, of a patient or prospective patient, means a person who provides the patient with ongoing care or support*

***voluntary inpatient**, of an approved facility, means a person who*

(a) has been admitted to the facility voluntarily to receive treatment for a mental illness; and

(b) is receiving that treatment on the basis of informed consent

***voluntary patient** means a person who is not an involuntary patient or a forensic patient*

6. Meaning of treatment

*(1) For the purposes of this Act, **treatment** is the professional intervention necessary to –*

(a) prevent or remedy mental illness; or

(b) manage and alleviate, where possible, the ill effects of mental illness; or

(c) reduce the risks that persons with mental illness may, on that account, pose to themselves or others; or

(d) monitor or evaluate a person's mental state.

(2) However, this professional intervention does not extend to –

(a) special psychiatric treatment; or

(b) a termination of pregnancy; or

(c) a procedure that could render a person permanently infertile; or

(d) the removal, for transplantation, of human tissue that cannot thereafter be replaced by natural processes of growth or repair; or

(e) general health care.

*(3) For the purposes of this Act, **treatment** does not include seclusion, chemical restraint, mechanical restraint or physical restraint.*

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7. Capacity of adults and children to make decisions about their own assessment and treatment

*(1) For the purposes of this Act, an adult is taken to have the capacity to make a decision about his or her own assessment or treatment (**decision-making capacity**) unless it is established, on the balance of probabilities, that –*

(a) he or she is unable to make the decision because of an impairment of, or disturbance in, the functioning of the mind or brain; and

(b) he or she is unable to –

(i) understand information relevant to the decision; or

(ii) retain information relevant to the decision; or

(iii) use or weigh information relevant to the decision; or

(iv) communicate the decision (whether by speech, gesture or other means).

*(2) For the purposes of this Act, a child is taken to have the capacity to make a decision about his or her own assessment or treatment (**decision-making capacity**) only if it is established on the balance of probabilities that –*

(a) the child is sufficiently mature to make the decision; and

(b) notwithstanding any impairment of, or disturbance in, the functioning of the child's mind or brain, the child is able to –

(i) understand information relevant to the decision; and

(ii) retain information relevant to the decision; and

(iii) use or weigh information relevant to the decision; and

(iv) communicate the decision (whether by speech, gesture or other means).

(3) For the purposes of this section –

(a) an adult or child may be taken to understand information relevant to a decision if it reasonably appears that he or she is able to understand an explanation of the nature and consequences of the decision given in a way that is appropriate to his or her circumstances (whether by words, signs or other means); and

(b) an adult or child may be taken to be able to retain information relevant to a decision even if he or she may only be able to retain the information briefly.

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(4) In this section –

***information** relevant to a decision includes information on the consequences of –*

(a) making the decision one way or the other; and

(b) deferring the making of the decision; and

(c) failing to make the decision.

8. Meaning of informed consent to assessment or treatment

(1) For the purposes of this Act, a medical practitioner may regard a person's consent to an assessment or a treatment as being informed consent if satisfied that –

(a) the person, at the time of giving the consent, has decision-making capacity; and

(b) the person has had a reasonable opportunity to make a considered decision whether or not to give the consent; and

(c) the person, having had that opportunity, has given the consent freely by some positive means, not by mere acquiescence.

(2) For the purposes of subsection 1(b) in its application to a treatment, a person may be taken to have had the requisite reasonable opportunity if –

(a) the treating medical practitioner and the person have discussed the treatment; and

(b) in those discussions the person was given an opportunity to disclose his or her priorities, expectations and fears about the treatment; and

(c) following those discussions the person was given –

(i) a clear and candid explanation of the advantages and disadvantages of the treatment, including information about the associated risks and common or expected side effects; and

(ii) where applicable, a clear and candid explanation of the alternative treatments that may be available, including information about the associated advantages and disadvantages; and

(iii) clear and candid answers to any questions the person may have had; and

(iv) any other information that was considered, by the treating medical practitioner or person, to be of relevant importance and likely to influence the person's decision-making with regard to the treatment; and

(v) a reasonable opportunity to –

(A) obtain independent medical or other advice; and

(B) consider the advantages and disadvantages of giving the consent.

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(3) For the purposes of subsection 1(c), a person is taken to have given consent freely if the consent is given without coercion, pressure or undue influence, whether from another person or a medication.

(4) For the purposes of subsection (2), the information, explanations or answers must have been in a language and form that the person could understand.

