Health
Justice Health &
Forensic Mental Health Network

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Consent to Medical Treatment - Patient Information

Policy Number 1.085

Policy Function Continuum of Care

Issue Date 20 June 2016

Summary This Policy contains a summary of the Ministry of Health policy and legal requirements for consent. This Policy applies to all facilities and services of the Justice Health & Forensic Mental Health Network and all staff (including employees, contractors and any other health service providers) involved in the provision of health care.

This Policy provides advice on the most important aspects of patient consent to medical treatment relevant to services provided by Justice Health & Forensic Mental Health Network. This policy should be read in conjunction with NSW Ministry of Health PD2005_406 *Consent to Medical Treatment - Patient Information*.

This policy also provides advice for staff of JH&FMHN regarding compliance with compulsory medical treatment provisions as defined in section 73 of the *Crimes (Administration of Sentences) Act 1999* and similar 'medical attention' provisions within section 27 of the *Children (Detention Centres) Act 1987 (NSW)*.

Responsible Officer Executive Medical Director

Applicable Sites

☒ Administration Centres
☒ Community Sites (e.g. Court Liaison Service, Community Integration Team, etc.)
☒ Health Centres (Adult Correctional Centres or Police Cells)
☒ Health Centres (Juvenile Justice Centres)
☒ Long Bay Hospital
☒ Forensic Hospital

Previous Issue(s) Policy 1.085 (June 2007)

Policy 1.181 Compulsory Medical Treatment (August 2010)

Change Summary

- Major reworking of format, structure and content.
- Incorporate relevant updates from recent case law.
- Addition of comprehensive guidance on consent for mental health

patients.

- Added a section on notification of Consulate for foreign nationals.
- Incorporation of prior policy 1.181 *Compulsory Medical Treatment*.

TRIM Reference POLJH/1085

Authorised by Chief Executive, Justice Health & Forensic Mental Health Network

1. Preface

The purpose of this document is to set out the policy and law in New South Wales in relation to consent to medical treatment and to provide guidance on how the law is to be applied within Justice Health and Forensic Mental Health Network (JH&FMHN). This policy should be read in conjunction with the NSW Ministry of Health (MoH) PD2005_406 *Consent to Medical Treatment - Patient Information*.

According to NSW MoH PD2005_406 *Consent to Medical Treatment - Patient Information*, the outcomes required of this policy are as follows:

- Health care professionals and managers are informed and understand the legal requirements for obtaining consent from patients, and advising patients of material risks associated with treatment, to assist them in discharging their legal obligations.
- Ensure that documented evidence of a patient's consent or any refusal of treatment is recorded.
- Ensure that patient autonomy and decision making are respected and that patients are provided with appropriate information relevant to their treatment.
- Health care professionals and managers are informed and understand their legal obligations with regard to providing medical treatment to patients who do not have the capacity to consent.

The Principles informing this policy are set out as follows:

- Competent adult patients have a right to decide what happens to their own bodies. This means that, in general, medical treatment cannot be provided without consent.
- Except in rare circumstances, competent adults have the right to refuse treatment, for any reason, even if refusal of treatment is likely to lead to serious injury or death.
- Patients, including adults and mature minors as per section 3.5, must be provided with sufficient information about their condition and treatment options in order to make their own treatment decisions.
- Information provided to patients needs to be tailored to the individual's needs and circumstances.
- Subject to therapeutic limits as well as relevant legislative provisions (eg for mental health patients), patients without the capacity to consent have a right to a substitute decision maker and to be provided with care consistent with valid advance care directives that they have made.

2. Policy Content

2.1 Mandatory Requirements

Patients are normally entitled to make their own decisions about medical treatment. Therefore, as a general rule, no operation, procedure or treatment may be undertaken without consent of the patient. The only exceptions are in an emergency or where the law otherwise allows or requires treatment to be given without consent.

Adequately informing patients about their treatment and obtaining consent are both legal requirements and an accepted part of good clinical practice. In the absence of legally recognised exceptions, treating a patient

in the absence of any form of valid consent would constitute an assault subjecting JH&FMHN and/or the clinician to civil liability or in more extreme cases the possibility of criminal liability.

2.2 Implementation - Roles & Responsibilities

Executive Directors, Service Directors and Clinical Directors must ensure that:

- the principles and requirements of this policy are applied, achieved and sustained;
- all staff are made aware of their obligations in relation to this policy;
- documented procedures are in place to support the policy where required; and
- there are documented procedures in place to effectively respond to and investigate any breaches of this policy where required.

Health service managers and clinical staff have a responsibility to understand:

- the legal requirements for obtaining consent;
- what information must be provided to a patient before a patient gives their consent;
- when consent should be provided by a substitute decision maker and correctly identify who the substitute decision maker should be; and
- the requirements to document consent and the consent process.

3. Procedure Content

3.1 Mandatory requirements for a valid consent

A legally valid consent requires the following elements:

3.1.1 Patient must have the capacity to give consent.

A person has decision making capacity if they can:

- understand the facts and choices involved;
- weigh up the consequences; and
- communicate their decision.

A *NSW Capacity Toolkit* produced by the Attorney General's Department of NSW provides a useful reference for the assessment of capacity.

3.1.2 Consent must be freely given.

The patient must not be pressured, coerced or intimidated into giving consent by a family member, hospital staff, or a medical practitioner.

3.1.3 The consent must be sufficiently specific

Consent is only valid in relation to the treatment or procedure for which the patient has been informed and has agreed.

3.1.4 The patient must be advised in broad terms of the procedure

The patient must be informed in broad terms of the procedure which is intended in a way the patient can understand. The requirement is different to the requirement to warn of material risks as discussed below.

3.2 Requirement to warn of material risks

In addition to meeting the requirements for obtaining a valid consent, the patient must be provided with sufficient information to enable them to gain a genuine understanding of the nature of the operation, procedure or treatment. Failure to warn a patient about the material risks inherent in a proposed procedure is a breach of the medical practitioner's duty of care to the patient and could give rise to legal action for negligence.

