SA Health

Guideline

Consent (including where consent cannot be obtained)

Version 1.0
Approval date: 28 March 2024
PDS Reference No: G0203

Government of South Australia
SA Health

Contents

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1. Name of guideline

Consent (including where consent cannot be obtained)

2. Relationship to parent policy

The Consent to Medical Treatment and Health Care Policy (Consent Policy) is the parent policy to this Consent (including where consent cannot be obtained) Guideline.

3. Guideline statement

To support best practice in line with legislative and legal responsibilities in relation to consent and authority to provide medical treatment or health care.

Every person, 16 years or older, is presumed to be mentally competent to make decisions, unless there is clear evidence or knowledge to the contrary.

4. Applicability

This Guideline applies to all medical and health practitioners within SA Health; that is all medical and health practitioners of the Department for Health and Wellbeing (DHW), Local Health Networks (LHNs) including state-wide services aligned with those Networks and SA Ambulance Service (SAAS), when providing medical treatment, medical assessment and/or health care.

For the purposes of this policy health practitioners includes all individuals practicing a health profession recognised under the *Health Practitioner Regulation National Law (South Australia) Act 2010* and any other health professional with direct or indirect clinical contact who are credentialed by a health service within SA Health.

5. General Consent Requirements

5.1 Who is responsible for obtaining consent?

All medical and health practitioners are responsible for ensuring valid consent is obtained before assessing or providing medical treatment or health care to a patient (in accordance with their scope of clinical practice).

5.2 The common law, and the Consent Act

The *Consent to Medical Treatment and Palliative Care Act 1995* (Consent Act) applies generally to medical practitioners (including dentists) (Part 2A applies to all health practitioners and is discussed at part 7 of this Guideline).

The Consent Act covers:

- Seeking consent for medical treatment of a child
- Providing emergency medical treatment without consent
- Seeking consent for persons without decision-making capacity (covered in part 7 of this Guideline)
- Medical practitioners' duty to explain, and
- Legal protection for medical practitioners from liability.

Other legal (common law (the body of law developed through decisions of courts/judges) and statutory) protections also apply to everyone (whether or not they are captured under the Consent Act).

Under common law and the Consent Act all adults with decision-making capacity can consent to and refuse medical treatment or health care.

The limited circumstances under which practitioners can provide treatment without consent are discussed at part 7 of this Guideline.

5.3 Consent by health practitioners

Health practitioners are responsible for obtaining consent for the health treatment and care they provide within their approved scope of clinical practice. Health practitioners are subject to a duty to explain which is discussed in detail at paragraph 5.12.

Health practitioners are subject to the common law for general consent matters (they are only captured under Part 2A of the Consent Act in relation to third party consent and not the general provisions under Parts 1, 2 and 3).

The common law and the Consent Act have similar requirements and are covered in detail in the Consent Policy. This Guideline provides information necessary to understand the legal requirements for valid consent.

5.4 Examination by students

If a patient is to be examined or treated by a student as part of their training experience, verbal consent (at a minimum) should be obtained from the patient (in relation to being treated by the student) and the consent should be documented, wherever possible, in the person's medical record.

If a specific treatment is to be taught to students, the patient should be given a full explanation of the role of the student prior to the consent being obtained.

All conversations should be recorded in the patient's medical record.

If a person objects, the objection should, wherever possible, be recorded in the patient's medical record and the examination/treatment stopped.

Recording details about the consent in the person's medical record is intended to protect the student should the person make a complaint or claim in relation to the treatment provided by the student.

5.5 What are the implications if you provide treatment without consent?

Failure to obtain consent, other than in exceptional circumstances discussed at part 7 of this Guideline, may expose staff to disciplinary proceedings and can amount to a criminal offence (assault) or a civil tort of trespass (assault, battery, false imprisonment).

Under criminal law and civil law:

- the threat to administer medication or other treatment may constitute an assault
- touching a patient without consent for the purposes of diagnosis, treatment, or general care, may constitute battery under civil law and assault under criminal law
- preventing a person from leaving the hospital or ambulance, or administering chemical restraint may constitute false imprisonment, and
- failure to provide adequate information about risks of the treatment may constitute negligence.

5.6 What is valid consent?

The legal requirements for valid consent are described below.

Valid consent is:

Informed	Practitioners should ensure the patient: > Is informed of the diagnosis; > Is informed of the nature, consequences and risks of the recommended treatment; > Is informed of the likely consequences of not proceeding with the treatment; > Is informed of any alternative medical treatment or courses of action that might reasonably be considered in the circumstances of the particular case; > Is informed of any other material risks (that a reasonable person would attach significance to); > Is clearly able to understand the information (i.e. is provided in a language or via means the patient can understand); > Has sufficient time to consider and clarify information (taking account of the context of the clinical situation)
Voluntary	Consent should be given free from pressure, coercion, manipulation, or undue influence from family, friends, medical staff, or other influences. > The mere existence of pressures and influence will not necessarily mean that a decision is involuntary; patients will often choose to discuss options and treatments with one or all of the above and have them involved in the decision-making process. > Practitioners should consider the vulnerability of the patient, their state of mind, whether they are under the influence of drugs or alcohol, the nature of the relationship between the patient and the person influencing the other party, and the nature of the decision.
Specific	The scope of the consent should clearly cover the procedure in question. The patient should be expressly or implicitly be consenting to all aspects of the specific treatment to be provided.
Decision-making capacity	To ensure that the patient providing consent has decision-making capacity in relation to the specific health or medical treatment the practitioner should ensure that they: > Understand information relevant to the decision and, > Understand the risks and benefits of the choices and, > Remember the information (even if only for a short time) and, > Use that information to make the decision and, > Communicate the decision.

5.7 What form of consent is appropriate, written, verbal, or implied?

Valid consent can be taken in any form (written, verbal, or implied) so long as the criteria for valid consent are met.

In practice it is recommended that practitioners always seek written consent as it provides the best evidence should any issues or disputes arise and reduces exposure to risk.

Written consent:

It is recommended that practitioners obtain written consent where possible via the appropriate medical record form.

Under the Consent Policy practitioners are required to obtain written consent where treatment is of a serious nature, has inherent risks of complications, where the treatment is controversial, or where there are difficulties in assessing a person's capacity to consent.

Examples where written consent should be obtained include where:

- Treatment carries significant risks or consequences to the patient.
- There is any doubt about the patient's decision-making capacity.
- The person consenting is a minor (under 16 years).
- Treatment includes blood products or blood transfusions.
- The treatment can be regarded as sensitive (e.g., breast, genital, or rectal examinations).
- Photographs, video or audio recordings are taken (particularly for inclusion in publications and educational material).
- Birth in water or home births are planned.
- Treatment involves sterilisation.
- Anaesthetic is to be administered.
- The administration of pre-operative medication which is likely to impair cognitive ability.

Consent forms are available through the health service intranet or the Health Information Governance Unit – Medical Record Forms Page.

See paragraph 5.8 in relation to what should be included in written consent.

Written consent provides clear evidence that consent was obtained and is particularly important where a procedure is invasive or involves risk. It provides:

- vital information in the event of any legal proceedings,
- evidence that standards of care have been met,
- evidence that the duty to explain and warn of risks has been fulfilled,
- evidence of the facts and ensures no ambiguity.

It is useful to remember that in civil actions the practitioner will have to prove that consent was obtained, as opposed to the patient proving the absence of consent. Keeping sufficient records and documentation that provide evidence of the provision of consent is recommended to protect the practitioner.

A signature alone is not sufficient to show consent is valid. While a signature (for example on a signed consent form) may provide some evidence of consent, it does not stop a patient later advising they were not sufficiently informed of all relevant information to give consent. Particularly where a form uses vague or generic terms to describe the treatments being consented to (e.g. where a patient does not speak English, or was intoxicated when they signed).

Practitioners should ensure they note details of any conversations in the patient's medical record.

In case of dispute about whether valid consent was obtained, practitioners will need to provide evidence via appropriately detailed and specific information either included on the form or documented in the patient's medical record.

Verbal consent

Verbal consent may be appropriate where there are no significant risks or consequences to the patient, or where it is not possible to obtain written consent. For example: a general examination; medical imaging; routine procedures such as checking or changing a dressing. Verbal consent should be recorded in a patient's medical record.

Implied consent

Consent (non-verbal) may be implied by a patient's words or actions. For example, where a nurse presents the patient with a blood pressure cuff and the patient moves their arm toward the nurse to apply the cuff. In that circumstance the nurse can presume consent.

Implied consent can usually be relied on where the medical treatment or health care does not have significant risks, is not complex, not invasive, routine in nature, the patient's actions clearly demonstrate their consent, and the practitioner has no reason to doubt that the patient is knowingly consenting.

The use of implied consent needs to incorporate adequate attention to confirming the assessment and/or treatment has been adequately matched to the patient it is intended for.

Care needs to be taken when relying on implied consent as it may expose the practitioner to a greater risk of liability as it will be more difficult to prove valid consent was provided.

Students should take extra care when relying on implied consent as it is not appropriate to presume that a patient has consented to treatment or examination by a student where consent has been provided to a practitioner. Students should seek explicit/express verbal or, where appropriate written, consent wherever possible.

The responsibility is always on the practitioner to actively determine that the patient consents.

Implied consent is not usually recorded in a persons' medical record.

5.8 Requirements for consent forms and recording and documenting consent

Consent forms provide evidence that the practitioner has obtained valid consent and met their duty to explain and warn of risks and should contain at a minimum the following:

- Patient acknowledgement that the nature, consequences and risks of each procedure or treatment have been explained by the medical or health practitioner.
- Patient acknowledgement that specific risks to the patient have been explained by the medical or health practitioner.
- Patient acknowledgement that the consequences of not proceeding with the procedure or treatment have been explained by the medical or health practitioner.
- Patient acknowledgement that alternative procedures, treatments, or courses of action have been explained by the medical or health practitioner.
- Patient acknowledgement that the patient has understood each explanation.
- Patient acknowledgement of consent to each procedure or treatment.
- Space for patient signature to verify the information provided in the form.
- Space for signature of either the medical or health practitioner (operating within their scope of practice) who is providing the procedure and taking consent.

If SA Health entities choose to draft their own consent forms they should refer to the Health Information Governance Unit's Medical Record Forms Design and Development flowchart for more details and use the templates provided.

Wherever possible, practitioners should record, either on the consent form or in the patient's medical records:

- The time and date of clinical assessment of the patient.
- Whether the patient consented themselves and when.
- A description of the advice given by staff to the patient, including the risks and consequences and the language used to describe the risks, including any diagrams used to describe the medical treatment or health care.
- Discussions between the medical or health practitioner and the patient.
- If a person is provided with material, such as a drug information sheet or an educational video, a notation should be made in the medical record.
- Any concerns raised by the patient.
- The outcome of a decision-making capacity assessment.
- The outcome of any clinical assessment of the patient.
- If a substitute decision-maker or person responsible (see part 7 of this Guideline) consented on behalf of the person, when and why.
- If the health care is administered in accordance with the wishes and instructions of the patient's advance care directive.
- The reasons for administering health care contrary to the wishes and instructions of the patient's advance care directive or substitute decision makers decision.
- Where relevant, note if patient refused to sign an Acknowledgment of Medical Advice Form.
- Any witnesses to the discussion with the patient/Substitute Decision-Makers/Persons Responsible.
- Reasons for any restrictive practices that may have been utilised in the provision of medical treatment or health care.
- Signature (where appropriate) of the medical or health practitioner supporting reasons to use restrictive practices on the patient to provide assessment, treatment, treatment or care.

If a patient brings an action against the practitioner either regarding the treatment or the information provided, the record will be useful to support the actions of the medical or health practitioner.

Patients should be given the opportunity to sign a consent form in their own language if available. If a form is not available in a person's own language, the form should be translated verbally by an interpreter who should indicate on the consent form that such a verbal and literal translation has been given. Refer to the Equity of Access and Interpreting and Translating Policy.