(5) Nothing in this Act is to be taken to prevent a person with decision-making capacity from withdrawing his or her consent to an assessment or a treatment before the assessment or treatment is made or provided and, if he or she does so, he or she is not to be taken to have given informed consent to the assessment or treatment.

9. Informed consent for child who lacks capacity to decide on own assessment or treatment

(1) For the purposes of this Act, informed consent for the assessment or treatment of a child who lacks decision-making capacity may be given by a parent of the child.

(2) To avoid doubt, for subsection (1) the informed consent of one parent is sufficient.

(3) Informed consent for the assessment or treatment of a child who lacks decision-making capacity may be withdrawn before the assessment or treatment is made or provided, but only by each parent of the child consenting to the withdrawal of consent.

(4) Nothing in this Act is to be taken to prevent the withdrawal under subsection (3) of consent to an assessment or a treatment before the assessment or treatment is made or provided and, if the consent is withdrawn, informed consent is not to be taken to have been given to the assessment or treatment.

12. Objects of this Act

The objects of this Act are as follows:

(a) to provide for the assessment and treatment of persons with mental illnesses;

(b) to provide for appropriate oversight and safeguards in relation to such assessment and treatment;

(c) to give everyone involved with such assessment and treatment clear direction as to their rights and responsibilities;

(d) to provide for such assessment and treatment to be given in the least restrictive setting consistent with clinical need, legal and judicial constraints, public safety and patient health, safety and welfare;

(e) to promote voluntary over involuntary assessment and treatment and the making of free and informed assessment and treatment choices;

(f) to provide for all incidental and ancillary matters.

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15. Mental health service delivery principles

All persons exercising responsibilities under this Act are to have regard to the mental health service delivery principles set out in Schedule 1.

24. Making an assessment order

(1) A medical practitioner may make an assessment order in respect of a person in, and only in, the following circumstances:

(a) the medical practitioner must have examined the person; and

(b) the examination must have been done in the 24-hour period immediately before the assessment order is made; and

(c) the medical practitioner must be satisfied from the examination that the person needs to be assessed against the assessment criteria; and

(d) the medical practitioner must be satisfied that a reasonable attempt to have the person assessed, with informed consent, has failed or that it would be futile or inappropriate to make such an attempt.

(2) A medical practitioner may make an assessment order authorising a patient's admission to, and if necessary, detention in an approved hospital.

(3) Despite subsection (2), a medical practitioner is not to make an assessment order authorising a patient who is a child to be admitted to and, if necessary, detained in an approved hospital unless the medical practitioner is satisfied that the hospital:

(a) has facilities and staff or the assessment of the patient; and

(b) is, in the circumstances, the most appropriate place to accommodate the patient.

(4) A medical practitioner may make an assessment order without having received an application for the order.

25. Assessment criteria

The assessment criteria are –

(a) the person has, or appears to have, a mental illness that requires or is likely to require treatment for –

(i) the person's health or safety; or

(ii) the safety of other persons; and

(b) the person cannot be properly assessed with regard to the mental illness or the making of a treatment order except under the authority of the assessment order; and

(c) the person does not have decision-making capacity.

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32. Affirmation or discharge of assessment order

(1) This section applies once a patient who is subject to an assessment order has been independently assessed by an approved medical practitioner.

(2) The approved medical practitioner must immediately affirm or discharge the assessment order.

(3) To affirm the assessment order, the approved medical practitioner must be satisfied that:

(a) the patient meets the assessment criteria; and

(b) the order has not already been discharged.

(4) If the approved medical practitioner affirms the assessment order, he or she may simultaneously extend its operation, once, by a period not exceeding 72 hours commencing from the time of affirmation.

(5) The affirmation is to be effected by means of a signed instrument in writing in a CCP approved form, and is invalid if not in that form.

(6) The instrument of affirmation takes effect as soon as it is signed.

(7) If the approved medical practitioner affirms the assessment order, the procedure in section 33 is to be followed.

(8) If the approved medical practitioner discharges the assessment order, the procedure in section 35(3) and (4) is to be followed.

35. Discharge of assessment order by medical practitioner or Tribunal

(1) An assessment order may be discharged at any time for sufficient cause by –

(a) the medical practitioner who made it; or

(b) any approved medical practitioner; or

(c) the Tribunal under section 180.