A risk is 'material' if:

"in the circumstances, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it, or if the medical practitioner is, or should reasonably be aware, that the particular patient, if warned of the risk, would be likely to attach significance to it."[1]

Known risks should be disclosed when an adverse outcome is a common event though the detriment is slight, or when an outcome is severe even though its occurrence is rare. Medical practitioners must also carefully consider whether knowing about a risk is likely to influence a patient's decision and carefully consider patients' reactions to specific risks, however unlikely those risks might be, particularly where specific concerns regarding adverse outcomes are raised by the patient.

3.3 Other general considerations for consent

3.3.1 Written or verbal consent

Patient consent can be "express", either orally or in writing, or it can be "implied" from a person's conduct. For example, a patient may voluntarily hold out their arm to receive an injection, and this action would imply their consent.

It is NSW Health Policy that written consent must be sought for major procedures including:

- all operations (excluding minor procedures);
- all operations or procedures requiring general, spinal, epidural, or regional anaesthesia or intravenous sedation;
- any invasive procedure or treatment where there are known significant risks or complications;
- blood transfusions or the administration of blood products; and
- any treatment for which the approval of an ethics committee is also required (unless there are sound reasons for doing otherwise) See also section 3.8 regarding consent for research and clinical trials.

Written consent forms are not required for minor procedures performed under local anaesthesia (eg insertion of IV cannula, urethral catheterisation, or suture of minor lacerations). However, the criteria for obtaining a valid consent must still be met, the procedure must still be explained to the patient and it is strongly advisable for a written note to be made in the patient's health record to this effect.

[1] Rogers v Whitaker [1992] HCA 58

In view of the importance of the consent form as a part of the patient's health care record, it is essential that the document is clear and legible, and accordingly only standard abbreviations and symbols should be used on consent forms.

3.3.2 Patient information forms, brochures or other material

Pre-prepared material about a procedure or treatment may be useful if given to the patient as a means of stimulating discussion and for guiding the medical practitioner when informing the patient. However, providing pre-prepared material alone will not generally be sufficient to discharge the legal duty to inform patients of material risks.

3.3.3 Patients from culturally and linguistically diverse (CALD) backgrounds

To ensure that a valid consent is obtained, interpreters should be used, where necessary, for any non-English speaking patients in accordance with policy 1.230 *Health care Interpreter Services - Culturally and Linguistically Diverse Patients* and NSW MoH PD2006_053 - *Interpreters - Standard Procedures for Working with Health Care Interpreters*. A professional interpreter should be present to ensure patient consent and understanding when a recommendation for surgery, treatment or research is communicated to a non-English speaking patient.

Consent for treatment may not be valid if it is obtained through a child or family members, other patients, visitors or non-accredited staff acting as interpreters.

3.3.4 Health practitioner responsible for obtaining consent

A health care practitioner, who performs a procedure, operation or treatment without obtaining a valid consent as per section 3.1 above, may be liable at law for assault. Further, a failure to adequately inform a patient of material risks as per section 3.2 above, could give rise to a legal action for negligence. While the health care practitioner can ask another health care practitioner to seek consent on their behalf, they could still be held responsible if a valid consent has not been obtained, particularly if the task was inappropriately delegated to someone without the necessary skills and experience.

Administrative and nursing staff cannot be delegated the task of informing a patient about the material risks of an operation, procedure or treatment and obtaining consent, where the procedure is to be performed by a medical practitioner. However in some cases, the medical practitioner may inform the patient and obtain verbal consent and subsequently ask a hospital staff member to have the patient complete the form. The medical practitioner is still required to complete the relevant "Provision of Information to Patient" or "Medical Advice" section of the consent form.

Many other minor procedures, which are not required to be performed by medical practitioners, may be performed in health centres. In most cases, consent will be given verbally by the patient expressly agreeing to the procedure or impliedly by their actions. However, the criteria for obtaining a valid consent must still be met, the procedure must still be explained to the patient and it is advisable for a written note to be made in the patient's health record to this effect.

Nurses or midwives who are authorised to initiate medications, order diagnostic tests or undertake procedures (such as nurse practitioners), have the same obligations as medical practitioners when obtaining consent for the procedures which they are authorised to perform.

Any other health care practitioner who performs procedures on patients, such as dentists, physiotherapists, speech pathologists, occupational therapists, also have the same obligations when obtaining consent for the procedures which they are authorised to perform.

3.3.5 Refusal of treatment – adults

Note: this section discusses the general right of patients to refuse treatment. For more specific guidance regarding end of life treatment decisions and/or the use of advanced care directives, see Section 3.7 below.

A competent adult patient is entitled to refuse medical treatment even if that treatment is necessary to keep them alive. A competent adult patient can refuse treatment, regardless of whether the reasons for making the choice seem to be irrational, unknown or even non-existent.

Like consent to medical treatment, a refusal must be provided by a competent patient, be freely given, and specific to the proposed treatment or procedure. It is strongly recommended that the medical practitioner inform the patient of the consequences of refusing treatment. As with consent, if the patient's circumstances change significantly, the refusal may not remain valid and may need to be confirmed.

A refusal can be express, implied or in writing, however, it is preferable that a refusal of treatment is recorded in writing and signed by the patient. Any discussions with patients about refusal of treatment should be recorded in detail in the health record.

There are some scenarios where it is not lawful for an otherwise competent patient to refuse treatment, for example when patients are subject to mental health orders (see Section 3.6).

3.3.5.1 Pregnant patients and possible fetal compromise

In general, Australian law does not recognise a fetus as a separate legal entity until it is born alive. Therefore, legally, a competent pregnant woman has the right to make decisions about her own treatment.

In Australia, a court would be unlikely to qualify a pregnant woman's right to refuse treatment (or overrule an Advanced Care Directive refusing treatment) unless the competence of the patient is called into question. This will be the case even if the decision made by the patient threatens the life of a viable fetus.

