About Advance Health Directives for Mental Health

○ What is an Advance Health Directive for Mental Health (AHD-MH)?

The AHD-MH allows a person to record directions about their mental healthcare should they lose capacity. In addition, it allows a person to record their ‘views, wishes, and preferences’ for future treatment and care should they lose capacity.

An Advance Health Directive for Mental Health (AHD-MH) is created under the Powers of Attorney Act 1998 (Qld) and the Mental Health Act 2016 (Qld) (MHA2016).

○ What happens if an AHD-MH does not exist when a person is admitted?

When a person is admitted and they lack capacity to consent to their mental healthcare, healthcare can be authorised by the consent of:

• Queensland Civil and Administrative Tribunal (QCAT) appointed Guardian for health matters
• Attorney for personal matters under an Enduring Power of Attorney (EPOA)
• Statutory Health Attorney

If a suitable decision maker is not available to make the required decisions, then the treating team may consider treatment under a Treatment Authority.

○ How does an AHD-MH differ from a general Advance Health Directive?

Advance Health Directives (AHD), including AHD-MH, are created under the Powers of Attorney Act 1998 (Qld). An AHD gives directions about health matters, including end-of-life care, in the event the person loses capacity to make those decisions. The AHD-MH has been specifically developed for people with lived experience of mental illness to record their directions, including views, wishes and preferences, about their future mental health treatment and care. In addition, an AHD-MH enables a person to nominate attorney/s to make health care decisions.

○ How are AHD-MHs and Statement of Choices different?

The Statement of Choices (SOC) is not a legal document and is a general guidance form which includes a person’s wishes and choices for health care into the future, but it cannot make legal directions about a person’s future health care. SOCs, like AHD-MHs, will only be used if a person is unable to make or communicate their decisions. The SOC is not made under the Powers of Attorney Act 2016.
What are the principles of the MHA2016 that clinicians / health professionals must be aware of?

Clinicians and other health employees working under the Act have a responsibility to know and understand rights and principles under the MHA2016. Refer to Part 2 of the Act.

Section 5 outlines the following principles about:

- Same human rights
- Matters to be considered in making decisions
- Support persons, provision of support and information
- Achievement of maximum potential and self-reliance
- Acknowledgement of needs & Provision of treatment and care
- Aboriginal people and Torres Strait Islanders & persons from culturally and linguistically diverse backgrounds
- Minors
- Maintenance of supportive relationships and community participation
- Importance of recovery-oriented services and reduction of stigma
- Privacy and confidentiality

These principles are similar to those found in the Guardianship and Administration Act 2000. publicguardian.qld.gov.au/__data/assets/pdf_file/0004/466645/opg-fact-sheet-general-principles.pdf

Regard to principles: In performing a function or exercising a power under this Act, a person is to have regard to the principles mentioned in sections 5 and 6.

How can I access MHA2016, and other guardianship legislation?


Click on ‘In Force Legislation’ tab and select the Act by clicking on the letter for the Act’s first word (i.e. click on M for Mental Health Act to appear in the list).

Making an Advance Health Directive for Mental Health

Who can make an AHD-MH?

The MHA2016 states persons over 18 years of age with capacity are eligible to make an AHD-MH. A person has ‘capacity’ to make an AHD-MH if they can freely and voluntarily make decisions about their healthcare, can communicate those decisions, and understand:

- the nature and likely effect of each matter in the advance health directive;
- the advance health directive only applies when they do no have capacity to make decisions for themselves about the matters in the directive;
- they can revoke their directive at any time if they have capacity to make the decision; and
- they will be unable to oversee the implementation of their AHD-MH at a future time, as their directive is only effective when they do not have capacity to make decisions for themselves.

Refer also to Queensland guardianship legislation, and the Queensland Health document ‘Guide and form for completing an advance health directive for mental health’.
Are persons subject to a Treatment Authority (TA) able to make an AHD-MH?

An AHD-MH cannot be finalised while a person is subject to a Treatment Authority. However, discussions with the person about their directions, views, wishes and preferences may occur and be documented into a ‘DRAFT’ version. After the Treatment Authority has been revoked and the person has capacity to consent to treatment as per the MHA2016 definition, then the clinician should encourage the person to review their DRAFT before requesting an eligible doctor certify section 7 and meeting with a qualified witness so that section 8 can be completed.