5.9 What if a patient is physically unable to sign a consent form?

Where a patient is competent but unable to sign a consent form due to physical symptoms (e.g. cerebral palsy) or where a patient cannot read a consent form (due to blindness or illiteracy) practitioners should ensure:

- a witness is present,
- careful notes are taken of any discussions between the patient, staff, and others, and that the patients express views are detailed,
- these notes are signed by all witnesses as being an accurate record of those discussions.

If there is an advocate present it would also be beneficial to have them witness the record as additional evidence that the patient's views were clearly expressed.

If the patient is capable of some movement and can, for example, make a mark or a cross then this is sufficient to constitute their 'signature'. The witnesses should also write a brief note on the form regarding the circumstances surrounding the patients mark and sign next to that note.

Where a patient cannot read a consent form (due to blindness or illiteracy) the practitioner should ensure the contents of the form are read to the patient and that the patient understands.

5.10 Can consent forms be signed electronically?

Yes. Consent forms can be signed electronically.

The documented consent (whether electronic or hard copy) should be saved within a person's medical record.

5.11 What is the duty to explain and warn of risks?

Medical practitioners have a duty to explain and warn of risks established under section 15 of the Consent Act and through the common law.

Consent to Medical Treatment and Palliative Care Act 1995

Section 15—Medical practitioner's duty to explain

A medical practitioner has a duty to explain to a patient (or the patient's representative), so far as may be practicable and reasonable in the circumstances—

(a) the nature, consequences and risks of proposed medical treatment; and

(b) the likely consequences of not undertaking the treatment; and

(c) any alternative treatment or courses of action that might be reasonably considered in the circumstances of the particular case.

Health practitioners are not captured under section 15 of the Consent Act but are subject to the duty to explain under the common law.

CASE STUDY

Rogers v Whitaker [1992] HCA 58

Maree Whitaker, who was blinded in her right eye when she was nine, went to see Dr Christopher Rogers, an ophthalmic surgeon to perform a cosmetic procedure on her right eye. Ms Whitaker asked Dr Rogers about the risks to her right eye and showed a keen interest in possible complications. Ms Whitaker made it clear she was nervous about any mistake being made. Ms Whitaker did not directly ask Dr Rogers if any complications might affect her left "good" eye and Dr Rogers did not mention a small risk of the procedure, of about 1 in 14,000, of sympathetic ophthalmia causing blindness in the left eye.

The procedure was unsuccessful and as a result Ms Whitaker developed sympathetic ophthalmia in her left eye and became blind. Ms Whitaker successfully sued Dr Rogers for damage caused by medical negligence.

The court found that: *"a doctor has a duty to warn a patient of a material risk inherent in the proposed treatment; a risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would 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".*

To ensure that the duty to explain is satisfied the medical and health practitioners should:

- Explain the nature, consequences, and risks of proposed medical treatment or health care.
- Explain the likely consequences of not undertaking the medical treatment or health care.
- Explain any alternative treatment or courses of action that might be reasonably considered in the circumstances.
- Provide the patient with an opportunity to ask questions and raise concerns.

- Arrange a further consultation with any patient whose history, concerns and questions indicate that they are either at a more serious risk of complications or would have greater concerns about risks than the usual patient to ensure the risks and concerns can be adequately addressed.

A breach of duty will be established (failure to obtain valid consent) if the practitioner does not warn of a material risk and that risk eventuates.

5.12 Can taking of consent be delegated?

The consent taking process can be delegated, but the duty to ensure that valid consent is taken (and the related risk of liability, should something go wrong in the consent process) remains with the medical or health practitioner responsible for the treatment.

Practitioners should be aware that the legal duty to explain under section 15 of the Consent Act, and the common law, which ensures that a patient is properly informed (see paragraph 5.11 the duty to explain), cannot be delegated (the practitioner cannot abdicate responsibility entirely).

In some circumstances it is operationally impractical for the treating practitioner to personally take consent for a variety of reasons, and procedures are adopted to delegate the task to an appropriately trained and knowledgeable professional, or via other means (i.e. digital patient portal). In these circumstances the risk of liability can be appropriately managed through procedures designed to ensure that valid consent is obtained from the patient.

LHNs and the SAAS should ensure that procedures are in place to manage risks where alternative consent processes are adopted.

To ensure risks are appropriately managed the following principles should inform procedures related to alternative consent processes:

- Practitioners endorse the information that is provided to the patient (see paragraphs 5.6 and 5.11) and / or are confident in the skills, knowledge or experience of the practitioner responsible for informing the patient.
- Processes are in place to ensure the patient understands the information.
- Processes are in place to ascertain whether the patient's circumstances or particular concerns require further explanation and discussion (i.e. they are at greater risk of complications or have greater concern about the risks of a treatment than other patients).
- Patients are given the opportunity to personally meet and discuss concerns or questions with the treating practitioner before the treatment is provided.

Where consent processes have been delegated it is recommended that the treating practitioner undertake a 'review' process to assure themselves as much as possible that valid consent has been taken. This may include ensuring the patient's consent form is properly completed and verbally confirming the consent with the patient before proceeding with treatment.

Wherever possible, to assist with meeting the legal duty to explain, the treating practitioner should give the patient a final opportunity to discuss any concerns or questions in relation to the treatment/procedure and personally ask the patient whether they wish to discuss any concerns or questions before signing the consent form.

If a practitioner who is acting under supervision is aware that valid consent has not been taken they may also be held liable.

5.13 How long will consent remain valid?

Consent is valid until the patient withdraws it or there has been a significant change to the patient's circumstances.

All elements of valid consent still need to apply. Refer to paragraph 5.6.

In situations where a written consent form has been signed to cover a course of treatment/health care, there is an obligation on the practitioner to confirm verbally that consent is still current before each instance of providing treatment or health care.

As a general guide consent should be renewed after 12 months.

Consent that has been taken within the previous 12 months can be relied on if:

- the patient can recall the comprehensive process of informed consent, and the information provided, and
- there has been no significant change in health status and/or nature of intended medical treatment or health care, and
- there have been no other developments or changes (new risks, side effects, potential treatments) relevant to the patient.

If 12 months has passed since a consent form was signed a new form should be signed.
A person can give consent for a course of medical treatment or health care and that consent will remain valid provided that:

- there has not been an excessive interruption or delay to the course of medical treatment or health care,
- there has not been a change in a person's circumstances such as to affect the original consent,
- there is no change in the medical treatment or health care that has not been explained to the person,
- there is no reason to think the person has revoked, or intended to revoke, the original consent.

If there is evidence of a change in a person's condition, decision-making capacity, social status, or other circumstances, it is prudent to check with the person that their consent still applies.

5.14 Will the consent to a course of treatment remain valid where a person loses capacity?

No. If a person loses capacity their circumstances have changed enough to invalidate their original consent and practitioners will be required to seek third party consent as discussed below at part 7 of this Guideline.

5.15 How to assess whether your patient has decision-making capacity

All patients are presumed to have decision-making capacity about their own medical treatment or health care unless there is clear evidence to suggest otherwise following initial assessment.

Section 4(2) of the Consent Act provides that a person has impaired decision-making capacity in respect of a particular decision if the person is not capable of:

- understanding any information that may be relevant to the decision (including information relating to the consequences of making a particular decision), or
- retaining such information, even for a short time, or
- using such information while making the decision, or
- communicating the decision in any manner.

In addition, a person does not have decision-making capacity if:

- they are comatose or unconscious, or
- they have satisfied a requirement in their advance care directive that sets out when they are to be considered to have impaired decision-making capacity.

It is not a global assessment of a person's ability to manage their own affairs and it is not linked to a diagnosis.

For the purposes of the Consent Act and the *Advance Care Directives Act 2013* a person:

- will not be considered incapable of understanding information merely because the person is not able to understand matters of a technical or trivial nature, and
- will not be considered incapable of retaining information merely because they can only retain it for the limited time, and
- may fluctuate between having impaired decision-making capacity and full decision-making capacity, and
- will not be taken to be impaired merely because a decision made by the person may result in an adverse outcome.

Impaired decision-making capacity cannot be assumed simply from the fact that practitioners consider a decision to be "irrational" in the sense that it is not one that would be made by the vast majority.

See What is impaired decision-making capacity and how is it assessed Fact Sheet. This Fact Sheet is also available on the SA Health website.

Medical and health practitioners may encounter behaviour that presents a risk to themselves or others (e.g. aggression or violence). Of itself, the patient's behaviour may not be indicative of their decision-making capacity. Such behaviour may be caused by a physical illness, a psychiatric illness, drug induced mental illness, extreme alcohol or drug intoxication, intellectual impairment or an acquired brain injury. These problems can occur in combination. In these circumstances medical and health practitioners should make an initial assessment about a person's decision-making capacity based on the patient's physical and mental wellbeing, factoring in the patient's behaviour and information from third parties.

If a patient has given an advance care directive, and time permits, under the *Advance Care Directives Act 2013* an eligible person can make an application to the Office of the Public Advocate who can issue a declaration in relation to the patient's decision-making capacity. See paragraph 5.15 below.

5.16 What if there a dispute about whether a person has decision-making capacity?

Further information about dispute resolution can be found below at paragraph 5.26 and Part 3A of the Consent Act.

A practitioner, or other eligible person can make an application to the Office of the Public Advocate who can aid in resolving the matter and initiate mediation. The Public Advocate may refer a matter to the SACAT for a declaration or direction. Depending on the circumstances applications can also be made to SACAT.

In all instances initial contact about a dispute should be made to the Office of the Public Advocate rather than SACAT.

If a patient has given an advance care directive, and time permits, a medical and health practitioner or other eligible person can make an application to the Office of the Public Advocate who can issue a declaration in relation to the patient's decision-making capacity in relation to a specified decision, under the *Advance Care Directives Act 2013* (section 45(5)(a)(iii)).

Eligible persons include a child, parent or guardian, persons responsible, a medical and health practitioner and any other person who the Public Advocate considers has a proper interest in the matter.

5.17 Treatment Refusal and Withdrawal of Consent

A person can amend or withdraw their consent at any time. Patients should be informed of their right to do so.

Where a patient who has decision-making capacity refuses a medical assessment and/or medical treatment or health care the medical and health practitioner cannot legally:

- proceed with the assessment or treatment, or
- authorise restrictive practices, or
- prevent the patient leaving the health service.

The same applies to a relevant refusal of health care in an advance care directive or where a Substitute Decision-Maker or Person Responsible has refused health care on behalf of the person (see paragraph 7.8).

A person of or over 16 years of age who has decision-making capacity can consent or refuse medical treatment or health care, including the withdrawal of life sustaining measures and including in advance, even where the refusal gives rise to serious risks, including death, and is against all advice. (Note: only adults of or over 18 years of age can make an advance care directive.)

The medical and health practitioner has an obligation to provide the patient with full information, in a format they can understand, on the available medical treatment or health care options and benefits and consequences of each option, including not having any treatment.

Where a patient withdraws consent or refuses treatment a medical or health practitioner should:

- Make best efforts to inform the patient of the consequences or risks associated with their decision to not have treatment.
- Suggest the patient obtain a second opinion.
- Ask the patient to sign the Acknowledgement of Medical Advice form acknowledging that they have had the nature, consequences and risks associated with their decision explained to them.
- Where a patient refuses to sign the form it should be noted on the person's medical record.
- Document the details of the interaction with the patient including any conversations and reasons for refusing medical treatment or health care in the patient's medical record and on any consent form previously signed by the patient, and record the names of any witnesses.
- Encourage the patient to inform their family, Substitute Decision-Maker, or Person Responsible of their decision.
- Consider alerting SA Police if the patient, refusing medical treatment or health care and self-discharging, is considered a risk to themselves or others.