(2) A medical practitioner has sufficient cause to discharge an assessment order if he or she is satisfied, after examining the patient or on other reasonable grounds, that the patient does not meet the assessment criteria.

(3) In the case of a medical practitioner, the discharge is to be effected by means of a signed instrument in writing in a CCP approved form (the "discharge paper").

(4) A medical practitioner who discharges an assessment order is to –

(a) give a copy of the discharge paper to –

(i) the patient; and

(ii) the CCP; and

(iii) the Tribunal; and

(iv) if the relevant independent assessment has not been done, the approved medical practitioner who was expected to do the assessment or, if applicable, the controlling authority of the approved facility where the assessment was to have been done; and

(b) place a copy of the discharge paper on the patient's clinical record.

Note For a Tribunal discharge – see Division 2 of Part 3 of Chapter 3.

37. Application for treatment order

(1) Any approved medical practitioner may apply to the Tribunal for a treatment order in respect of a person.

(2) The application may be made whether or not the person is subject to an assessment order.

(3) If the person is subject to an assessment order, the application should only be made if:

(a) the applicant has assessed the person under the authority of the assessment order; and

(b) the applicant is satisfied from the assessment that the person meets the treatment criteria.

Note: The treatment criteria are set out in section 40.

(4) If the person is not subject to an assessment order, the application should only be made if -

(a) the person has been assessed by the applicant and one other approved medical practitioner, separately, within the preceding 7 days; and

(b) the applicant and the other approved medical practitioner are both satisfied from their respective assessments that the person meets the treatment criteria.

(5) The application in relation to a person is to be in accordance with section 195 and be accompanied by -

(a) a statement by the applicant affirming that (and explaining how) the person meets the treatment criteria; and

(b) an indication as to whether an interim treatment order is needed; and

(c) if the person is subject to an assessment order, a copy of that order.

(6) The applicant is to -

(a) give a copy of the application to the person (together with a statement of rights in a form approved by the President of the Tribunal); and

(b) place a copy of the application (and accompanying documentation) on the person's clinical record (ensuring that such a clinical record is created if one does not already exist).

40. Treatment criteria

The treatment criteria in relation to a person are –

(a) the person has a mental illness; and

(b) without treatment, the mental illness will, or is likely to, seriously harm –

(i) the person's health or safety; or

(ii) the safety of other persons; and

(c) the treatment will be appropriate and effective in terms of the outcomes referred to in section 6(1); and

(d) the treatment cannot be adequately given except under a treatment order; and

(e) the person does not have decision-making capacity.

62. Rights of involuntary patients

Every involuntary patient has the following rights:

(a) the right to have the restrictions on, and interference with, his or her dignity, rights and freedoms kept to a minimum consistent with his or her health or safety and the safety of other persons;

(b) the right to have his or her decision-making capacity promoted, and his or her wishes respected, to the maximum extent consistent with his or her health or safety and the safety of other persons; (c) the right, while in an approved hospital, to have access to current information about local, national and world events;

(d) the right to be given clear, accurate and timely information about –

(i) his or her rights as an involuntary patient; and

(ii) the rules and conditions governing his or her conduct in the hospital; and

(iii) his or her diagnosis and treatment;

(e) the right, while in an approved hospital, to apply for leave of absence in accordance with this Act;

(f) the right to have contact with, and to correspond privately with, his or her representatives and support persons and with Official Visitors;

(g) the right, while in an approved hospital, to be provided with general health care;

(h) the right, while in an approved hospital, to wear his or her own clothing (where appropriate to the treatment setting);

(i) the right, while in an approved hospital, not to be unreasonably deprived of any necessary physical aids;

(j) the right, while in an approved hospital, to be detained in a manner befitting his or her assessment, treatment or care requirements;

(k) the right, while in an approved hospital, to practise a religion of the patient's choice, to join with other patients in practising that religion and to possess such articles as are reasonably necessary for the practice of that religion (to such extent as is consistent with his or her health or safety, the safety of other persons and the management, good order and security of the hospital);

(l) the right, while in an approved hospital –

(i) to practise customs in accordance with the patient's cultural beliefs or cultural background; and

(ii) to join with other patients in practising those customs; and

(iii) to possess articles that are reasonably necessary for the practice of those customs –

to the extent that the practice of those customs is not contrary to any law and is consistent with the health and safety of the patient and other patients and the management, good order and security of the hospital;

(m) the right, while in an approved hospital, to ask for and be given such reasonable help from hospital staff as will enable the patient to enjoy these rights.