Are persons subject to a Forensic Order (FO) or Treatment Support Order (TSO) able to make an AHD-MH?

A FO or TSO has no connection to capacity to consent to mental health treatment, so there is no barrier to developing an AHD for persons subject to a FO or TSO.

Treatment decisions however are authorised by the FO and TSO, but ideally would be aligned with the AHD going back to general principles outlined in the Act.

A person on a FO (mental health) or TSO cannot be made subject to a TA (unless the person is subject to a FO (Disability)).

Note also that the Chief Psychiatrist Policy ‘Advance Health Directives and less restrictive way of treatment’ specifically states under [2. Scope] “This Policy does not apply to persons on a forensic order or treatment support order”.

Who should initiate discussion about making an AHD-MH with a person experiencing mental health concerns?

Any clinician and/or health professional (including but not limited to allied health professionals, case workers, indigenous officers and/or community mental health workers) can initiate discussions about advance care planning with a person to check their awareness of the process and the documentation options and their level of interest.

The discussion should be had when a person has capacity, when they understand what the document is about, and they understand their rights and the possible benefits of making an advance health directive for mental health.

When making an AHD-MH, is a lawyer required?

No, a lawyer is not required to assist a person to complete an AHD-MH but the person may wish to approach a lawyer to witness section 8. Section 8 of the AHD-MH requires that a lawyer, Justice of the Peace (JP) or Commissioner of Declarations (Cdec) witnesses the AHD-MH document.

It is important to note that ‘Witness’ under the MHA2016 implies that the witness verifies the person’s identity and also confirms that the person appeared to have capacity to understand the nature and effect etc. of the document.


Please refer to [AHD-MH Factsheet #4] for definitions of bolded words
When making an AHD-MH, is a doctor required?

Yes, it is best practice that a doctor is involved in discussions with the person when they are developing their AHD-MH. Ideally, a person should discuss their AHD-MH with a doctor that knows their mental health history so they can discuss previous history, treatment and care and use these discussions to inform and update the AHD-MH. Section 7 of the AHD-MH requires a doctor to sign off the document and certify that the person appears to have capacity to make the document. The definition for capacity is defined under section 14 MHA2016 [Meaning of capacity to consent to be treated].

Section 7 of the AHD-MH document can be signed by any doctor including a registrar, GP, other medical doctor, or psychiatrist, however it is preferable that a doctor, GP or psychiatrist familiar with the person’s mental health history signs the AHD-MH.


What questions may a person ask their doctor when making an AHD-MH?

An individual may approach health professionals with questions such as:

- What is the difference between an AHD and a AHD-MH? Do I need to do both?
- What is my current treatment? What are my alternative treatment options?
- What are the benefits and risks of treatment, and not receiving treatment?
- What healthcare may I need in the future?
- What treatments and medications have not worked well for me in the past?
- Does my proposed AHD-MH appropriately address future mental health care needs?
- Will my AHD-MH for mental health be followed if I become unwell?
- Will treatment be given to me against my wishes even if I have a valid AHD-MH?
- If treatment is given against my wishes will the doctors explain why?
- Would it be useful for me to appoint an attorney?

Who should you recommend a person speak with about their AHD-MH for mental health?

A person should be encouraged to discuss their directions, including views, wishes, and preferences with people they trust; including attorney/s, nominated support persons and all relevant health professionals, including their GP/doctor, treating team, and/or psychiatrist.

Consider being proactive in guiding the person to focus on their own care, starting with their views, wishes and preferences.

If a person is making an AHD-MH at a time they are not being treated under the MHA2016, can they receive the support of an Independent Patient Rights Adviser (IPRA)?

Yes, a person can approach an IPRA for support to complete the making of an AHD-MH. The Mental Health Act 2016 establishes the IPRA positions state-wide. A key function of the IPRA position is to advise persons of their rights under the MHA2016. These positions play a very important role in liaising between clinical teams, patients and support persons.
In section 2 of the AHD-MH document, what is the difference between the two option boxes ‘Consent to Healthcare’ and ‘Views, Wishes and Preferences’?

The ‘Consent to Healthcare’ box allows the person to state what future treatment and care they will accept and consent to, and also what treatment and care they do not agree to. This section may include information about medications (i.e. what medications they prefer / worked well, and medications which caused previous adverse reactions), and other healthcare and special healthcare matters, such as ECT.