A patient with decision-making capacity may choose to give or refuse consent without the benefit of full information and advice, and the refusal will still be valid including when given in advance in a provision of an advance care directive.

Continuing to provide medical treatment or health care where a patient with decision-making capacity, their Substitute Decision-Maker or Person Responsible has refused to consent, or against a relevant refusal in an advance care directive, may constitute assault and battery and/or unlawful imprisonment and could lead to civil or criminal charges being raised against the medical and health practitioner.

5.18 Discharge Against Advice

A patient with decision making-capacity has a right to decide whether they will accept medical assessment, medical treatment or health care and remain admitted to a hospital, a health facility, or being transported by an Ambulance, and is able to discharge themselves even though a course of medical treatment or health care is incomplete, it is against medical advice, and may put the person at risk of injury or death.

Medical and health practitioners should follow the same procedure as described above at paragraph 5.17.

The person should be asked to sign an acknowledgement of medical advice form prior to discharge, acknowledging that they have had the nature, consequences and risks associated with their discharge explained to them and that they agree to discharge and indemnify the hospital against all claims arising out of the decision to discharge themselves against medical advice.

If a patient leaves the health service without talking to a practitioner and refuses to sign the acknowledgement of medical advice form, the practitioner should note this in the persons medical record including any relevant details and witnesses. If the patient has decision-making capacity the health service should not stop the person from leaving. If the patient presents a risk to themselves or others it may be appropriate to call SA Police.

5.19 What if a patient refuses to be discharged?

Refer to the Managing Transfer or Discharge of Patients Policy for information about what to do if a patient refuses to be discharged.

5.20 Consent to participate in research

Consent to participate in research is separate from consent to treatment. Refer the Research Ethics and Governance Policy.

Consent to participate in a research study should be sought separately from consent to treatment.

Medical research does not generally fall within the definition of “medical treatment” or “health care” under section 4 and 14 of the *Consent Act.*

5.21 Consent in relation to collecting and storing personal information.

Handling of personal information, including in relation to seeking consent for the collection, use and disclosure of personal information, is covered in the Privacy Policy and Privacy Guideline.

5.22 What if a person cannot communicate in English?

The South Australian Interpreting and Translating Policy and the Equity of Access, Interpreting and Translating Policy requires that professional interpreting services be engaged where proficiency in English is a barrier to effective communication, or where requested by a consumer.

For people whose primary language is not English and for deaf persons the services of a professional interpreter should be offered at the time of:

- a diagnosis of a person’s condition, and
- the explanation of any proposed medical treatment or health care and all other aspects of obtaining valid consent (see paragraph 5.6) and signing of the consent form, and
- admission and taking of a person’s details, and
- when specific post-operative advice is given, including at the time of discharge.

The use of a person’s family, friends, substitute decision-maker or person responsible as interpreter may raise issues including misunderstanding, a possible breach of confidentiality, or conflict of interest. In particular it is not appropriate to use minor’s (i.e. the patient’s child) to provide interpretation to family members about diagnosis or treatment. It is always preferable to obtain the services of an independent accredited interpreter.

Interpreters are available 24 hours from the preferred suppliers described in the SA Health Interpreters and Translators Panel Contracts:

- **Interpreting and Translating Centre (ITC)** on 1800 280 203 or at Interpreting and Translating Centre - Home (translate.sa.gov.au)
- **Oncall Language Services** on 08 8410 5111 / 0400 123 123 or at http://oncallinterpreters.com.au.
- For Deaf or Deafblind interpreting **Deaf Connect** on 1800 893 855 or Contact Us - Deaf Connect.

Persons who are of Aboriginal or Torres Strait Island Descent

It is acknowledged that cultural influences and language differences play a significant role in determining if consent has been obtained from an Aboriginal or Torres Strait Islander patient. Language barriers for Aboriginal people may result in requests for consent being misinterpreted. It is therefore suggested that where possible, the assistance of an Aboriginal Health Professional or Aboriginal Interpreter be sought in obtaining consent.

The **Interpreting and Translating Centre** provides interpreting services for a range of Aboriginal languages. Call 1800 280 203.

Further information on obtaining consent for Aboriginal and Torres Strait Islander people can be obtained from Aboriginal Health Teams and/or Aboriginal Liaison Officers/Health Workers in Local Health Networks.

5.23 Is consent required for taking clinical images (particularly on a smart phone or personal device)?

Practitioners are increasingly using devices including smart phones to take and distribute photographs to facilitate diagnosis, treatment, health care, and training. Photographs can:

- Support clinical examination.
- Aid in the diagnostic process.
- Facilitate collaboration and learning.
- Improve clinical practice and patient access to timely clinical care.
- Demonstrate progression of treatment, healing, and changes over time.
- Assist teaching and research.
- Involve on-call consultants in treatment decisions without the need for them to attend.

Clinical images form part of the patient's medical record and are therefore subject to compliance with privacy rules and should be retained and disposed of in accordance with the *State Records Act 1997*.

The practitioner should obtain written consent, where possible, for the use of any photographs or video footage. It is important that the patients consent include:

- The photograph/video being taken.
- The purpose of the photograph/video.
- The storage of the photograph/video on either a personal or work device.
- The extent of the distribution of the photograph/video.
- The eventual storage of the photograph/video.

The medical record should include the date and time the photograph is taken and include a note every time the photo is distributed including information about who and for what purpose the photo was sent.

Consent should be clearly obtained and recorded because photographs of this nature are likely to be sensitive and may include children.

Consent forms should include the use of personal devices noting that the photographs will be deleted as soon as they are transferred to the medical record.

Consent to photographs should also be included in 'pre-surgery' consent processes and forms. This will ensure that practitioners do not find themselves in a position where they need to take photos mid-surgery without consent.

5.24 Palliative Care

Where a patient is in the terminal phase of a terminal illness, medical practitioners (or a person participating in the medical treatment or health care of the patient under the medical practitioner's supervision) may administer medical treatment with the intention of relieving pain or distress, even if an incidental effect of the treatment is to hasten the death of the patient (Section 17(1) of the Consent Act).

They may only do so:

- with consent of the patient or the patient's representative, and
- in good faith and without negligence, and
- in accordance with proper professional standards of palliative care.

In situations where consent for the provision of medical treatment for the purpose of relieving pain or distress is not forthcoming despite the distress and discomfort of the patient the medical practitioner should contact the Office of the Public Advocate or SACAT to seek further advice and resolution. (See paragraph 5.26.)

A substitute decision-maker does not have the power to refuse the natural provision of food and water, or pain/distress relieving drugs (section 23(4) of the ACD Act).

A medical practitioner responsible for the medical treatment or care of a patient in the terminal phase of a terminal illness (section 17(2) of the Consent Act) (or a person participating in the medical treatment or care of the patient under the medical practitioner's supervision):

- is under no duty to use, or to continue to use, life sustaining measures in treating the patient if the effect of doing so would be merely to prolong life in a moribund state without any real prospect of recovery or in a persistent vegetative state (whether the patient or the patient's representative has requested that such measures be used or continued); and
- is required under the Act to withdraw life sustaining measures from the patient, if the patient or the patient's representative directs it.

This applies irrespective of whether the patient has an advance care directive.

5.25 Voluntary Assisted Dying

The Consent Act does not apply in relation to medical treatment consisting of or given during the administration of a voluntary assisted dying substance or any other medical treatment relating to voluntary assisted dying under the *Voluntary Assisted Dying Act 2021*(VAD Act).

Section 5 of the VAD Act specifies that administration of a voluntary assisted dying substance under the Act does not constitute palliative care. Further the VAD Act does not limit the operation of the palliative care provisions under the Consent Act at Part 3 Division 2.

See the Voluntary Assisted Dying Policy and the Voluntary Assisted Dying in South Australia webpage for more information.

5.26 Dispute Resolution

It is recommended that LHNs have staged dispute resolution processes established locally, to assist in resolving disputes about consent for health care and/or advance care directives. This service should be available 24/7.

In the first instance steps to resolve the dispute should be undertaken consistent with LHN or local procedures. This could include:

- a case conference,
- a second medical opinion,
- referral to the Clinical Risk Manager/Divisional Director,
- referral to the Patient Care Ethics Committee.

If disputes cannot be resolved locally, then refer to Part 3A of the Consent Act:

- Medical and/or health practitioners should contact the Office of the Public Advocate for advice about any issues arising about 'consent to medical treatment' before making an application to SACAT.
- The Office of the Public Advocate is able to provide advice or mediate disputes onsite through a 24 hour service. The Office of the Public Advocate can be contacted on 8342 8200, Toll Free (for country SA only) 1800 066 969 and has fact sheets about this available on its website: Dispute resolution | Office of the Public Advocate (opa.sa.gov.au)
- Eligible people may apply to SACAT either for a review of the matter mediated by the Public Advocate or to seek a declaration or direction in relation to the matter. Further information is available on SACAT's website at: Consent to medical treatment | South Australian Civil and Administrative Tribunal (sacat.sa.gov.au)

5.27 Care for Persons who are Jehovah's Witnesses

Persons who are Jehovah's Witnesses may refuse a blood transfusion or administration of specific medication. This information should be recorded in the person's medical record. A Jehovah's Witness may carry an advance care directive or an Alert Card, which alerts medical and health practitioners to their preferences, and which is signed by two other witnesses, usually a family member and a religious elder.

Where a person can give informed refusal of a blood transfusion, an Acknowledgement of Medical Advice form should be completed.

Where a parent or guardian refuses consent to administering blood products or medication in the emergency treatment of their child, section 13(5) (emergency medical treatment) of the Consent Act may apply which provides that while parents or guardian's consent needs to be sought, the treatment may be administered despite the refusal if it is in the best interests of the child's health and well-being. See paragraph 6.17 for further guidance.

If a child is capable of consenting, their consent may be sought pursuant to section 12 of the *Consent Act*. Section 12 provides that a medical practitioner may give medical treatment to a child if the parent or guardian consents OR if the child consents (and the other conditions in section 12 are satisfied). Similarly, health practitioners are able to take consent from competent minors in accordance with the test of 'Gillick competence'. See paragraph 6.2 of this Guideline for further information.

5.28 Consent for Blood transfusion and other blood products

Ideally, written consent of the patient should be sought for blood transfusions (including in an advance care directive or from a substitute decision-maker appointed under an advance care directive, or in the absence of a substitute decision-maker a person responsible). Although Australia has one of the safest blood supplies in the world there are still significant risks associated with transfusion.

If it is not possible to get written consent via a consent form, then at the very least, verbal consent should be obtained and recorded in the patient's medical record.

5.29 Screening of Detainees/Prisoners (including detained youths)

Medical and health practitioners should not provide medical treatment or health care to a prisoner without the prisoner's consent.

However, consent is not required where the Chief Executive of the Department for Human Services has made a direction that a prisoner undergo a specified medical examination or test in accordance with regulation 41 of the *Correctional Services Regulations 2016* for the purposes of assessing a prisoner under section 23 of the *Correctional Services Act 1982*.

In addition, there is no requirement to obtain the consent of a youth (defined as a person who is between 10-18 years) or their parent/guardian if the medical examination is for the purpose of the screening required under section 23(3) of the *Youth Justice Administration Act 2016* when the youth is first admitted under that Act.

Refer to People in Custody - Care and Treatment in Public Hospitals and Health Services Policy.

5.30 Indemnity

In accordance with section 74 of the *Public Sector Act 2009,* no civil liability attaches to a public sector employee for an act or omission in the exercise or purported exercise of official powers or functions. Volunteers (including SAAS Volunteer Ambulance Officers) are protected from civil liability under the *Volunteers Protection Act 2001*.

An action that would lie against a public sector employee (or volunteer) lies instead against the Crown i.e. the relevant Government Agency, in this instance the relevant LHN or SAAS.