In cases where a competent obstetric patient is refusing to consent to medical treatment, and the refusal to undergo the treatment may result in the death of her viable fetus, advice should be sought from the relevant Clinical Director / Executive Director. It is important that good communication with the patient is maintained by providing unbiased and accurate information regarding the options available to the patient and the consequences of each. Meticulous record keeping regarding the discussions that have taken place with the patient and professional colleagues is essential. Legal advice may be required including from the NSW MoH, Legal & Regulatory Services Branch.

3.3.6 Medical practitioner obligations to treat a patient

Medical practitioners are under no obligation to provide treatments that are futile. Futile treatment generally means treatment that is unreasonable and/or offers negligible prospect of benefit to the patient.

Alternatively, on occasion a medical practitioner may have a conscientious objection to providing a specific procedure or treatment to a patient. In these cases the medical practitioner should advise their relevant Clinical Director and seek advice as to obtaining appropriate care for the patient.

In rare circumstances, the therapeutic relationship between a medical practitioner, or a treating team and a patient becomes difficult to manage. Whilst JH&FMHN has an obligation to treat all patients based on clinical need, in these circumstances it may be appropriate to refer the patient to a different medical practitioner within JH&FMHN or to a different service if it is practicable to do so and patient care is not compromised.

3.4 Patients without capacity - adults and young persons (over 16 years old)

A person cannot consent if they lack capacity (see section 3.1 above). A patient can potentially lack capacity due to a number of reasons. These include:

- temporary factors such as the patient's medical condition (i.e. unconsciousness, use of certain medications);
- intellectual impairment, dementia, or brain damage;
- mental illness;
- age / maturity (minors)

The *Guardianship Act 1987* applies to patients aged 16 and over who do not have capacity. As per that Act, a person (over 16 years old) is incapable of giving consent where the person:

- is incapable of understanding the general nature and effect of the proposed treatment, or
- is incapable of indicating whether or not the patient consents to the treatment.

The general principles for consent to treatment for patients over 16 years of age who lack capacity are described further in this section. In addition, Appendix A to this policy contains a summary table for requirements under the *Guardianship Act 1987*.

Note that the specific requirements for consent for minors (persons under 18 years of age) are discussed in more detail in Section 3.5 of this policy. Consent for mental health patients is discussed in detail in Section 3.6 of this policy. In addition, the NSW MoH PD2005_406 *Consent to Medical Treatment - Patient Information* provides more information on consent in a broad range of specific clinical scenarios.

3.4.1 Emergency treatment for patients who lack capacity

In an emergency, where an adult patient (18 years old or higher) is unable to give consent and the treatment is required immediately:

- to save the person's life; or
- to prevent serious injury to a person's health; or
- except in the case of *special medical treatment* (see Appendix A), to prevent the patient from suffering or continuing to suffer significant pain or distress.

The procedure/treatment may be carried out in the absence of consent provided there is no unequivocal written direction by the patient to the contrary (for example a valid advance care directive).

Similar authority exists to treat minors (patients under 18 years of age) without consent in an emergency – see section 3.5 below for specific details.

3.4.2 Non-emergency treatment for patients over 16 years old who lack capacity

The *Guardianship Act 1987* defines the obligations to obtain consent for persons over 16 years of age. When a person over 16 years of age lacks decision making capacity and it is not an emergency, all healthcare practitioners are required under law to consult and seek consent to treatment from the 'Person Responsible' as defined under the *Guardianship Act 1987* as per the following hierarchy:

1. An appointed guardian (including enduring guardian) with the function of consenting to medical and dental treatment. If there is no-one in this category:
2. A spouse or de facto spouse (including same sex partners) who has a close and continuing relationship with the person. If there is no-one in this category:
3. The carer or person who arranges care regularly or did so before the person went into residential care, and who is unpaid (note: the carer pension does not count as payment). If there is no-one in this category:
4. A close friend or relative.
5. If none of these are available – it may be necessary to make an application to the Guardianship Division of NSW Civil and Administrative Tribunal (NCAT).

Health care practitioners have an obligation to consult with the person highest on the hierarchy. If that person isn't present, all reasonable attempts should be made to contact them. If the person responsible lacks decision making capacity, or does not wish to make medical treatment decisions for a patient, the next person on the hierarchy will become the person responsible. These matters and decisions should all be documented in the patient's health record.

In the absence of the existence or ability to locate a person responsible, or if no person responsible is able or willing to make a decision regarding consent, an application must be made for any non-emergency treatment to the Guardianship Division of NCAT for consent. The exception to this is in the case of treatment defined as *minor treatment* under section 33 of the *Guardianship Act 1987* which may be provided in the absence of consent where the medical or dental practitioner certifies in writing that the (minor) treatment is necessary and will most successfully promote the patient's health and well-being, and that the patient does not object to the carrying out of the (minor) treatment as per section 37 of the *Guardianship Act 1987*. All other major medical or major dental treatments as per section 11 and 12 of the *Guardianship Regulation 2010* require an application to the Guardianship Division of NCAT.

With respect to other treatments that require an application to the Guardianship Division of NCAT, for special treatment see Section 3.4.3, and for treatment as part of a clinical trial see Section 3.8.

Appendix A includes a table that summarises the main categories of treatment types and consent requirements under the *Guardianship Act 1987*.

If there are concerns that a Person Responsible is not acting in the best interests of the patient; the Public Health Organisation can also make an application for a determination on the matter to the Guardianship Division of NCAT.

3.4.3 Special Treatment under the Guardianship Act

There are a number of procedures and treatments defined as 'Special Treatment' under the *Guardianship Act 1987.* See Appendix A of this policy for these definitions.

A Person Responsible (ie a person acting as substitute decision maker) is not able to provide consent for Special Treatment. Consent for Special Treatment is required from the Guardianship Division of NCAT, or from a Guardian who has been given specific authority by the Tribunal to consent to further or continuing Special Treatment.