88. Authorisation of treatment by Tribunal

(1) The Tribunal may authorise treatment for a forensic patient if satisfied that –

(a) the treatment has been recommended and applied for by an approved medical practitioner (the applicant) in accordance with section 195 of the Act; and

(b) the patient has a mental illness; and

(c) without the treatment, the mental illness will, or is likely to, seriously harm –

(i) the patient's health or safety; or

(ii) the safety of other persons; and

(d) the treatment will be appropriate and effective in terms of the outcomes referred to in section 6(1); and

(e) the patient does not have decision-making capacity.

(2) The Tribunal is to determine the application by way of a hearing before a division of the Tribunal constituted by 3 members.

(3) The treatment may be authorised unconditionally or on such conditions as to time, method, supervision or otherwise as the Tribunal considers necessary or desirable and specifies in the authorisation.

(4) The authorisation is to be in a form approved by the President of the Tribunal.

(5) The Tribunal is to –

(a) give a copy of the authorisation to the patient (together with a statement of rights in a form approved by the President of the Tribunal); and

(b) give a copy of the authorisation to –

(i) the applicant; and

(ii) the CFP.

(6) The authorisation has effect according to its terms.

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91. Interim authorisation of treatment by Tribunal member

(1) A single member of the Tribunal (the MHT member) may authorise treatment for a forensic patient if satisfied that –

> *(a) the treatment has been recommended and applied for by an approved medical practitioner (the applicant) in accordance with section 195 of the Act; and*
>
> *(b) the Tribunal cannot immediately determine the application; and*
>
> *(c) the criteria specified in section 88(1)(b), (c), (d) and (e) are satisfied; and*
>
> *(d) achieving the treatment outcomes would be compromised by waiting for the treatment to be authorised by the Tribunal.*

(2) The MHT member may authorise the treatment on the basis of the application alone, without any hearing or further investigation.

(3) The treatment may be authorised unconditionally or on such conditions as to time, method, supervision or otherwise as the MHT member considers necessary or desirable and specifies in the authorisation.

(4) The MHT member is to advise the patient, the applicant and the CFP of the authorisation without delay, and this may be done by any means of communication the MHT member considers appropriate in the circumstances.

(5) However, if the advice of the authorisation is given orally, the MHT member is to confirm it in writing by means of a form approved by the President of the Tribunal.

(6) The MHT member or the Tribunal may revoke or vary the authorisation at any time.

(7) The MHT member or the Tribunal, as the case may be, is to advise the patient, applicant and CFP of the revocation or variation of the authorisation without delay, and this may be done by any means of communication the MHT member or Tribunal considers appropriate in the circumstances.

(8) However, if the advice of the revocation or variation of the authorisation is given orally, the MHT member or the Tribunal, as the case may be, is to confirm it in writing by means of a form approved by the President of the Tribunal.

(9) Subject to subsection (6), the authorisation continues in effect according to its terms until the relevant application is determined by the Tribunal.

(10) However, the authorisation lapses after 14 days (calculated from the precise time it is given) if, by then, the Tribunal has not determined the relevant application.

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(11) Once an advice under subsection (4) or (7) has been put in writing, the MHT member or the Tribunal, as the case may be, is to –

(a) give a copy of the advice to the patient (together with a statement of rights in a form approved by the President of the Tribunal); and

(b) give a copy of the advice to –

(i) the applicant; and

(ii) the CFP.

108. Further rights of forensic patients

Every forensic patient has the following rights:

(a) the right to have the restrictions on, and interference with, his or her dignity, rights and freedoms, kept to a minimum consistent with his or her health or safety and the safety of other persons;

(b) the right to have his or her decision-making capacity promoted, and his or her wishes respected, to the maximum extent consistent with his or her health or safety and the safety of other persons;

(c) the right, while in an SMHU, to have access to current information about local, national and world events;

(d) the right to be given clear, accurate and timely information about –

(i) his or her rights as a forensic patient; and

(ii) the rules and conditions governing his or her conduct in the SMHU; and

(iii) his or her diagnosis and treatment;

(e) the right, while in an SMHU, to apply for leave of absence in accordance with this Act;

(f) the right to be provided with general health care;

(g) the right to be provided with food that is adequate to maintain the health and wellbeing of the patient, and a diet that is not unvarying;