The ‘views, wishes and preferences’ box allows the person to state their views around their other personal (lifestyle) matters, health and care needs. This is the section where the person can help a future treating team understand their wishes, values and preferences.

Who can a person appoint as their attorneys?

A person is eligible to be an attorney if they are:

- 18 years of age of over; and
- Not the person’s paid carer or healthcare provider; and
- Not a person providing services in a residential service where the person lives.

The attorney/s must also have capacity to make health care decisions. If problematic issues arise with the attorney, then QCAT can be approached as they have jurisdiction to review the attorney’s conduct and consider appointing a Guardian for health or other personal matters.

For the meaning of eligible attorney, and definitions of paid carer and healthcare provider, please refer to section 29(2) and Schedule 3 of the Powers of Attorney Act 1998 (Qld).

Clinicians should be aware that some confusion often surrounds the criteria of ‘paid carer’. A paid carer performs services for the person’s care and receives remuneration from any source for the services; and a paid carer does not include a carer payment or other benefit received from the Commonwealth or a State for providing care for the person.

How many Attorneys can be appointed?

A person may appoint one or more Attorneys (see sections 3 & 5 of the AHD-MH) to make healthcare decisions on their behalf should they lack capacity at a future time. It is recommended that no more than four (4) Attorneys are appointed. Attorneys are guided by the instructions in the AHD-MH and they are not able to override any decisions made by the person in the AHD-MH.

Importantly, nominated attorneys must agree to be an attorney and sign the section on the form. The attorney/s must understand that they can only make decisions on the person’s behalf when the person lacks capacity and they must follow the principles outlined above. Conduct of an attorney can be reviewed by QCAT.

Can an Attorney override any directions in the AHD-MH?

An Attorney cannot override any explicit direction/s in an AHD-MH. An Attorney may only exercise power for a health matter as directed in the AHD-MH, otherwise as requested by the treating team or as allowed for in the principles outlined above.
Can an Attorney consent to a person receiving electroconvulsive therapy (ECT)?

No. An Attorney cannot consent to ECT as under legislation this is a ‘special health matter’. Under the MHA2016, a doctor may perform ECT on an adult only if the person gives informed consent or, if they are unable to give informed consent, the Mental Health Review Tribunal approves the treatment.

Importantly, the AHD-MH allows a person making a directive to consent to ECT (or to refuse consent for ECT), and also gives the person making the document an option of placing limits on the consent, such as the number of treatments.

Can someone else sign on behalf of a person making an AHD-MH for mental health?

Yes, if a person making an AHD-MH cannot physically sign their name then the AHD-MH form at section 8 allows an eligible signer to sign the document on behalf of the person. The eligible signer must sign the document when they are in the presence of the person making the AHD-MH.

A person is eligible to sign on behalf of the person making the AHD-MH if they are:

- At least 18 years of age; and
- Not the witness stated in section 8; and
- Not an attorney nominated in the AHD-MH.

What should a person know about getting their signature witnessed on the AHD-MH?

It is essential that a person understands that they do not sign their completed form until they are in the presence of an eligible witness. A person is eligible to be a witness if they are a JP, Lawyer or Commissioner of Declarations (Cdec) and is:

- At least 21 years of age; and
- Not a paid carer or health provider for the person; and
- Not a beneficiary under the person’s will; and
- Not identified as the eligible signer if the person is unable to sign; and
- Not one of the appointed attorneys or a relation of an appointed attorney.

The witness signing the document certifies that the person making the AHD-MH appears to have capacity at the time of signing the document.

Can a person change a validly completed AHD-MH?

Yes, if a person is deemed to have capacity to make or alter their AHD-MH, then they can:

- update changes by completing a new AHD-MH document and ticking the box in section 8 to revoke all previous documents they have made;
- revoke or change the appointment of an attorney (in writing);
- revoke their AHD-MH by completing a revocation form;

A doctor will need to sign an updated AHD-MH if changes are made about treatment preferences. Encourage a person updating or revoking their AHD-MH to advise their doctor, psychiatrist and/or treating team so that health records can be updated to reflect the change/s.
Can sections of the AHD-MH be intentionally left blank by the person?