Further information regarding consent for Special Treatment is provided within NSW MoH PD2005_406 *Consent to Medical Treatment - Patient Information*. Any such matters arsing within JH&FMHN should be referred in the first instance to the relevant Clinical Director / Executive Director.

3.4.4 Persons who lack capacity objecting to treatment

It is an offence under the *Guardianship Act 1987* for treatment to be carried out if the patient is objecting, unless:

- The Guardianship Division of NCAT has provided consent to the treatment, or
- The Guardianship Division of NCAT has made a guardianship order, appointing a guardian with a medical and dental consent authority and an additional authority to override the patient's objections, and the guardian has provided consent to the treatment.

For provisions regarding care of mental health patients who are objecting to treatment, see section 3.6 below.

3.4.5 Notification of Consulate for Foreign Nationals who lack capacity

Where a patient who is a foreign national lacks capacity and an application is made to the Guardianship Division of NCAT regarding consent and appointment of a Guardian, it is recommended that the patient's Consulate is informed of the relevant circumstances. Release of information to the Consulate must be consistent with relevant privacy obligations.

3.5 Consent for Minors

This section contains general guidance for the consent to treatment of minors being persons under the age of 18 years. Both the Guardianship Act 1987 (for minors aged 16 or 17 years old who do not have capacity to consent) and *Children and Young Person's Care and Protection Act 1998* (for children aged 15 years or under and young persons aged 16 or 17 years old) contain provisions relevant to consent for minors.

Also see *Table 1: Consent for Minors* for a general summary of the consent requirements for minors at the end of this section.

3.5.1 Emergency Treatment of a Minor

Section 174 of the *Children and Young Persons (Care and Protection) Act 1998* allows a medical practitioner to carry out medical treatment on a child (15 or under) or young person (aged 16 or 17) without the consent of the child or young person, or the consent of their parents, if the medical practitioner is of the opinion that it is necessary, as a matter of urgency, to carry out the treatment on the child or young person in order to save his or her life or to prevent serious damage to his or her health.

Part 5 of the *Guardianship Act 1987* also applies to minors aged 16 and 17 who do not have capacity to consent to medical treatment. Pursuant to the *Guardianship Act 1987*, 16 and 17 year olds can be treated without consent, if the treatment is necessary, as a matter of urgency, to save the patient's life, or to prevent serious damage to the patient's health.

3.5.2 Non-emergency treatment of a minor

A minor (that is a person under the age of 18 years) is capable of independently consenting to their medical treatment when he or she achieves a sufficient level of understanding and intelligence to enable him or her to understand fully what is proposed – so called "Gillick competence" based on the original UK based judgement[2]. This means that, according to law, there is no set formal age at which a child or young person is capable of giving consent (prior to them reaching the age of 18 years). However, at the time of publishing this policy, NSW MoH PD2005 406 *Consent to Medical Treatment - Patient Information* section 25.2 prescribes that if a patient is under the age of 14 years, then the consent of the parent or guardian is always necessary.

The significance of the proposed treatment will be a relevant factor with respect to assessing capacity for minors. It may be likely that a 15 year old is assessed as having the capacity to consent to receive contraceptive treatment, but less likely that she would be assessed as having the capacity to consent to a heart transplant. The child's capacity to consent will therefore need to be assessed carefully in relation to each decision to be made.

Where a minor lacks the capacity to consent, or is under 14 years of age, the consent of a parent or guardian is required. Note also it is good practice to involve the family in the decision making process where appropriate, even in a case where the minor is deemed Gillick competent. If there is any uncertainty regarding complex cases the advice of the relevant Clinical Director / Executive Director should be sought in the first instance, and legal advice may also be required.

3.5.3 'Special medical treatment' in relation to children

Both the *Guardianship Act 1987* and the *Children and Young Person's Care and Protection Act 1998* class some procedures as 'special treatment' or 'special medical treatment'. The exact definitions within the two acts are different.

It is an offence to carry out special medical treatment on a child less than 16 years unless in certain prescribed situations as per the *Children and Young Person's Care and Protection Act 1998*.

In general, other than in certain emergency situations, consent from the Guardianship Division of NCAT is required in order to provide special medical treatment to minors.

Further information regarding consent for special medical treatment should be sought from the NSW MoH PD2005 406 *Consent to Medical Treatment - Patient Information* and any such matters arsing within JH&FMHN should be referred in the first instance to the relevant Clinical Director / Executive Director.

3.5.4 Refusal of Treatment by a Minor

A minor who has capacity to consent to their own treatment may also refuse treatment. A parent or guardian may also refuse treatment on behalf of a minor.

However, a Court can potentially override a minor's decision, or the decision of a parent or guardian, in order to avoid serious consequences for the minor. In this situation, the Court would consider the minor's age and maturity, and make a decision in the minor's best interests.

[2] Gillick v West Norfolk & Wisbech Area Health Authority [1986] 1 AC 112 and accepted by the majority of the High Court in Australia in Marion's case (Secretary of the Department of Health and Community Services v JWB and SMB (1992) 175 CLR 218)

Any circumstances where a minor or young person is refusing treatment and which might result in serious adverse consequences should be referred to the relevant Clinical Director / Executive Director for advice in the first instance, and legal advice may also be required.

Table 1: Consent for Minors:

The following is suggested as a general guide only and will not apply to all minors in all circumstances.