(h) the right to be provided with special dietary food if the CFP is satisfied that such food is necessary for medical reasons, on account of the patient's religious beliefs or because the patient is a vegetarian;

(i) the right to be provided with basic clean clothing that is suitable for the climate, of suitable size and adequate to maintain the health of the patient;

(j) the right to wear suitable clothing owned by the patient;

(k) the right not to be unreasonably deprived of any necessary physical aids;

(l) the right to adequate toilet and sanitary arrangements;

(m) the right to adequate light and ventilation;

(n) the right to practise a religion of the patient's choice and, if consistent with the management, good order and security of the SMHU, to join with other forensic patients in practising that religion and to possess such articles as are reasonably necessary for the practice of that religion;

(o) the right –

(i) to practise customs in accordance with the patient's cultural beliefs or cultural background; and

(ii) to join with other patients in practising those customs; and

(iii) to possess articles that are reasonably necessary for the practice of those customs –

to the extent that the practice of those customs is not contrary to any law and is consistent with the health and safety of the patient and other patients and the management, good order and security of any approved facility in which the person is present;

(p) the right to have access to legal advice;

(q) the right to be provided with information about the rules and conditions which will govern the patient's behaviour in the SMHU;

(r) the right, while in the SMHU, to ask for and be given such reasonable help from the SMHU staff as will enable the patient to enjoy these rights.

Schedule 1

1. The mental health service delivery principles are as follows:

(a) to respect, observe and promote the inherent rights, liberty, dignity, autonomy and self-respect of persons with mental illness;

(b) to interfere with or restrict the rights of persons with mental illness in the least restrictive way and to the least extent consistent with the protection of those persons, the protection of the public and the proper delivery of the relevant service;

(c) to provide a service that is comprehensive, accessible, inclusive, equitable and free from stigma;

(d) to be sensitive and responsive to individual needs (whether as to culture, language, age, religion, gender or other factors);

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(e) to emphasise and value promotion, prevention and early detection and intervention;

(f) to seek to bring about the best therapeutic outcomes and promote patient recovery;

(g) to provide services that are consistent with patient treatment plans;

(h) to recognise the difficulty, importance and value of the role played by families, and support persons, of persons with mental illness;

(i) to recognise, observe and promote the rights, welfare and safety of the children and other dependants of persons with mental illness;

(j) to promote the ability of persons with mental illness to make their own choices;

(k) to involve persons receiving services, and where appropriate their families and support persons, in decision-making;

(l) to recognise families, and support persons, of persons with mental illness as partners, with mental health service providers, in the provision of their treatment and care to the extent that this is appropriate and consistent with their own wishes;

(m) to respect the wishes of persons receiving services, and the wishes of their families and support persons, to the maximum extent consistent with the health and safety of those persons and the safety of others;

(n) to promote and enable persons with mental illness to live, work and participate in their own community;

(o) to operate so as to raise community awareness and understanding of mental illness and to foster community-wide respect for the inherent rights, liberty, dignity, autonomy and self-respect of persons with mental illness;

(p) to be accountable;

(q) to recognise and be responsive to national and international clinical, technical and human rights trends, developments and advances.

[i] Skene, L 2008, *Law and Medical Practice: Rights, Duties, Claims and Defences* 3rd edition, Reed International Books Australia Pty Ltd, page 81.

[ii] The development of a partnership model of health care provision is strongly promoted in documentation intended to guide clinicians in the provision of health care including the United Kingdom General Medical Council 2008 document *Consent: Patients and Doctors Making Decisions Together*, General Medical Council of the United Kingdom, and the Medical Board of Australia 2009 document *Good Medical Practice: A Code of Conduct for Doctors in Australia*, Medical Board of Australia.

[iii] *Hunter and New England Area Health Services v A* [2009] NSW SC 761

iv *Hunter and New England Area Health Services v A* [2009] NSW SC 761, [10]; *Re T (Adult: Refusal of Treatment)* [1992] EWCA Civ 18

[v] *Department of Health and Human Services (NT) v JWB* (Marion's case) (1992) 175 CLR 218 at 233; 106 385 at 391 (HCA),

[vi] *Rogers v Whitaker* (1992) 175 CLR 479; [1992] HCA 58

[vii] *F v West Berkshire Health Authority* [1989] 2 All ER 545

[viii] McIlwraith, J and Madden, B 2010, *Health Care & The Law* 5th edition, Thomas Reuters (Professional) Australia Limited, page 64