This section does not prejudice rights of action of the Crown or a public sector agency in respect of an act or omission of a public sector employee that is not in good faith.

The *Crown Solicitor's Office, Legal Bulletin 3*, provides further advice on this matter.

In addition, under section 16 of the Consent Act a medical practitioner responsible for the treatment or care of a patient, or a person participating in the treatment or care of the patient under the medical practitioner's supervision, incurs no civil or criminal liability for an act or omission done or made—

(a) with the consent of the patient or the patient's representative (third parties set out above) or without consent but in accordance with an authority conferred by the Consent Act or any other Act, and

(b) in good faith and without negligence, and

(c) in accordance with proper professional standards of medical practice, and

(d) in order to preserve or improve the quality of life.

In accordance with section 41 of the *Advance Care Directives Act 2013* a health practitioner, Substitute Decision-Maker or other person incurs no criminal or civil liability for an act or omission done or made in good faith, without negligence and in accordance with, or purportedly in accordance with, an advance care directive.

A patient with decision-making capacity may refuse medical assessment and/or treatment at any time before and during the assessment or treatment. Continuing to provide the assessment and/or treatment when the patient has refused to consent may constitute assault and battery and/or unlawful imprisonment and could lead to disciplinary, professional, regulatory, civil or criminal action against the medical and/or health practitioner.

5.31 Criminal proceedings regarding alleged unlawful imprisonment or assault

Where a practitioner is subject to criminal proceedings, for example a patient claims that they have been unlawfully imprisoned or assaulted, the conditions for reimbursement of costs associated with defending the allegation will be in accordance with the Crown Solicitor's Office (CSO) *Legal Bulletin 5*.

Due to a potential conflict of interest, the Crown will not represent an employee (which includes volunteers in accordance with *Legal Bulletin 5*) charged with a criminal offence arising out of the performance of their duty. It is the responsibility of the employee to arrange their own legal representation. The CSO requires the employee immediately report, in writing, the charge to their department or employer in accordance with standard procedures.

The decision as to whether the legal costs to the employee will be paid by the Government will be made on the completion of the case.

The criteria for reimbursement under *Legal Bulletin 5* are:

1. no material adverse finding or material dereliction of duty is revealed through the proceedings or investigation; and
2. the Crown Solicitor (or some other person authorised by the Crown Solicitor) has, in writing:
    a. advised the employee that they will not be represented by the Crown Solicitor for the purposes of responding to or participating in the relevant proceedings or investigation (or the Crown Solicitor considers that it was appropriate in all the circumstances for the employee not approach the Crown Solicitor before obtaining legal representation), and
    b. agreed that the legal representation of the employee for the purposes of responding to or participating in the proceedings or investigation is or was reasonably required, and
3. the Crown Solicitor (or some other person authorised by the Crown Solicitor) has, in writing, certified that the costs to be reimbursed are reasonable,
4. the employee is not indemnified in relation to those costs (including by the State of South Australia (through SAFA or another agency), or under a policy of insurance) and is not entitled to assistance pursuant to the Department of Health Professional Indemnity (Medical Malpractice) Program, and
5. the employee has assigned to the Crown in the right of the State of South Australia any right to recover the costs to be reimbursed from any other party, and
6. the Attorney-General (or their nominee) has approved the reimbursement.

6. Children and Young People (under 16 years)

6.1 Consent to treat and disclose medical information about 16 years and older

Under section 6 of the Consent Act persons 16 years and older may make decisions about their own medical treatment as validly and effectively as an adult.

In general, it can also be inferred from this provision that 16-year-olds are entitled to confidentiality in relation to their medical information. This means that their consent is required before their personal information can be shared, including where it is to be shared with parents.

If personal information is released without consent, the child may potentially have an action for breach of confidence or for damages if some loss is suffered by the child because of that breach.

However, a health service provider may disclose personal information in accordance with section 93(3)(c) of the *Health Care Act 2008* or section 106(2)(c) of the *Mental Health Act 2009* if the disclosure is deemed necessary for the treatment, care and rehabilitation of the patient and wouldn't be contrary to the patient's wishes. Noting that if a person is subject to an ITO or CTO under the *Mental Health Act 2009*, information can be shared with relatives, carers or friends even if the person objects, in accordance with section 106(4) of that Act.

There is no positive obligation to disclose under these provisions.

CASE STUDY

Gloria is the mother of a seventeen-year-old patient. Gloria has called the hospital to request that copies of her daughter's medical records be sent to her so that she can provide them to a private practitioner interstate.

The medical records team advise that they cannot disclose Gloria's daughter's medical records without Gloria's consent and suggest that Gloria's daughter make the request herself. Gloria's daughter does not provide consent and the medical records team are unable to provide copies to Gloria.

In addition, a person can only make an advance care directive if they are 18 years or older.

6.2 When can a child consent to (and refuse) their own treatment (including use of 'Gillick Competence' to assess a child's capacity to consent)?

Unlike adults who are presumed to have capacity unless otherwise proved, children (under 16 years) are presumed incompetent unless they satisfy the requirements of section 12(b) of the Consent Act or the common law test of 'Gillick competence'.

Section 12(b) of the Consent Act, and the common law 'Gillick Competence' assessments are similar. The principles of the common law Gillick Competence (from the English case Gillick v West Norfolk and Wisbech AHA [1985] UKHL 7) were used as the basis for drafting section 12 of the Consent Act.

Section 12 of the Consent Act only applies to medical practitioners. Other health practitioners may rely on the common law Gillick competence test.

For medical practitioners:

Under section 12 of the Consent Act a child can consent if the medical practitioner, who is to provide the treatment, believes that the child is:

1. capable of understanding the nature, consequences, and risks of the treatment; and
2. the treatment is in the best interests of the child's health and wellbeing; and
3. this opinion is supported by the written opinion of at least one other medical practitioner who has personally examined the child.

For health practitioners:

Gillick competence refers to an English case, adopted in Australia, that found children under the age of 16 who can demonstrate sufficient maturity and intelligence to understand and assess the nature and implication of proposed treatment, including the risks, and any alternative courses of action, can give valid consent.

Health practitioners are not required to seek a second opinion.

As the gravity or significance of any proposed treatment increases, so too does the onus on the practitioner to establish that the child understands all elements of what is proposed and is competent.

Capacity needs to be assessed carefully in relation to each treatment decision.

Capacity assessment should include documenting:

- how things were explained,
- any questions or responses or comments from the child,
- any concerns raised by the child,
- how the child communicated their decision,
- details of any written materials,
- whether there were other persons supporting the child who were included in discussions,
- any social or environmental factors impacting the child's ability to understand.

Where a competent child agrees, it is still good practice to involve parents in the decision-making process subject to any express or implied request for confidentiality by the child. If possible and appropriate, confirmation of the child's consent from the parent(s) should be sought and recorded in the child's medical record.

CASE STUDY

Logan is a twelve-year-old presenting to emergency with a deep laceration in the lower right leg.

The practitioner explains that the injury requires stitches and that a local anaesthetic will be administered and that the possible consequences of not performing the stitches would be scarring and infection.

The clinician concludes that Logan is not competent to make the decision to consent to treatment himself for the following reasons:

- Logan struggles to make any decision about treatment and express the rationale or thinking behind his indecision.
- Logan expresses acute concern and distress about the process of receiving stitches and local anaesthetic.
- Logan does not show concern or appreciation for the probability of scarring or infection should he not receive the recommended treatment.

The practitioner should seek consent from the parents or guardians.

6.3 Who can consent on behalf of a child?

Where the child cannot consent themselves, parents or guardians can usually consent to medical or health treatment for their children (under 16 years).

The definition of a parent under section 4 of the Consent Act includes:

- a step-parent, and
- an adult who acts *in loco parentis* in relation to the child (see paragraph 6.4).

There is no legal distinction between the consent of a parent, guardian, step-parent, and an adult acting in loco parentis. Where more than one person is available the medical or health practitioner should use their judgement about who should provide the consent for the child.

While parents can generally consent, the law recognises that there are limits to parental power to refuse or consent to medical treatment or health care:

- Parents can only consent to medical treatment or health care which is in the best interests of the child.[i]
- There are also certain prescribed kinds of treatment that are outside the scope of a parent's power to consent whether it is in the best interests of the child or not, these include:
    - sterilisation[ii]
    - termination of pregnancy[iii]
    - removal of healthy organs or tissue for donation to another person[iv]
    - neurosurgery[v].

If medical or health practitioners are presented with a situation where these types of prescribed treatments are proposed, advice should be sought from the DHWs Legal Unit at healthlegalrequests@sa.gov.au.

6.4 How to determine when someone is acting in loco parentis?

In loco parentis, Latin for 'in the place of a parent'.

When a parent or guardian is not available, an adult who is acting 'in loco parentis' can consent to the medical treatment or health care. Section 4 of the Consent Act provides that the definition of a parent includes an adult who acts *in loco parentis*.

A person is acting 'in loco parentis' when they:

- have assumed some or all the responsibilities of the parent either temporarily or permanently, and
- have a close and continuing relationship with the child, and
- provide the day-to-day care and supervision of the child.

In Australian case law[vi], the basic features of a "parental-style relationship" are described as follows:

- the adult and child live in the same house, and
- the adult stands in the actual shoes of the parent, and
- the child looks to the adult for care, protection, maintenance, and upbringing.

To determine if a person is in loco parentis a practitioner should look at:

- the age of the child,
- the degree to which the child is dependent on the person,
- the amount of financial support, if any, provided,
- the extent to which duties commonly associated with parenthood are exercised, and
- the length of time lived together.

The above are considerations for practitioners in determining whether an adult stands in loco parentis to a child.

Medical and health practitioners also should be aware of Aboriginal kinship groups. It may be the case that a child may have several adults who can stand in loco parentis to the child, even when they are still also living with their biological parent, provided they have a parent-style relationship with the child.

In many Aboriginal families, other family members, asides from the parents (e.g. aunts, uncles) share the parenting role. These family members may be in loco parentis, and this will always be a matter of fact to be considered in each circumstance. See the SA Health Aboriginal Culture and History Handbook. If in doubt, the health service should contact their Aboriginal health worker or unit.

In each case a medical or health practitioner needs to satisfy themselves that a carer is acting in the place of a parent. The following statutory declaration may assist: Informal-Relative-Caregivers-Statutory-Declaration-with-FAQ.pdf (gfgsa.com.au)

A person acting in loco parentis is a person responsible under section 3 the *Guardianship and Administration Act 1993* and is eligible to make applications for administration orders or special powers under that Act.

6.5 Can a person who is acting in loco parentis consent to release of information?

Medical and health practitioners may provide the necessary medical information to those acting in loco parentis to enable consent to medical treatment or health care of a child.

Section 93(3)(c) of the *Health Care Act 2008* allows for disclosure of medical information to a relative, carer or friend if the disclosure is reasonably required for the treatment, care or rehabilitation of the person and there is no reason to believe the disclosure would be contrary to the person's best interests.

The person acting in loco parentis needs relevant information about what is wrong with the child, what the assessment and/or treatment options are, and any risks to enable them to provide informed consent for the proposed medical treatment or health care.

6.6 Seeking consent where a parent or a guardian is not available

In the absence of a parent (or caregiver acting in loco parentis) or guardian the practitioner should first consider:

- Whether the child is competent to consent to their own treatment (see paragraph 6.2).
- Whether emergency medical treatment is required (see paragraph 6.17).

If the above scenarios do not apply the practitioner will be required to consider:

- Whether the treatment can be deferred until the parent, caregiver, or guardian can be contacted and is available.
- Whether to contact SAPOL for a welfare check.
- Whether to consult with SA Health Child Protection Services at Health.ChiefChildProtectionOfficer@sa.gov.au.
- Whether a mandatory notification to DCP is necessary Mandatory Reporting of Suspicion that a Child or Young Person is or may be at Risk Policy.