Age Guide	Recommendation	Legislative Definition
13 years old and under	Consent from a parent or guardian should be obtained	"Child" as defined in the *Children (Care and Protection) Act*
14 and 15 years old	Consent from the young person may be sufficient if deemed 'Gillick Competent', however the consent of a parent or guardian should also be obtained, unless the young person objects (refer discussion above on Gillick competence)	"Child" as defined in the *Children (Care and Protection) Act*
16 and 17 years old	Consent of the young person may be sufficient (refer discussion above on Gillick competence)	"Young person" as defined in the *Children (Care and Protection) Act*

3.6 Consent under the Mental Health Act 2007 (NSW)

Note that the terms used in this section referring to 'voluntary patients', 'involuntary patients', 'assessable persons', 'forensic patients', and 'correctional patients', are based on the definitions contained within the section 4 of the *Mental Health Act 2007* and section 3 of the *Mental Health (Forensic Provisions) Act 1990*. The Secretary refers to the Secretary of the MoH (previously known as the Director General). The Tribunal refers to the Mental Health Review Tribunal. References to an authorised medical officer include the medical superintendent of the mental health facility as per section 111 of the *Mental Health Act 2007*, or a medical officer nominated by that medical superintendent. Within JH&FMHN the authorised medical officer position is filled by the Clinical Director Forensic and Long Bay Hospitals or their nominated delegate.

There is a relatively high prevalence of mental illness across patients of JH&FMHN. In addition, JH&FMHN contains specialised mental health facilities comprising the Forensic Hospital (including primarily forensic patients and involuntary patients) and Long Bay Hospital (including primarily correctional patients and forensic patients). The principles of consent for mental health patients are an important consideration for many patients of JH&FMHN, and in particular the specific requirements for involuntary patients, forensic patients, and correctional patients contained within the *Mental Health Act 2007* and *the Mental Health (Forensic Provisions) Act 1990*.

3.6.1 General Principles

Where a patient is detained under the *Mental Health Act 2007*, the authorised medical officer of the mental health facility can authorise the patient to be provided with such necessary treatment for their mental illness or condition, and this treatment may be provided in the absence of patient consent in accordance with section 84 of the *Mental Health Act 2007*. The *Mental Health Act 2007* also sets out specific procedures when a detained mental health patient requires surgical treatment or certain other forms of treatment, which are

summarised below. The Act also provides guidance on consent procedures for patients defined as Forensic Patients and Correctional Patients.

Note that if a patient is a voluntary mental health patient (not generally relevant to JH&FMHN) the patient's consent is required before any treatment is provided. If the voluntary patient lacks of the capacity to provide consent due to mental illness or otherwise, the substitute consent provisions of the *Guardianship Act 1987* will generally apply.

3.6.2 Designated Carer

The *Mental Health Act 2007* requires that the authorised medical officer notify a patient's 'designated carer' of the intention to seek consent for surgery. The response of the designated carer depends on whether the application will be to the Tribunal or the Secretary.

The Designated Carer is defined in section 71 of the *Mental Health Act 2007* as follows:

(1) The "designated carer" of a person (the "patient") for the purposes of this Act is:

(a) the guardian of the patient, or

(b) the parent of a patient who is a child (subject to any nomination by a patient referred to in paragraph (c)), or

(c) if the patient is over the age of 14 years and is not a person under guardianship, the person nominated by the patient as the designated carer under this Part under a nomination that is in force, or

(d) if the patient is not a patient referred to in paragraph (a) or (b) or there is no nomination in force as referred to in paragraph (c):

(i) the spouse of the patient, if any, if the relationship between the patient and the spouse is close and continuing, or

(ii) any person who is primarily responsible for providing support or care to the patient (other than wholly or substantially on a commercial basis), or

(iii) a close friend or relative of the patient.

(2) In this section:

"close friend or relative" of a patient means a friend or relative of the patient who maintains both a close personal relationship with the patient through frequent personal contact and a personal interest in the patient's welfare and who does not provide support to the patient wholly or substantially on a commercial basis.

"Relative" of a patient who is an Aboriginal person or a Torres Strait Islander includes a person who is part of the extended family or kin of the patient according to the indigenous kinship system of the patient's culture.

3.6.3 Emergency surgery for patients under the Mental Health Act

(a) Involuntary Patients, and Forensic and Correctional Patients suffering from a Mental Illness[3]

An authorised medical officer under the *Mental Health Act 2007* or the Secretary can consent to emergency surgery on behalf of an involuntary patient, (including forensic patients and correctional patients suffering from a mental illness) if, in the authorised medical officer's or Secretary's opinion, the patient is incapable of giving consent, or is capable of giving consent and refuses to do so, or neither gives nor refuses consent, and the surgery is necessary, as a matter of urgency, in order to save the patient's life or to prevent serious damage to the patients' health or to prevent the patient from suffering or continuing to suffer significant pain or distress.

(b) Forensic Patients and Correctional Patients not suffering a mental illness[4]

An authorised medical officer under the *Mental Health Act 2007* or the Secretary can consent to emergency surgery on behalf of a forensic patient or a correctional patient NOT suffering from mental illness, if in the medical superintendent's opinion, the patient is incapable of giving consent, and the surgery is necessary, as a matter of urgency, in order to save the patient's life or to prevent serious damage to the patient's health or to prevent the patient from suffering or continuing to suffer significant pain or distress.

With respect to (a) and (b) above, the consent should be provided in writing and signed by the person giving the consent. The authorised medical officer must notify the Tribunal as soon as practicable after the performance of the emergency surgery.

3.6.4 Surgical Operations other than Emergency Surgery for Patients under the Mental Health Act

The *Mental Health Act 2007* has different requirements for obtaining consent for non-emergency surgical procedures for patients in mental health facilities depending on the status of the patient under the *Mental Health Act 2007*.

(a) Involuntary patients, and Forensic and Correctional Patients where designated carer has agreed to surgery – application to the Secretary[5]

If an involuntary patient, or a forensic patient or a correctional patient, requires a surgical operation and a patient's designated carer has agreed in writing to the performance of the procedure, the authorised medical officer can apply to the Secretary for consent. Consent can only be provided by the Secretary if they consider that the patient is incapable of giving consent, and it is desirable, having regard to the interests of the patient, to perform the surgical operation on the patient.