Yes. Any section of the AHD-MH can be left blank, including restrictive practices. If the section is left blank it does not apply and no consideration is given to it.

A doctor can sign off on section 7 of the AHD-MH form even if the person is aware of the blank sections and does not wish to complete those sections at that time (for whatever reason).

For best practice and to ensure future treating teams know the section/s intentionally left blank, the doctor may wish to encourage the person to cross through the section/s and initial.

Use of an Advance Health Directive for Mental Health

What happens in an emergency?

If a person has an AHD-MH, or appointed an Attorney for health care, this does not prevent health care being given in an emergency without their consent. Health care can be given if the health provider reasonably considers that the person does not have capacity and the treatment is necessary to avoid risks and harm to themselves and/or others.

Should the AHD-MH be followed, and why?

Yes, if an AHD-MH exists and is clinically appropriate and reasonably necessary for the person’s current treatment needs, then it should be followed.

The MHA2016 states that if a ‘less restrictive way’ for a person to receive treatment and care for the person’s mental illness is available then the treating team should follow the less restrictive way. The AHD-MH provides valuable information to guide clinical decision-making. Clinicians should enquire with a patient and/or their support persons to confirm if an AHD-MH exists, and also check the state-wide system (i.e. CIMHA and/or The Viewer).

If a person has fluctuating capacity, should their AHD-MH be followed?

Often, a person with mental illness may have fluctuating capacity, so, an AHD-MH document only operates at the times when the person is assessed as not having capacity to consent to mental health treatment and care. Individual assessment of capacity for treatment decisions is required always. Remember, a person may have capacity for other decisions when they may lack capacity for mental health treatment.

NOTE: The Guardianship and Administration and Other Legislation Amendment Bill 2018 proposes to amend the Powers of Attorney Act 1998 (Qld), specifically to section 42 [Person’s capacity to make an advance health directive]. If proposed changes are made, this may clarify the confusion between the criteria to make an AHD-MH under the POA Act 1998, and the MHA2016 treatment criteria and definition of ‘capacity to consent to treatment’.
When can an AHD-MH be overridden with a Treatment Authority?

The directives, views, wishes and preferences written on validly completed AHD-MH documents must be clinically relevant to the presenting issue/s. If not, a Treatment Authority (TA) may be required. If a TA is made, this does not cancel out the AHD-MH. If a person is on a TA for treatment decisions, follow other parts of the AHD-MH relating to other matters where possible.

In all instances, where an AHD-MH is not followed in whole or parts, the clinician/health professional must discuss the reasons with the person; and then document all reasons clearly in the patient’s health record. Where possible, the treating team should consider the less restrictive way and be guided by an AHD-MH with a view to upholding and respecting views, wishes, and preferences where possible.

Refer MHA2016, particularly to section 13 [Meaning of ‘Less Restrictive Way’]; Section 18 [Treatment Authorities]; and Section 54 [When Advance Health Directive not followed].

What happens if only part/s of the AHD-MH can be followed?

If any of the directions, views, wishes or preferences provided for in an AHD-MH are not clinically appropriate at the time, then the treating team are required to document the reasons in the person’s clinical record as to why they are not clinically appropriate. However, parts of the AHD-MH may still be relevant and should be followed. If other directions, views, wishes or preferences in the AHD-MH are appropriate then they should be followed.

What happens if a person has previously completed a valid AHD-MH and demands the treatment they have stipulated in the AHD-MH?

It is important that a person understands from the outset that an AHD-MH cannot demand or guarantee treatment. The treating team should always aim to treat the person in the less restrictive way, including under an AHD-MH if one has been made. An AHD-MH does not guarantee treatment and care being delivered in the way specified in the AHD-MH. The treating team is guided by the AHD-MH and follows the AHD-MH if the treatment and care specified is reasonably necessary and appropriate.

Does a person have the right to refuse medical treatment?

Yes, a person can refuse medical treatment if they are deemed to have capacity to make that decision. A person can also state their refusal for future treatment in a validly completed AHD-MH document. However, if the AHD-MH does not adequately address treatment needs, then the treating team may not follow the AHD-MH and make a Treatment Authority.

When should a review occur if a person is treated under an AHD-MH?