Refer to the Child Safe Environments (Child Protection) Policy.

6.7 Can a parent or guardian provide consent over the phone?

Yes. Where a parent or guardian is not present to sign the consent form (e.g. they are enroute to the hospital) consent can be obtained over the phone provided that all of the elements of valid consent (see paragraph 5.6) are satisfied.

Where consent is obtained via phone it is recommended that a second practitioner act as a witness. This will protect the treating practitioner should a dispute arise. If possible, the relevant consent form should be completed with a notation that the consent was provided over the phone. All details of the consent should be included in the medical record.

The parent or guardian should be asked to confirm their consent with a signature when/if they arrive at the health facility.

6.8 Where there are doubts about a parent or guardian's decision-making capacity

Decision-making capacity is required for valid consent. If there are doubts about whether a parent or guardian has decision-making capacity the practitioner should:

- Consider whether the child is competent to consent to their own medical treatment or health care (see paragraph 6.2).
- Consider whether the impairment is temporary (e.g. intoxication) and if so whether assessment, treatment, or health care can be deferred until capacity has been regained.
- Consider whether an alternative parent or guardian can be contacted to provide consent.
- Consider whether emergency medical treatment is required (see paragraph 6.17 for further information about providing emergency medical treatment under section 13 of the Consent Act).

6.9 When practitioners are concerned that the decisions of the parent or guardian are not in the best interests of the child?

The dominant factor in any decision is always what is in the "best interests of the child".

Where the practitioner who is providing the medical treatment or health care strongly believes that the decisions of a parent or guardian in relation to refusal of treatment are not in the best interests of the child, the practitioner could initiate formal proceedings and:

- make an application to the Office of the Public Advocate under the dispute resolution provisions in the Consent Act. Dispute Resolution is discussed at paragraph 6.16.
- pursue formal court proceedings to adjudicate on these matters in either the Supreme Court or the Family Court. Legal advice should be sought if the medical or health practitioner considers that applications should be made to the courts to allow for treatment. A decision to pursue a court order is a significant decision and legal advice is required before such a matter can be progressed. Contact the Clinical Risk Manager in the first instance or if they are unavailable the DHWs Legal Unit at Healthlegalrequests@sa.gov.au.

In circumstances where parental decision-making appears to be putting a child at risk of harm:

- The practitioner could consider:
  - whether a mandatory notification to DCP is necessary in accordance with the Mandatory Reporting of Suspicion that a Child or Young Person is or may be at Risk Policy.

- Whether to consult with a Forensic Paediatrician at WCHN PFMS:

  Office hours: Registrar pager 18114
  After hours: 8161 7000 switchboard - PFMS doctor on call
  All hours: WCHNPaediatricForensicMedicalService@sa.gov.au
  FMS was established in January 2024 as a specialist forensic medical service under WCHN governance. It is staffed by Paediatricians with forensic expertise previously working within WCHN CPS. Referrals for consultation can be made direct to PFMS regardless of where the child resides.

- If the concern relates to a child that is an inpatient of Flinders Medical Centre contact SALHN CPS: FMCchildprotectionservice@sa.gov.au
- If the concerns relate to a child In Lyell McEwin Hospital contact NALHN CPS: CPSIntakeNALHN@sa.gov.au

Practitioners should consider:

- whether a referral to a Social Worker or other supports should be sought,
- whether to contact SAPOL for a welfare check,
- whether to consult with SA Health Child Protection Services at Health.ChiefChildProtectionOfficer@sa.gov.au.
- whether a mandatory notification to DCP is necessary Mandatory Reporting of Suspicion that a Child or Young Person is or may be at Risk Policy.

Refer to the Child Safe Environments (Child Protection) Policy.

6.10 Where a competent child requests that their personal information remain confidential and not be disclosed to parents/guardians/caregivers

Whether or not a practitioner can or should disclose where a competent child refuses to consent to the disclosure depends on the circumstances of each case.

There is no straightforward answer to this question, and it is recommended legal advice be sought, where practical and appropriate in the circumstances, through the Clinical Risk Manager or if they are unavailable, the DHWs Legal Unit at heatlhlegalrequests@sa.gov.au as cases arise.

Section 93 the *Health Care Act 2008* imposes confidentiality obligations in relation to personal information with exceptions including that a person can disclose “at the request of, or with the consent of the person to whom the information relates or a guardian of the person to whom the information relates”.

While this provision allows for disclosure at the request of parents it does not direct that the disclosure occur, and there is no positive duty on the practitioner to make a disclosure, particularly where the disclosure is contrary to the wishes of the child.

6.11 Should practitioners inform an absent parent?

There is no positive legal duty to ascertain the views of an absent parent or legal guardian before proceeding with medical treatment or health care.

Section 12 of the Consent Act only requires the consent of one parent.

In addition, it may be a breach of patient confidentiality to proactively disclose this information.

The *Health Care Act 2008* allows for disclosure where a parent or guardian requests or consents to the disclosure. If the parent/guardian has not requested the information and there is no consent, then its disclosure may constitute a breach of confidentiality. Section 93(3)(c) allows for disclosure of information to a relative, carer of friend of the person (here, the child) if the disclosure is reasonably required for the person's treatment, care or rehabilitation and there is no reason to believe that the disclosure would be contrary to the person's best interests.

6.12 When parents or guardians refuse consent?

Parents or guardians do not ordinarily have the power to refuse lifesaving or life-prolonging treatment.[vii]

In the first instance practitioners should assess whether the child can consent to the medical treatment or health care themselves. Refer to paragraph 6.2.

Where the child is not capable of making the decision themselves then:

In emergency situations

Refer to paragraph 6.17 in relation to emergency treatment.

If the parent or guardian refuses consent, or they are not available, then a medical or health practitioner may administer the treatment or health care if they are of the opinion that it is in the best interests of the child's health and wellbeing. This is despite any refusal of the parent or guardian in accordance with section 13(5) of the Consent Act.

Refer to the Consent to Medical Treatment and Health Care Policy.

In non-emergency situations:

In cases where parents or guardians are refusing medical treatment or health care for their child, medical or health practitioners should make all efforts to engage with the parents and to obtain their consent for the recommended treatment.

In most cases a refusal of medical treatment or health care by a parent or guardian is acceptable if it is in the best interests of the child. Provided practitioners have fulfilled the duty to explain (see paragraph 5.12) no further action is required.

Practitioners should record details of discussions with parents where consent for medical treatment or health care is being sought and refused. These details will be required if formal proceedings are initiated.

Where the practitioner who is providing the medical treatment or health care strongly believes that the refusal of treatment is not in the best interests of the child see paragraph 6.9.

CASE STUDY

Dr Briggs has recommended that a five-year old have their tonsils removed due to frequent and severe tonsilitis. The parents have refused the recommended treatment. Dr Briggs has noted the conversations with the parents in the patient medical record and developed an appropriate conservative treatment plan in accordance with the parents' wishes.

6.13 Obtaining consent when there are Court Orders in place

It is important to note that the existence of a Family Court parenting order does not impact on the ability of a mature competent child to make decisions and consent to their own medical treatment or health care. A parenting order does not deprive a competent child of their decision-making capacity. Refer to paragraph 6.2.

Medical and health practitioners should request to see any Court orders if a parent or guardian says that one exists, or it is otherwise suspected or becomes known there is one in place. Practitioners should record information or advice about Court orders in the patient medical record.

Where there is an order under the *Family Law Act 1995* (Cth) that each parent have equal shared parental responsibility (a Family Court parenting order), decisions about issues that are major long-term issues are to be made jointly. It is the responsibility of the parent seeking the medical treatment or health care to consult with the other parent, and for both parents to make a genuine effort to come to a joint decision. Practitioners are entitled to assume that the consent of one parent is valid, however if they become aware that there is a dispute or that the other parent does not consent, they should stop medical treatment or health care immediately until the matter is resolved (unless emergency treatment is required).

Where an order states that only one parent has parental responsibility for the child then it is that parent who can consent to the medical treatment or health care. The other parent cannot consent in those circumstances and should not be informed by the practitioner of the child's condition or treatment or health care management plan unless there is consent.

Court orders may contain directions about consent to medical treatment or health care (e.g. assign a specific treating practitioner) or vary the authority of a parent in relation to a child. It is recommended to seek legal advice about how to interpret a court order through the local Clinical Risk Manager or if they are unavailable the Department for Health and Wellbeing's Legal Unit at healthlegalrequests@sa.gov.au.

6.14 Managing disputes between parents/guardians/caregivers

It is not necessary to get the consent of both parents (unless the authority of the parent to consent is constrained by a court order, see above paragraph 6.13) for the purposes of the Consent Act.

One parent's consent is sufficient. A parent includes a guardian, a step-parent, or an adult who acts in loco parentis to the child.

Where there are disputes between parents (including dispute between someone acting in loco parentis/guardian/step-parent) the health service should try to work through the issues to reach consensus.

If consensus cannot be reached and the practitioner believes it is in the best interests of the child to proceed with medical treatment or health care, then the consent of one person is sufficient.

For example, in cases where there is a dispute between parents and a person acting in loco parentis the consent of the person acting in loco parentis can be relied on (see paragraph 6.4 on what constitutes a person acting in loco parentis).

The child's best interest, health and well-being is to be at the centre of decision-making process.

Details of the consent process should be noted in the patient medical record.

Disputing parties can be referred to the OPA or SACAT. They are also entitled to make an application to the Court. See paragraph 6.16 for further information about the dispute resolution process.

If parents cannot mutually consent, then the dispute resolution scheme under Part 3A of the Consent Act can be utilised and the medical or health practitioner can refer the matter to the Office of the Public Advocate.

Where the Public Advocate is unable to mediate agreement between the parents, the Public Advocate may refer the matter to SACAT for resolution.

Where SACAT has made a direction or declaration that is inconsistent with an order of the Family Court, the Family Court Order will prevail.

Advice should be sought from the Clinical Risk Manager where there are apparently conflicting orders or directions.

Practitioners should ensure they record all details of their observations and conversations in the patient medical record.

See paragraph 6.16 for more information about dispute resolution.

CASE STUDY

Parents of a nine-month-old infant are in dispute about providing their child with vaccinations. One parent, Ms J wishes to vaccinate their child and the other Ms P does not.

The health service has obtained written consent from Ms J to provide the vaccinations. Ms P has emailed the health service raising concerns about Ms J's capacity to consent.

The health service proceeds to vaccinate the infant as under the Consent Act they only require the consent of one parent to provide treatment and the medical practitioner has satisfied themself that Ms J has sufficient capacity to consent to the vaccination.

6.15 Dispute between parents and child?

Whatever healthcare is performed it is to be in the best interests of the child. Practitioners are under no obligation to provide medical treatment or health care where they believe it is not in the best interests of the child.

If the practitioner forms the view that the child is competent and can consent themselves (refer to paragraph 6.2) then the consent or refusal of the parent is not relevant.

If a child is not competent it is preferable that they be included in decision making as much as possible.

The parties can be referred to the Office of the Public Advocate. See paragraph 6.16 for more information about dispute resolution.

Practitioners should ensure they record all details of their observations and conversations in the patient medical record.

6.16 Dispute resolution

Part 3A of the Consent Act legislates a dispute resolution scheme in relation to decisions of a parent or guardian to consent or refuse to consent to medical treatment or health care of a child.

Under the scheme a parent, health professional or any other party that the Public Advocate or SACAT consider has a proper interest in the matter (e.g. the child) may make an application to the Public Advocate or to SACAT for assistance to resolve a matter.

In some cases it may be appropriate to engage local dispute resolution processes before making formal applications.

1. Local processes:

In the first instance steps to resolve the dispute should be undertaken consistent with LHN or local procedures. This could include:

- a case conference,
- a second medical opinion,
- referral to the Clinical Risk Manager/Divisional Director,
- referral to the Patient Care Ethics Committee.