(b) Involuntary Patients, and Forensic and Correctional Patients where no designated carer has agreed to surgery –application to Tribunal[6]

If an involuntary patient or a forensic patient or correctional patient requires a surgical operation, and no designated carer has agreed in writing to the performance of the procedure, the authorised medical officer may apply to the Mental Health Review Tribunal for consent to perform the surgical

[3] s99(1) *Mental Health Act 2007* (NSW)
[4] s99(2) *Mental Health Act 2007*
[5] s100 *Mental Health Act 2007*
[6] s101 *Mental Health Act 2007*

operation. Consent can only be provided by the Mental Health Review Tribunal where in the opinion of the tribunal:

- It is desirable, having regard to the interests of the patient, to perform the surgical operation on the patient; AND either
- For involuntary patients and forensic patients and correctional patients suffering from a mental illness, the patient is incapable of giving consent to the operation, or is capable of giving consent and refuses to do so, or neither gives nor refuses consent; OR
- For forensic patients and correctional patients NOT suffering from a mental illness, the patient is incapable of giving consent to the operation.

With respect to (a) and (b) above, applications should only be made 14 days after notice of the proposed treatment has been given to the patient's designated carer, unless the authorised medical officer is of the opinion that the urgency of the circumstances requires an earlier determination, or the patient's designated carer does not object. Further information may be obtained within Section 7 of the Mental Health Review Tribunal's *Civil Hearing Kit*.

(c) Assessable persons

An 'assessable person' is a person detained in a mental health facility for whom a mental health inquiry is required but has not yet been held. This category may occasionally apply to JH&FMHN. Assessable persons can be given treatment for their mental health illness or condition under the *Mental Health Act 2007* but the other provisions of the *Mental Health Act 2007* relating to surgical treatment that apply to other patients, do not apply to assessable persons. As such, if an assessable person requires surgery and lacks the capacity to consent, consent must be obtained in accordance with the *Guardianship Act 1987*.

3.6.5 Rapid tranquilisation and enforced medication

Policy 1.180 *Enforced Medication and Rapid Tranquilisation – The Forensic Hospital and Long Bay Hospital Mental Health Unit* provides guidance on policies and procedures to be followed in the event that rapid tranquilisation and enforced medication is required within the Forensic Hospital or the Long Bay Hospital. The provisions of that policy must be followed with respect to the treatment of any patient with rapid tranquilisation or enforced medication.

Treatment in such circumstances must be compliant with the *Mental Health Act 2007* and the *Mental Health (Forensic Provisions) Act 1990* and other relevant legislative requirements regarding administration of medication.

3.6.6 Electro-Convulsive Therapy (ECT)

(a) Voluntary Patient

ECT can only be given to a voluntary patient (not generally relevant to JH&FMHN) if the patient gives their informed written consent in accordance with section 93 of the *Mental Health Act 2007*. Note that section 91 of the *Mental Health Act 2007* sets out a number of requirements for obtaining informed consent in these circumstances. In circumstances where the capacity of the patient is uncertain an application may be made to the Tribunal for a consent inquiry pursuant to section 93(3) of the *Mental Health Act 2007*

(b) Involuntary Patient

ECT treatment cannot be given to involuntary patients, forensic patients, correctional patients, or assessable persons without the consent of the Mental Health Review Tribunal as per the requirements of section 94 of the *Mental Health Act 2007*.

For further information on ECT treatment refer to the Mental Health Review Tribunal website (http://www.mhrt.nsw.gov.au/civil-patients/electro-convulsive-therapy.html)

3.6.7 "Special Medical Treatment" under the Mental Health Act

Special Medical Treatment under section 98 of the *Mental Health Act 2007* is defined as any treatment, procedure, operation or examination that is intended, or is reasonably likely to have the effect of rendering, a patient permanently infertile.

In accordance with section 102 of the *Mental Health Act 2007* Special Medical Treatment cannot be provided to any mental health patient (including voluntary patients, involuntary patients, forensic patients, and correctional patients) unless:

(i) the medical practitioner providing the treatment is of the opinion that the treatment is necessary, as a matter of urgency, in order to save the patient's life, or prevent serious damage to the patients' health; or

(ii) the Mental Health Review Tribunal has consented to the treatment, or NCAT has consented in the case of a child under 16.

Any matters arsing within JH&FMHN regarding special medical treatment for mental health patients should be referred in the first instance to the relevant Clinical Director / Executive Director.

3.6.8 Advance Care Directives Made by a Mental Health Patient

In general, mental health patients have the same rights with regard to making decisions about their end of life care as people who are not mental health patients (see section 3.7 below) and may therefore document these within an advance care directive (ACD). However the validity of the ACD may be called into question where:

- there is doubt regarding the competency of the patient at the time of making the ACD;
- the patient has previously engaged in self-harming / suicidal behaviour;
- there is evidence that the ACD was not made voluntarily.

Further, an ACD cannot be used to override the authority to detain and treat patients if required and authorised under the *Mental Health Act 2007*. An ACD may include specific wishes that can be used to inform treating doctors about the patient's wishes, and these may be taken into account with respect to relevant aspects of the patient's medical care. Advice from the relevant Clinical Director / Executive Director should be sought in such circumstances, as well as legal advice where appropriate.

3.7 End of life decision making and advance care directives for adult patients

3.7.1 General Principles

Except in rare circumstances, competent adults can refuse medical treatment even if that treatment is necessary to keep them alive. A refusal of treatment can be express, implied or in writing. However it is preferable that any refusal of treatment is in writing and signed by the patient, especially where the refusal of

treatment may lead to the death of the patient. It is also important in such cases that information communicated to the patient about the likely effect of refusal of treatment is documented clearly in the clinical records.

3.7.2 Advance Care Directives

An advance care directive (ACD) is a type of advance planning tool that can only be completed by a person with decision making capacity. ACD's generally record decisions or value statements that describe a person's future preferences relating to medical treatment that are to be used in circumstances where the person loses capacity. Where a patient has made a valid ACD it will be an important component of end of life decision making.