For inpatients being treated under an AHD-MH, a Clinical Director of a mental health service must review the person’s treatment and care 14 days after admission date. During this review, the clinical director may determine if the person should remain an inpatient or if treatment in the community would be more appropriate. The Clinical Director can also determine if treatment should continue under the AHD-MH or whether a Treatment Authority should be made to better protect the rights of the person.
What happens if a person has a validly completed AHD-MH and has a Guardian appointed by QCAT to make healthcare decisions? Who makes the decisions?

When a person lacks capacity to consent to healthcare decisions then clinicians should follow the healthcare decision-making hierarchy below. This priority order for dealing with healthcare decisions (including where more than one document or decision-maker exists) should be followed when a person lacks capacity to make mental health treatment and care decisions.

It is possible that QCAT appoint a guardian for healthcare without being aware that a completed and valid AHD-MH exists. In this instance, if it becomes known that a valid AHD-MH or AHD exists, then QCAT must be notified and a review of the decision may be set down for hearing. At a review, QCAT may consider what the person’s needs are at that time and decide accordingly.

Decision-making alternatives if persons lack capacity for healthcare*

- **Advance Health Directive for Mental Health (AHD-MH):** Provides future consent for mental health treatment and care, and other health matters, for when persons lack capacity to make healthcare decisions due to mental illness.
- **Advance Health Directive (AHD):** Provides a future healthcare agreement for general healthcare, and end of life matters.

- **Guardian:** Application to Queensland Civil and Administrative Tribunal (QCAT) can be made for a:
  - [1] Guardian (for personal/healthcare decisions);
  - Appointments can be reviewed at QCAT with correct QCAT forms.

- **Enduring Power of Attorney (EPOA):** When persons have capacity they can make an EPOA and appoint attorney/s for personal decisions (which includes healthcare).

- **Statutory Health Attorney (SHA):** Spouse, carer, family or friend.
  - Option of last resort: The Public Guardian of Queensland.

* Hierarchy wording tailored for persons lacking capacity due to mental illness

Storing, changing or revoking an existing document

- Where should documents be stored, and who requires a copy?

People should be encouraged to store the original copy of the AHD-MH in a dry and safe location where the person lives. Also encourage the person to make certified copies so that a copy can be given to the public mental health service for uploading, and other copies should be distributed by the person to a few trusted parties so that the AHD-MH document is accessible if/when required.

It is preferable that a copy of an AHD-MH is given to the person’s GP and local public mental health service, NGO service providers and any Attorneys. The AHD-MH can be uploaded and accessed in the state-wide database (e.g. CIMHA, The Viewer) for public mental health services.
Frequently Asked Questions: Advance Health Directives for Mental Health (AHD-MH) MHA2016 (Qld) AHD-MH Factsheet #3

- **How many copies should be made?**
  The person should always keep the original and make four to six certified copies.

- **How does a person get copies certified?**
  Copies of AHD-MH for mental health can be certified by a Lawyer, a JP, or a Commissioner of Declarations (Cdec) when the person has their signature witnessed, or later. Section 45 of the *Powers of Attorney Act 1996* provides for how a copy of an enduring document may be legally proved.

  Clinicians may wish to confirm if a JP service is set-up within the HHS and/or contact the IPRA service to query if any of the IPRA/s hold qualifications (Lawyer, JP, Cdec) and are available to witness. Alternatively, the person may wish to see if a JP service is available within their local area (e.g. shopping centre and/or library).

  The closest JP or Cdec location can also be determined by searching the ‘Find a Justice of the Peace’ on the Queensland Government website.
  

- **What if a person presents with their original AHD-MH document and requests it be uploaded, or requests a copy that is not certified to be uploaded to the state-wide system?**
  
  Section 45 of the *Powers of Attorney Act 1996* provides for how a copy of an enduring document may be legally proved. The Act does not prevent another way for the enduring document to be proved (s 45(6) PAA). If a person hands the original or a copy of a validly completed AHD-MH to the clinician and/or AMHS staff for uploading but it is not certified on each page, then the view taken is that the submitting (giving) of a validly completed AHD-MH by the person is ‘proving’ the document.

  The position of the Department of Health – Office of the Chief Psychiatrist is that validly completed AHD-MH should be available on the state-wide system where possible, and copies of complete and valid AHD-MH documents given to the AMHS by the person can be uploaded. Clinicians should encourage people making an AHD-MH to obtain certified copies of the document once it is valid (sections 7 and 8 have been validly signed).