The child's best interest, health and well-being needs to be at the centre of all discussions.

2. Office of the Public Advocate:

If disputes regarding consent cannot be resolved at the local level, the Office of the Public Advocate (OPA) may assist with on-site advice or *mediation* at:

- 8342 8200 or *opa@agd.sa.gov.au* (24/7 service)

3. SA Civil and Administrative Tribunal:

SACAT can review matters dealt with by the OPA and make declarations or directions in relation to the matter. SACAT will usually only review or make a declaration if the Public Advocate had previously tried to resolve the matter or mediate the issue.

However, if the matter is urgent (there is a serious risk to the person or to others) the practitioner may contact SACAT directly to arrange an urgent hearing.

SACAT contact details are:

- 1800 723 767 or *sacat@sacat.sa.gov.au*

4. Court Orders:

In rare cases an application can be made to the Supreme Court (or in some cases to the Family Court) to make orders to overrule a decision of the parents or child.

An application will ask the Court to make a decision within its *parens patriae* jurisdiction. This jurisdiction derives from the doctrine that the Sovereign has an obligation to protect the interests of those unable to protect themselves. Its exercise most often arises in cases where medical treatment is strongly advised for a child but the child and/or the parents refuse to consent.

Advice should be sought through the Clinical Risk Management team if an order of this nature is being considered.

CASE STUDY

In *DoCS v Y [1999] NSWSC 644 [106]* the NSW Supreme Court made orders in the Court's *parens patriae* jurisdiction that included overriding the refusal of treatment by the child, who suffered from anorexia, and the refusal of her parents for necessary treatment.

In this case the Court made orders to compel the child to stay in a particular hospital and undergo treatment, authorised her detention in and the reasonable use of force by the hospital and restricted her parents contact with her.

CASE STUDY

In *CYWHS v YJL, MHL and TL (2010) 107 SASR 343* the Supreme Court of South Australia made orders allowing doctors treating a 10-year-old boy suffering from a malignant tumour, to provide blood transfusions to the boy without his parents' consent. The boy and his parents are Jehovah's witnesses and objected to the transfusions on religious grounds. Expert evidence established that without the recommended course of treatment the boy would likely face a "painful death within a matter of weeks or months." The Court found that it was in the boy's best interests to allow the doctors to administer the transfusions.

6.17 Emergency treatment for children

See paragraph 7.6 and 7.8 for general information about providing emergency treatment.

Under section 13(5) of the Consent Act, if a parent or guardian is available, the medical practitioner needs to seek consent from the parent or guardian to provide emergency treatment.

While the emergency treatment under s13 of the Consent Act only applies to medical practitioners, other health practitioners can rely on the common law in the provision of other emergency treatment and care.

Emergency treatment under the Consent Act may be provided despite parent or guardian refusal where treatment is in the best interests of the child's health and well-being.

The principles of the Consent Act and the common law align. The common law provides that parental authority does not extend to decisions that are not in the child's best interests.

6.18 Can parents consent to the use of restrictive practices?

A parent or guardian of a child who is not yet of adequate maturity can consent to very limited and brief restrictive practices to support medical treatment or health care or in response to challenging behaviours. See paragraph 6.2 for further information about assessing the maturity of a child.

Refer to the Minimising Restrictive Practices in Public Health Care Services Policy and Clinical Guideline. See paragraph 7.17 for further information about restrictive practices including under the *Mental Health Act 2009* and the *Guardianship and Administration Act 1993*.

Where the use of a restrictive practice is outside the scope of a parent or guardian's power to consent (either because the restraint is too significant, and/or the child is too mature) then legislative provisions in the *Guardianship and Administration Act 1993* (or other Acts including the *Mental Health Act 2009* may be appropriate.

The legal framework for the use of restrictive practices in discussed further at paragraph 7.17.

Details of the circumstances surrounding the use of restrictive practices and the parent or guardian's consent should be recorded in the child's medical record.

6.19 Seeking consent when the child is under guardianship of the CE of DCP (children under a protection order)?

Refer to the Department for Child Protection's (DCP) *Who can say OK* Booklet.

Carers should be generally aware of what decisions they can make versus the decisions that need to be referred to a DCP case worker. Practitioners taking consent from carers should be able to rely on this assumption as long as they are acting in the best interests of the child.

If there is any doubt the practitioner should contact DCP and seek advice from the case worker.

Generally, who consents for treatment for children under the guardianship of the CE of DCP depends on the urgency and/or risks of the proposed treatment:

- Carers can consent to routine medical treatment or health care (including making appointments, seeking assessment and treatment for common illnesses and minor ailments and injuries, treatment that does not involve anaesthesia or surgery, diagnostic tests, ongoing treatment of a diagnosed condition).
- Department of Child Protection should generally consent to non-routine medical treatment or health care where possible if not an emergency (including general anaesthesia, surgery, and high-risk procedures).

Refer to the Providing Health Services to Children and Young People in Out of Home Care (Schedule 1 of the Health Services Agreement for Children and Young People in out of Home Care)

6.20 Seeking consent for a baby where the parent is a child

Where a medical treatment or health care decision is required for a baby or a child and the parent of the child is also a child (under 16 years of age), the parent who is a child can consent if they have decision-making capacity (in the same way as a child is assessed in accordance with section 12 of the Consent Ac or in accordance with the common law). The practitioner needs to:

- be of the opinion that the child is capable of understanding the nature, consequences and risks of the medical treatment or health care; and
- be of the opinion that the medical treatment or health care is in the best interests of the patient's health and well-being; and
- ensure the opinion that the child has capacity (can understand the nature, risks and consequences of the medical treatment or health care) is supported by the written opinion of at least one other medical practitioner.

If there is some uncertainty as to whether the parent who is a child can understand the nature, consequences and risks of the treatment, they should be provided with all possible support to assist with their decision-making.

This could include ensuring that the parent who is a child has their own support people, including their own parents or guardians, with them to assist in coming to a decision.

In situations where there is doubt that the parent who is a child has capacity it may be useful to consider whether there is someone else in the child's life who is acting *in loco parentis* to the baby.

If the parent who is a child does not have capacity urgent liaison with the Department of Child Protection should occur. Clinicians should contact their local Clinical Risk Management Office for advice.

6.21 Seeking consent where the baby is subject to a surrogacy arrangement.

Surrogate Mother Consent:

The surrogate mother retains the right to consent to the medical treatment and health care for herself and the unborn child during pregnancy.

Under section 8 of the *Surrogacy Act 2019* the surrogate mother is the "parent" of the child until a parentage order is made by the Court. Applications for parentage orders are not able to be made for 30 days after the birth of the child (but are required to be made within 12 months).

The practitioner can rely on the consent of the surrogate mother for treatment of the child for the first 30 days of the child's life, and up to the time when the parentage order is made.

Intended Parent Consent:

The intended parents are not the legal parents of the child until the parentage order is made. However, if the child is living with the intended parents and they have taken up the role of parenting the child (before the parentage order is made by the Court) the practitioner may form a view that they are acting *in loco parentis* and able to consent. Refer to paragraph 6.4.

Refer to the *Surrogacy in SA Public Health Services Patient Information Brochure*.

Practitioners should try to involve both the surrogate mother and the intended parents in the decision-making process where possible and if there is a need confirm the parentage status (i.e. where there is conflict) ask to sight the parentage order.

6.22 Gender dysphoria treatment

A parent may consent to stage 1 (fully reversible interventions involving delaying onset or progression of puberty), 2 (partially reversible interventions involving hormone treatment to feminise or masculinise the body), and 3 (irreversible interventions involving surgery) treatments for gender dysphoria, or a child can consent if they are sufficiently mature in accordance with the criteria of section 12(b) of the Consent Act.

The competence of the child to consent will need to be assessed alongside the severity of the treatment proposed.

Where medical practitioners have determined that a child is competent to consent to treatment, it is agreed that the treatment is therapeutic and where there is no dispute, treatment can proceed.

Where a medical practitioner administering the treatment has concerns about the consent or the treatment then the medical practitioner should not proceed.

If there is a challenge to any decisions made in the Supreme Court of SA or the Family Court. It is recommended legal advice be sought.

The Supreme Court or Family Court may override the medical treatment decisions of both the parents and the child. Intervention of the Supreme Court and Family Court will arise where a clinician, parent, or the child disagree on matters relating to the child's capacity to consent or relating to diagnosis or treatment of a child or where there are particular Family Court orders in place which are incompatible with consent being lawfully given under the Consent Act.

7. Providing treatment where consent cannot be obtained
(This section does not apply to children or young people under 16 years)

7.1 The Law

All patients over the age of 16 years, are presumed to have decision-making capacity about their own medical treatment or health care unless there is significant evidence to suggest otherwise following initial assessment. Refer to part 6 of this Guideline for information about treating children and young people under the age of 16 years.

There are four pieces of legislation that provide lawful authority to provide medical assessment, medical treatment or health care where a patient cannot consent.

The relevant provisions are found in the following Acts:

- *Consent to Medical Treatment and Palliative Care Act 1995*
- *Mental Health Act 2009*
- *Guardianship and Administration Act 1993*
- *Advance Care Directives Act 2013*

Continuing to provide treatment and/ or health care where a patient with decision-making capacity, their Substitute Decision-Maker or Person Responsible has refused to consent, or against a relevant refusal in an advance care directive, may constitute assault and battery and/or unlawful imprisonment and could lead to civil or criminal charges being brought against the medical or health practitioner.

7.2 Initial Assessment

Medical and health practitioners may encounter aggression and violence (referred to as challenging behaviours). In these circumstances practitioners will need to make an initial assessment based on the patient's physical and mental wellbeing, factoring in the patient's behaviour and information from third parties (including police). If the patient has impaired decision-making capacity consent to medical treatment or health care should be sought from an appropriate third party or emergency treatment if required.

Challenging behaviour may be caused by a physical illness, a psychiatric illness, drug induced mental illness, extreme alcohol or drug intoxication, intellectual impairment or acquired brain injury. These problems can occur in combination. Of itself, the patient's behaviour may not be indicative of their decision-making capacity.

It should be noted that a medical or health practitioner's initial assessment may change following a more detailed clinical assessment. It is vital that the initial assessment, as well as subsequent assessments, are documented in the patient's medical record (refer to paragraph 7.6).

7.3 Where decision-making capacity is in doubt

Where the patient's decision-making capacity is in doubt and the legal authority to provide medical treatment or health care (either with third party consent or through the emergency treatment provision of the Consent Act) is not clear, medical and health practitioners should seek the opinion of another clinician. See paragraph 5.15 for further information about assessing whether a patient has decision-making capacity.

Where two or more clinicians cannot agree on whether a patient has decision-making capacity then medical or health practitioners should contact the OPA for a determination.

It is important that the assessment process is documented in the patient's medical record (refer to paragraph 7.6).

For more information see the Impaired Decision-Making Fact Sheet.

7.4 Temporary incapacity

People may, at times, be unable to make a decision about their medical treatment or health care because of a temporary incapacity (e.g. intoxication, or unconsciousness).

In these situations:

- Practitioners should consider whether medical treatment and/or health care can be postponed (i.e. if it is of an elective or non-urgent nature) until the person has regained decision-making capacity in relation to the decision about the medical treatment and/or health care, or
- if treatment and/or health care is needed a third-party decision-maker should be sought to consent until such time as the patient regains capacity (see paragraph 7.9), or
- where treatment and/or health care is an emergency medical treatment and/or health care may be provided in accordance with section 13 of the Consent Act or the common law. (see paragraph 7.7 and 7.8).

If the patient is suffering from a longer lasting but still temporary incapacity, for example an elderly person has impaired decision-making capacity due to a serios UTI, (and they have no family or other person to consent on their behalf) it may be appropriate for the medical practitioner to make an application to SACAT under section 14(1)(e)(ii) for permission to provide relevant treatment. See paragraph 7.10 for further information about this.