An ACD is a statement made by a person that often states that they do not wish to receive medical treatment or medical treatment of specified kinds. If an ACD is made by a capable adult, and is clear and unambiguous and extends to the situation at hand, it must be respected. Even in an emergency, a patient cannot be treated if they have a clear, available ACD which states they do not want treatment. A formal ACD must be made by the patient themselves, and cannot be made on their behalf by the substitute decision maker.

If there is genuine and reasonable doubt as to the validity of an ACD, including whether the patient had capacity when it was written, or whether it was intended to apply to the current situation, advice should be sought from the relevant Clinical Director / Executive Director. If necessary, legal advice may be sought by JH&FMHN including from the NSW MoH, Legal & Regulatory Services Branch.

If the patient has a prior General Practitioner, other clinician, or family member that might assist in providing information about the circumstances of the ACD and whether it is consistent with the patient's wishes, they may also be contacted for advice, if it is practical to do so.

If there is delay in obtaining a copy of a patient's ACD, it is acceptable to treat the patient until the ACD document is available. Also, in cases where legal advice is being obtained or where court proceedings are being pursued, a health practitioner is justified in treating the patient in the interim until the clarification about the validity of the ACD is available.

An exception to the above guidance regarding ACDs may be with respect to involuntary detention and treatment of patients under the *Mental Health Act 2007*. See section 6 for guidance regarding mental health patients and the use of an ACD.

Relevant NSW Health Policies relating to end of Life Decision Making and Advance Care Directives are included within the references to this policy.

3.8 Consent for treatment as part of research or a clinical trial

The approval of the JH&FMHN Human Research & Ethics Committee must be sought for specific consent protocols for all operations, procedures and treatments that are part of clinical trials or studies that include patients or staff of JH&FMHN.

Further, for patients who lack capacity, consent from the Guardianship Division of NCAT is required for those patients to participate in a clinical trial.

3.9 Forensic examinations

A forensic medical examination is an examination by a medical practitioner or specially trained nurse recording injuries and taking samples that may be used as evidence in a police investigation and any

subsequent prosecution. Sexual assault forensic examinations require careful adherence to consent procedures. A valid, written consent from the patient must normally be obtained before a clinical forensic examination is conducted.

3.10 Consent for specific procedures or under other special circumstances

The NSW MoH PD2005_406 *Consent to Medical Treatment - Patient Information* contains detailed guidance regarding consent for specific procedures and treatments such as blood transfusion, anaesthetics, use of tissue, and other specific matters. JH&FMHN staff should refer to PD2005_406 for guidance regarding consent for these specific procedures or in other special circumstances.

3.11 'Compulsory Medical Treatment' under the Crimes (Administration of Sentences) Act and 'Medical Attention' under the Children (Detention Centres) Act

3.11.1 Legislative Background

Section 73 of the *Crimes (Administration of Sentences) Act 1999 (NSW)* states as follows:

> *s73 Compulsory medical treatment*
>
> *(1) A medical practitioner (whether that practitioner is a medical officer or not) may carry out medical treatment on an inmate without the inmate's consent if the Chief Executive Officer, Justice Health is of the opinion, having taken into account the cultural background and religious views of the inmate, that it is necessary to do so in order to save the inmate's life or to prevent serious damage to the inmate's health.*
>
> *(2) Medical treatment carried out on an inmate under this section is, for all purposes, taken to have been carried out with the inmate's consent.*
>
> *(3) Nothing in this section relieves a medical practitioner from liability in respect of the carrying out of medical treatment on an inmate, being a liability to which the medical practitioner would have been subject had the treatment been carried out with the inmate's consent.*
>
> *(4) If the Chief Executive Officer, Justice Health is not a medical practitioner, the reference to the Chief Executive Officer, Justice Health in subsection (1) is taken to be a reference to a person, designated by the Chief Executive Officer for the purposes of that subsection, who is a medical practitioner.*

Section 27 of the *Children (Detention Centres) Act 1987* contains equivalent wording with respect to providing medical treatment within detention centres under the jurisdiction of that act for the purpose of saving the detainee's life or preventing serious damage to their health.

These provisions potentially allows the treatment of persons in custody and within Juvenile Justice Centres without consent when authorised by a medical officer designated by the JH&FMHN Chief Executive and where the treatment is required to save the patient's life, or prevent serious damage to their health, and where the patient's cultural and religious views are taken into account.

3.11.2 JH&FMHN Policy Principles

Within JH&FMHN the following principles apply to the exercise of the above legislative provision:

(i) The policies and principles relating to consent for medical and dental treatment in the rest of this policy and NSW MoH Policy apply to patients treated within the corrective services and

juvenile justice environment. Treatment in the absence of consent under the Compulsory Medical Treatment and Medical Attention legislative provisions should only be considered in the most extraordinary circumstances.

(ii) Patients must be provided with every reasonable opportunity to consent to treatment prior to the application of these provisions.

(iii) Patients with a mental health condition within Corrective Services or Juvenile Justice should be preferentially treated under the provisions of the *Mental Health Act 2007* and the *Mental Health (Forensic Provisions) Act 1990* as appropriate, and not the Compulsory Medical Treatment or Medical Attention legislative provisions.

(iv) Every effort must be made to treat the patient according to general principles of consent before a Compulsory Medical Treatment order is considered. In particular, in addition to the cultural and religious views of the patient, any decision to treat should take into account the following:

- the wishes of the patient and the capacity of the patient to make decisions regarding his or her treatment;
- the prognosis of the patient;
- the patient's reasons for refusing the treatment;
- the objective health needs of the patient;
- any valid Advance Care Directive made by the patient;
- where the patient has an enduring guardian appointed under the *Guardianship Act 1987*, the views of the enduring guardian; and
- where appropriate, the views of the patient's family.
- for children and young persons, where appropriate the views of the patient's parents.

(v) Compulsory treatment orders may only be made by Clinical Directors or other senior medical staff of JH&FMHN who are specifically delegated that authority for the purpose of the treatment of a particular patient or patients by the Chief Executive.