  Queensland Health have created checklists for AHD-MHs and EPOAs and these checklists state how a document must be certified in accordance with the Act. Each page of the document must be certified that it is a true and correct copy. The last page of the document requires to be certified that the copy is true and complete.

  **NOTE:**
  
  - Information is available on the AHD-MH and EPOA checklist in relation to certifying copies of enduring documents for checking to make sure document is certified in accordance with the Act. It is noted that this is one of the likely amendments in the Guardianship and Administration and Other Legislation Amendment Bill 2018.

  - The My Health Records website does not require a certified copy as described above to be uploaded to the My Health Record.
Is there a national registry for completed documents?

There is currently no national registry for AHD-MH documents. A person can however request for their AHD-MH to be put on their nationally accessible e-health record.

Is it possible to upload completed and valid AHD-MH to the state-wide system if a person is not registered in Queensland’s public mental health system?

Not at present, but it has been identified as an issue, including the need for GPs to have improved access to electronic health record systems.

**Commonly questions asked by health professionals**

What does the *MHA2016* say about mechanical restraint, seclusion, and physical restraint?

The Act regulates the use of mechanical restraint, seclusion, physical restraint, and other practices. Chapter 8 of the Act provides for restrictions on the use of mechanical restraint, seclusion and physical restraint on patients in authorised mental health services.

The use of mechanical restraint on an **involuntary patient** in an Authorised Mental Health Service must be approved by the Chief Psychiatrist. Mechanical restraint and seclusion may be used only if there is no other reasonably practicable way to protect the patient or others from physical harm.

Can an AHD-MH provide consent to seclusion?

No. If someone is admitted under an AHD-MH and requires seclusion, then a **Treatment Authority** is required to authorise seclusion for the necessary time.

The Act states that seclusion only applies to a **relevant patient**. A relevant patient means an involuntary patient in an Authorised Mental Health Service who is subject to a treatment authority, forensic order or treatment support.

It is important that clinicians / health professionals understand how the Act defines **patient** and **relevant patient**. Refer to the *MHA2016* Schedule 3 Dictionary and/or **Factsheet 4 – Glossary**.

Do AHD-MHs from other states carry over if the person is admitted in Queensland?

Yes, section 40 of the *Powers of Attorney Act 1998* (Qld) recognises that if a person has enduring documents made in another state that comply with their legal requirements, and they are what a Queensland AHD-MH can contain, the document must be treated as if it were made in Queensland. Therefore, if a person has completed an AHD-MH from another state of Australia, the document is treated the same.
When is the best time for a person to make an AHD-MH under the MHA2016?

A person can make an AHD-MH if they are over 18 years of age and have capacity. A person must freely and voluntarily make decisions, be able to communicate those decisions, and understand:

- the nature and likely effect of each matter in the AHD-MH; and
- the AHD-MH only applies when the person does not have capacity to make decisions for themselves about matters in the directive; and
- the AHD-MH can be revoked at any time if the person is deemed to have capacity to make the decision.

For an AHD-MH to be validly completed, a doctor must sign off the AHD-MH and certify that the person appeared to have capacity to make the directive.

Is the AHD-MH binding?

Yes, the AHD-MH is a legal document that provides consent, or non-consent for future healthcare. The AHD-MH also contains guidance for the treating team to understand a person’s views, wishes, and preferences. The treating team should follow completed and valid AHD-MH documents in whole or parts, as discussed above. It is acknowledged that there are legitimately different ways to treat mental health conditions, so the treating team should start with the AHD-MH and follow all or parts of the document as clinically appropriate and reasonable.

What happens if a person is being treated under an AHD-MH and is deemed to be absent?

A person being treated under an AHD-MH is not an involuntary patient under the MHA2016. However, if a person being treated in a ‘less restrictive way’ is deemed to be absent without approval (AWA) then clinicians may utilise emergency responses that involve the Queensland Police Service (QPS) and/or Queensland Ambulance Service (QAS) if there are valid concerns for the person’s safety. If there is concern for the safety of the person and/or others, an Emergency Examination Authority (EEA) may be appropriate. An EEA will provide assessment options under the MHA2016, and ensure emergency services have power of entry to a person’s accommodation if required (the EEA is authorised by the Public Health Act 2005 - not the MHA2016).