7.5 Documenting assessment or treatment or health care undertaken without consent

Factual documentation in the patient's medical record outlining the clinical reasons and circumstances in which the medical assessment and/or treatment and/or health care was provided without consent and whether third party consent was obtained, is important.

It is vital information in the event of any legal proceeding arising because of the provision of the medical assessment and/or treatment of the patient without the patient's consent and/or with the use of restrictive practices.

Documentation should include the following information:

- the time and date of clinical assessment of the patient
- outcome of clinical assessment of the patient
- the outcome of a decision-making capacity assessment
- if a Substitute Decision-Maker or Person Responsible consented on behalf of the person, when and why
- if the medical treatment or health care is administered in accordance with the wishes and instructions of the patient's advance care directive
- the reasons for administering medical treatment or health care contrary to the wishes and instructions of the patient's advance care directive or Substitute Decision-Maker's decision
- where relevant, note if the patient refused to sign Acknowledgment of Medical Advice Form
- any witnesses to the discussion with the patient/Substitute Decision-Makers/Persons Responsible

- reasons for any restrictive practices that may have been utilised in the provision of medical treatment or health care
- signature (where appropriate) of the practitioner supporting reason to use restrictive practices on the patient to provide medical treatment or health care.

7.6 Emergency medical treatment where a patient cannot consent – for medical practitioners.

Section 13 of the Consent Act provides for emergency medical treatment and only applies to medical treatment administered by medical practitioners.

Other health practitioners can act at the direction of the medical practitioner in the provision of medical treatment. (Paragraph 7.8 describes requirements for health practitioners providing emergency health care (within their scope of practice) under common law or statutory defences.)

Section 13 of the Consent Act sets out the circumstances in which a medical practitioner can lawfully administer emergency medical treatment without the patient's consent. Emergency treatment can be provided where:

- the patient is incapable of consenting; and
- the medical practitioner who administers the treatment is of the opinion that the treatment is necessary to meet an imminent risk to the patient's life or health; and
- that opinion is supported by the written opinion of another practitioner who has personally examined the patient (a written supporting opinion is not necessary if it is not practicable to obtain it in the circumstances); and
- the patient (if 16 years of age or older) has not, to the best of the medical practitioner's knowledge, refused to consent to the treatment; and
- the medical practitioner proposing to administer the treatment has made, or has caused to be made, reasonable inquiries (if time permits) to ascertain whether the patient (over the age of 18) has given an advance care directive, and
- an appointed Substitute Decision-Maker (under an advance care directive) or a Person Responsible (s14 of the Consent Act) is not available to consent to the emergency treatment.

Assessing whether treatment is necessary to meet an imminent risk to life or health:

- An 'emergency' is a situation where the treatment is needed to save the patient's life or to prevent serious future harm or danger to the patient's health.
- In interpreting "imminent risk to life or health" courts have found that it applies to medical treatment that is reactive rather than merely preventative or facilitative.[viii]
- The authorisation under s 13 to provide treatment only continues for as long as there is an "imminent risk to [the] life or health" of the patient.

Assessing whether a patient is capable of consenting:

- The Consent Act stipulates that a person may be incapable of consenting whether or not they have impaired decision-making capacity in relation to a particular decision (section 13(1)(a)).
- A patient may be incapable of consenting because:
    - they have impaired decision-making capacity including that they are comatose or otherwise unconscious (refer to paragraph 5.15),
    - of the extent and type of physical injury,
    - of extreme pain.
- The authorisation to provide treatment ends once the patient has regained capacity to consent. Staff should turn their minds at intervals to the issue of the patient's capacity. As soon as the patient regains their capacity to consent, they are free to refuse any further treatment.

Where the patient has refused the treatment when they had capacity:

- The emergency provisions cannot be used when a patient has refused the treatment and had capacity to do so at the time of the refusal (e.g. they refused the emergency treatment before losing consciousness).
- If it is considered that the patient did not have capacity at the time of their refusal this needs to be fully documented in the patient notes.

Before going ahead with treatment, the medical practitioner should make reasonable enquiries (circumstances permitting) as to:

- Whether the patient (if over 18) has an advance care directive (ACD); and
- Whether consent can be obtained from a Substitute Decision-Maker under an ACD (if relevant), or a guardian, or a Person Responsible under the Consent Act.

Where restrictive practices or other treatments (other than the life-saving treatment) are required:

- s13 only authorises the restraint and force to the extent that is reasonably necessary to provide the lifesaving/serious risk-averting treatment. It does not give the medical practitioner a licence to provide any other treatment, even treatment that is related to the life-saving treatment.

What if there is a binding refusal in an advance care directive:

- Under the *Advance Care Directives Act 2013* a provision of an ACD comprising a refusal of health care is a binding provision. See paragraph 7.10 for further information about binding refusals in an ACD.
- Section 13(1a) of the Consent Act provides that a medical practitioner may lawfully provide treatment despite a binding refusal if:
    - the patient is unable to consent; and
    - it is an emergency (meets criteria of section 13 of Consent Act); and
    - the medical practitioner is of the opinion that the refusal was not intended by the person to apply to treatment of the kind proposed or in the current circumstances; and
    - it is not reasonably practicable to use the advice or mediation service provided by the Office of the Public Advocate as set out under Part 7 of the *Advance Care Directives Act 2013* - see paragraph 7.17 for further information about dispute resolution processes.
- This may be the case if the refusal is ambiguous, and there is no time to clarify the advance care directive provision/s or the person's condition, or to discuss it with an appointed Substitute Decision-Maker (if any) or a Person Responsible.
- The reasons for ignoring a refusal of health care should be clearly documented in the patient's medical record.

7.7 Emergency treatment or health care where a patient cannot consent – health practitioners

Health practitioners can provide emergency treatment or health care (within their scope of clinical practice) under other legal protections.

While section 13 of the Consent Act only applies to medical practitioners it does generally mirror the requirements that apply to health practitioners to establish common law or statutory defences to civil or criminal action. As such, health practitioners should ensure that they meet the requirements of section 13 of the Consent Act as laid out at paragraph 7.7. The only differences are that health practitioners do not need to seek a second opinion under the law, however local procedures may require this.

Refer to the Mandatory Instruction in the Consent to Health Care and Medical Treatment Policy.

7.8 Who can consent of behalf of the patient? (Third party consent)

Third party consent follows a legal hierarchy set out in Part 2A of the Consent Act and the *Advance Care Directives Act 2013*.

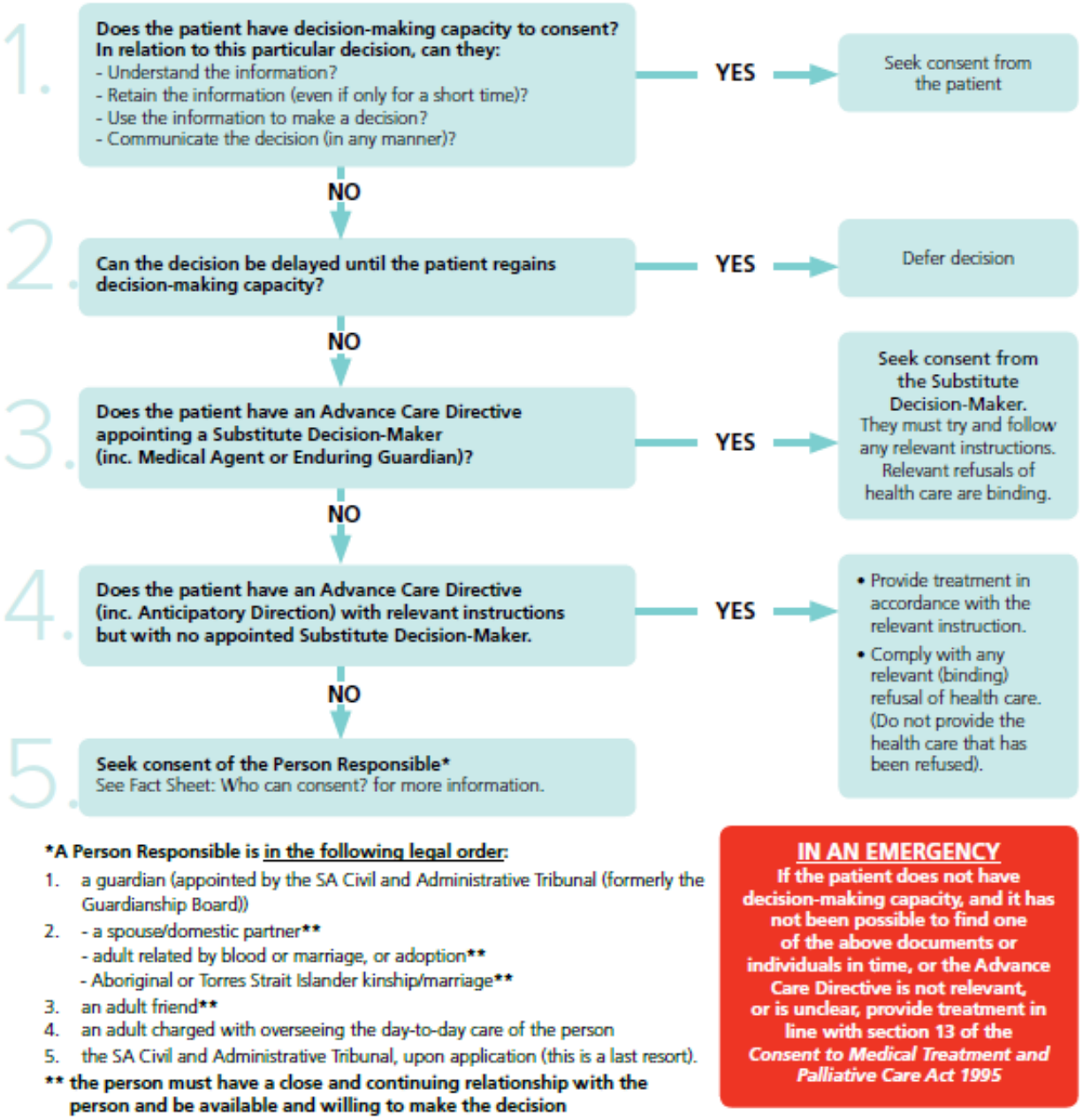
Part 2A of the Consent Act applies to all medical and health practitioners.

See the Who can Consent? poster and the Consent to Medical Treatment and Healthcare flowchart for an overview.

The legal hierarchy of persons able to consent on behalf of someone without decision-making capacity is:

1. A Substitute Decision-Maker appointed by an ACD.
2. A guardian appointed under the *Guardianship and Administration Act 1993* .
3. A prescribed relative with a close and continuing relationship with the patient, being:
    a. A person who is legally married to the patient,
    b. An adult domestic partner (within the meaning of the *Family Relationships Act 1975*),
    c. An adult related by blood or marriage,
    d. An adult related by adoption,
    e. An adult of Aboriginal or Torres Strait Islander descent who is related according to Aboriginal kinship rules or Torres Strait Islander kinship rules.
4. An adult friend who has a close and continuing relationship with the patient
5. An adult who is charged with overseeing the day-to-day supervision, care, and well-being of the patient.
6. With the permission of the South Australian Civil and Administrative Tribunal (SACAT) on application of a prescribed relative, the medical practitioner proposing to give the treatment, or anyone SACAT considers has a proper interest in the matter.

Figure 1: Details the process for seeking consent for patients who do not have decision-making capacity as provided in the *Consent to Medical Treatment and Healthcare flowchart*.



Practitioners should make appropriate enquiries to locate the person with higher responsibility however consent is effective even if the person was not in fact responsible for the person so long as the medical practitioner did not know this and could not reasonably be expected to have known.

Practitioners should ensure they make appropriate enquiries and document all relevant interactions in the patient's notes.