(vi) Under section 73, a designated medical officer may consent to treatment that will be carried out by a medical practitioner who is not an employee of JH&FMHN, for example, surgery performed by a surgeon at a Local Health District.

(vii) A proforma *Medical Assessment and Declaration Form* should be completed by the medical officer who has been delegated authority by the Chief Executive when authorising treatment of a patient under the Compulsory Medical Treatment provisions. Note that exercise of discretion under s73 is not dependent upon completion of this form if it is not practical in urgent or after hours circumstances.

(viii) A s73 compulsory medical treatment order does not authorise the use of force by JH&FMHN staff. However, Corrective Services or Juvenile Justice staff may have discretion to use force depending upon the particular circumstances and in accordance with relevant laws and policies which need to be assessed on a case by case basis.

(ix) Legal advice may also be sought as part of the decision process to use a Compulsory Medical Treatment order. Depending upon the circumstances this may be internal legal advice, or referral to the Ministry of Health Legal Branch.

4. Definitions

Must

Indicates a mandatory action required that must be complied with.

Should

Indicates a recommended action that should be followed unless there are sound reasons for taking a different course of action.

5. Legislation and Related Documents

Legislation	*Family Law Act 1975* (Cth) *Children and Young Person's Care and Protection Act 1998* *Crimes (Administration of Sentences) Act 1999* *Government Information (Public Access) Act 2009* *Guardianship Act 1987* *Health Practitioner Regulation National Law* *Health Records and Information Privacy Act 2002* *Health Services Act 1997* *Human Tissue Act 1983* *Mental Health Act 2007* *Mental Health (Forensic Provisions) Act 1990* *Minors (Property and Contracts) Act 1970*
JH&FMHN Policies and Procedures	1.180 *Enforced Medication and Rapid Tranquilisation – The Forensic Hospital and Long Bay Hospital Mental Health Unit* 1.230 *Health care Interpreter Services - Culturally and Linguistically Diverse Patients*
NSW MoH Policy Directives, and Guidelines	GL2005_056 *Advance Care Directives* GL2005_057 *End-of-Life Care and Decision-Making - Guidelines* PD2005_406 *Consent to Medical Treatment - Patient Information* PD2005_495 *Blood Alcohol Sampling by Hospital Staff* PD2005_587 *Pregnancy - Framework for Terminations in New South Wales*

	Public Health Organisations PD2005_607 *Sexual Assault Services Policy and Procedure Manual (Adult)* PD2006_053 *Interpreters - Standard Procedures for Working with Health Care Interpreters* PD2007_066 *Genetic Testing* PD2011_022 *Your Health Rights and Responsibilities* PD2012_069 *Health Care Records - Documentation and Management* PD2013_001 *Deceased Organ and Tissue Donation - Consent and Other Procedural Requirements* PD2014_025 *Departure of Emergency Department Patients* PD2014_030 *Using Resuscitation Plans in End of Life Decisions* PD2016_001 *Donation, Use and Retention of Tissue from Living Persons* *NSW Health Privacy Manual for Health Information 2015* *Guidelines – End of Life Care* *Advance Planning for Quality Care at End of Life: Action Plan 2013-2018*
Others	*NSW Capacity Toolkit* *NSW Genetic Health Guidelines: Use and disclosure of genetic information to a patient's genetic relatives: Guidelines for organisations in NSW*

APPENDIX A: Consent for Medical and Dental Treatment under the Guardianship Act.

Type of Treatment	Consent Requirements
Urgent Treatment Treatment is urgent and is considered necessary to save the patient's life , prevent serious damage to health, prevent or alleviate significant pain and distress	No consent needed
Major Treatment -Any medical or dental treatment involving general anesthetic or other sedation (except as listed as Minor or Special Treatment) -drugs of addiction(except where Special Treatment) -long acting injectable hormonal substance for contraception or menstrual regulation -any treatment for the purposes of eliminating menstruation -testing for HIV -any treatment involving substantial risk to the patient (as specified under section 3.8 above) -any dental treatment involving the removal of all teeth, or a procedure intended, or likely to result in, a significant impairment to the ability to chew food for an indefinite or prolonged period.	**Person responsible** can consent provided medical practitioner not aware the patient objects and in the best interests of health of patient If there is no person responsible or the person responsible is not available or unwilling then only the **NSW Civil and Administration Tribunal** can consent The request and consent must be in writing or, if not practicable, later confirmed in writing
Minor Treatment -All medical and dental treatments except those listed in Major or Special Treatment or treatment administered in the course of a clinical trial) -Treatment involving general anesthetic or other sedation: for management of fractured or dislocated limbs for endoscopes inserted through an orifice, not penetrating the skin or mucous membrane. -Medications that affect the central nervous system which are used: for analgesic, antipyretic, anti Parkinsonian, antihistaminic, antiemetic, anti-nauseant or anticonvulsant purposes or only once or on an "as required" basis but not more than 3 times per month or as sedation in minor procedures	**Person Responsible** can consent The **doctor or dentist** may treat without consent if the patient is not objecting and there is no person responsible or the person responsible is not available. It must be noted on the patient's record that the treatment is necessary to promote the patient's health and wellbeing and that the patient is not objecting.

Type of Treatment	Consent Requirements
Special Treatment -Termination of pregnancy -Treatments intended or likely to result in permanent infertility -Vasectomy and tubal occlusion; -Aversive treatment - mechanical, chemical, physical or otherwise -Any new treatment that has not yet gained the support of a substantial number of doctors or dentists specializing in the area -androgen reducing medications for behaviour control -use of medication affecting the central nervous system where dosage, duration or combination is outside the accepted norms	Only the **NSW Civil and Administrative Tribunal** can consent
Major or Minor treatment when the patient is objecting If the patient indicates , or has previously indicated, that he or she does not want the treatment	Only the **NSW Civil and Administrative Tribunal** can consent