The third-party consent provisions at Part 2A of the Consent Act do not apply to:

- Children (under the age of 16),
- patients with an ACD (to the extent a Substitute Decision-Maker has been appointed, and an ACD makes provision for relevant health care),
- or to prescribed treatment under the *Guardianship and Administration Act 1993*.

CASE STUDY

An adult patient is unable to consent for themselves due to an intellectual disability. The patient is supported in the community by MINDA and does not have any family support. A surgical procedure is being recommended to manage a health condition.

A medical practitioner can administer medical treatment to an individual with impaired decision-making capacity with the consent of a substitute decision-maker or a person responsible.

In this case, there is no substitute-decision maker, and the practitioner needs to go through the hierarchy of the person responsible to determine who can consent.

Person responsible is a hierarchical clause. In the absence of a guardian, a prescribed relative, or an adult friend with a close and continuing relationship, it is open for the medical practitioner to seek the consent of an adult overseeing the ongoing day-to-day supervision, care and wellbeing of the patient (note, whilst the person responsible is a hierarchical clause, a prescribed relative is not and anyone within the list can consent).

The medical practitioner should assess the relationship that the patient has with their community support officer. If the medical practitioner reasonably believes that the support officer is overseeing the ongoing day-to-day supervision, care and wellbeing of the patient and they are willing, they may consent on behalf of the patient.

If there is no-one overseeing the day-to-day care of the person, the medical practitioner will need to make an application to SACAT seeking a guardian to be appointed.

Substitute Decision-Maker:

In a non-emergency situation, if the practitioner is made aware that a patient with impaired decision-making capacity has an ACD and/or has appointed a Substitute Decision-Maker, medical treatment or health care can only be administered in accordance with a relevant provision of the ACD (constituting consent) or with the consent of the patient's Substitute Decision-Maker(s).

A decision by the Substitute Decision-Maker, and/or a relevant provision in an ACD is deemed to have the same effect as if the patient gave the consent or refused consent themselves.

A Substitute Decision-Maker cannot refuse the natural provision of food and water or pain/distress relieving drugs.

Failure to comply with the ACD or seek the consent of the Substitute Decision-Maker may expose the medical or health practitioner to either criminal or civil liability for providing the medical treatment or health care without consent or may lead to a complaint being made to the relevant health practitioner board for unprofessional conduct.

For further information about the application of ACDs, including practitioners' obligations and protections, refer to the Advance Care Directives Policy .

Person Responsible:

In the absence of a Substitute Decision-Maker or a relevant provision in an ACD, Part 2A of the Consent Act provides that a person responsible can consent/withhold consent to medical treatment or health care. Part 2A of the Consent Act does not relate to patients under the age of 16. Nor does it apply to prescribed treatment within the meaning of the *Guardianship and Administration Act 1993*.

A decision by a Person Responsible is deemed to have the same effect as if the patient gave, or refused to give, consent themselves.

Person Responsible for the patient means a person below listed in the following legal hierarchy:

a) A guardian appointed by the SA Civil and Administrative Tribunal (SACAT) (formerly the Guardianship Board); or if a guardian has not been appointed

b) a prescribed relative* with a close and continuing relationship with the patient who is available and willing to make the decision; or if none of the above apply

c) an adult friend who has close and continuing relationship with the patient who is available and willing to make the decision; or if none of the above apply

d) an adult charged with overseeing the day-to-day supervision, care and wellbeing of the patient who is available and willing to make the decision; or

e) SACAT—where none of the above applies or with their permission——on application of:

- a prescribed relative of the patient; or
- the medical practitioner proposing to give the treatment; or
- any other person who SACAT is satisfied has a proper interest in the matter.

*A prescribed relative of the patient includes the following:

- A person who is legally married to the patient;
- An adult domestic partner of the patient;
- An adult related by blood or marriage;
- An adult related to the patient by reason of adoption;
- An adult related to the patient according to Aboriginal kinship rules or Torres Strait Islander kinship rules.

There is no hierarchy within the list of prescribed relatives.

Practitioners who comply with a patient's ACD, Substitute Decision-Maker, or Person Responsible, in good faith and without negligence are protected from liability.

As a routine part of the admissions process, the practitioner should document the identity and current contact details of the patient's Substitute Decision-Maker (when appointed in an ACD) or Person Responsible in the patient's medical record.

Systems and practices for collecting and recording Person Responsible or Substitute Decision-Maker information should undergo monitoring and evaluation through local quality improvement activities.

7.9 When should medical practitioners seek permission from SACAT to provide treatment under section 14(1)(e)(ii) of the Consent Act?

Where a patient doesn't have a person responsible available to consent on their behalf the medical practitioner proposing to provide the treatment may make an application to SACAT under section 14(1)(e)(ii) of the Consent Act to authorise the proposed treatment.

Applications of this nature are appropriate where an ongoing guardianship arrangement (and an application to SACAT for a guardian to be appointed) is not necessary in the circumstances. This could be in situations where the patient has impaired decision-making capacity that is likely to resolve after the treatment is provided. For example, where a patient is suffering from a UTI causing delirium. It could also be appropriate in situations where the medical practitioner believes a person responsible will become available, for example, a family member's contact details have been found and a voicemail has been left on their phone.

7.10 Advance Care Directives – Binding Refusals

A provision in an ACD that is a refusal of medical treatment or health care is a binding provision as provided at section 19 of the *Advance Care Directives Act 2013.*

Medical and health practitioners who do not comply with a binding refusal are in breach of the *Advance Care Directives Act 2013.* Act and may risk a complaint being made to the relevant health practitioner board for unprofessional conduct or be subject to criminal or civil liability for providing the medical treatment or health care without consent.

Exceptions to Binding Refusals:

Section 12(b) of the *Advance Care Directives Act 2013* provides that provisions of an ACD that refuse mandatory medical treatment are void. Mandatory medical treatments include treatments required under:

- a community treatment order, or an involuntary treatment order under the *Mental Health Act 2009*, or
- a court order.

In addition, health practitioners should be aware that if they reasonably suspect that a person has attempted suicide or self-harmed and they are of the opinion that the provision of health care is reasonably necessary to save the life of the person, they:

- may disregard a binding provision of an ACD.
- may, if authorised to do so under another Act such as the Consent Act, provide medical treatment or health care to the person despite the person's refusal of the medical treatment or health care in their advance care directive.
- may nevertheless decide to comply with the person's refusal of medical treatment or health care in their Advance Care Directive and not provide such health care to the person.

See the Advance Care Directives Policy.

7.11 *Guardianship and Administration Act 1993*—Mental incapacity

If a person does not have an ACD appointing a substitute decision-maker, or family or friends who can make, or assist them to make, decisions about medical treatment or health care under the Consent Act, a guardianship order may be needed.

The *Guardianship and Administration Act 1993* provides that SACAT may make guardianship orders for a person who has a "mental incapacity".

Section 3(1) defines mental incapacity as the inability of a person to look after their own health, safety or welfare or to manage their own affairs, as a result of:

- Any damage to, or any illness, disorder, imperfect or delayed development, impairment or deterioration of, the brain or mind (e.g. brain injury), or
- Any physical illness or condition that renders the person unable to communicate their intentions or wishes in any manner whatsoever (e.g. stroke victims).

Applications can be made to SACAT by the following parties (see section 33(1) of the *Guardianship and Administration Act 1993*)

- the patient
- the Public Advocate
- a guardian or substitute decision maker
- a person responsible
- the administrator of the estate
- a person responsible
- a person with a proper interest in the welfare of the person (including medical and health practitioners)

7.12 Treatment under the Mental Health Act 2009

Treatment under the *Mental Health Act 2009* is limited to treatment of a person's mental illness or any other illness that may be causing of contributing to the mental illness. Consent for treatment for illnesses that are not the mental illness or causing or contributing to the mental illness needs to be sought through the processes provided under the Consent Act and/or *Guardianship and Administration Act 1993* as discussed above.

7.12.1 Where a person cannot consent due to mental illness – Initial medical examination and care and control under section 56.

Initial medical examination of patient can be undertaken by a medical practitioner or authorised mental health professional to determine whether to make an order under the *Mental Health Act 2009* (refer to paragraph 7.13.2).

Section 56 - Care and Control:

Authorised officers (refer to paragraph 7.12.3 for information about authorised officers) may take a person into their care and control to transport them to a treatment centre or other place for medical examination under section 56 of the *Mental Health Act 2009*, where the person:

- appears to have a mental illness; and
- has caused or there is a significant risk of the person causing, harm to self, others, or property, or the person otherwise requires medical examination, or
- the person is subject of a patient assistance request under s 54A(1) of the *Mental Health Act 2009* or a patient transport request under s55(1) of the *Mental Health Act 2009* or an authorised officer believes the person is a patient who is absent without leave

An authorised officer may form an opinion about a person based on the officer's observations of the person's behaviour or appearance or reports about the person's behaviour, appearance, or history.

Section 56 allows authorised officers to:

- take a person into their care and control,

- transport a person,
- restrain a person and use force as reasonably required in the circumstances,
- restrain a person by administration of a drug where reasonably required (if authorised under the *Controlled Substances Act 1984*),
- enter and remain in a place where the authorised officer reasonably suspects the person may be found,
- search the person's clothing or possessions and take possession of anything in the person's possession that the person may use to cause harm self, others, or property.

Section 56(4)(c)(ii) requires authorised officers give the person who they take into their care and control a "*statement of rights*". Statements of rights are available on the Chief Psychiatrist's website.

Authorised officers and their powers are discussed in detail at paragraph 7.13.3.

See the *Section 56 – Care and Control Fact Sheet.*

Section 56 can only be used to facilitate examination by a medical practitioner or authorised mental health professional, not to provide medical treatment without consent (outside of the administration of physical restraint or chemical sedation).

Authorised Officers using section 56 powers are required to record details of the use of these powers in the patient's medical record in accordance with the Chief Psychiatrist's requirements as prescribed under section 58A(1) of the Mental Health Act 2009. Requirements include:

- times when power exercised and when ceased,
- if another Authorised Officer or Police Officer provided care, name and designation of the officer),
- reason for use of powers,
- observations or reports of the persons behaviour, appearance, or history,
- if care transferred, time transferred, and name of authorised officer or police officer.

An Authorised Officer who takes a person into their care and control should, as soon as practicable:

- In the case of a person who is subject to a Patient Assistance Request under section 54A of the *Mental Health Act 2009*, provide such assistance as reasonably required for the purpose of enabling or facilitating treatment,
- In the case of a person who is subject to a Patient Transfer Request, transport the person, or arrange for the transport of the person by some other Authorised Officer or police officer, in accordance with the request,
- In the case of a person who is subject to an inpatient treatment order and is absent without leave from an approved treatment centre, transport the person, or arrange for the transport of the person by some other Authorised Officer or police officer, to a treatment centre,
- In the case of a person who appears to have a mental illness and is at risk to themselves or others or property, transport the person, or arrange for the transport of the person by some other Authorised Officer or police officer, to a treatment centre or other place for medical examination and give the person a copy of their Statement of Rights (as approved by the Chief Psychiatrist), informing the person about their legal rights.

7.12.2 Treatment for a Mental Illness – Involuntary Treatment Orders

If upon initial assessment by the medical practitioner or an authorised mental health professional it appears that a person is suffering from a mental illness that requires treatment to protect the person or others from harm, the medical practitioner or authorised mental health professional may make either a community treatment order or an inpatient treatment order in accordance with Part 4 and Part 5 of the *Mental Health Act 2009*

Involuntary treatment orders (Part 4 of the *Mental Health Act 2009* provides for community treatment orders and Part 5 of the *Mental Health Act 2009* provides for the involuntary inpatient treatment orders) can be made by a medical practitioner or authorised mental health professional when:

- the person appears to have a mental illness; and
- because of the mental illness, the person requires treatment for the person's own protection from harm (including harm involved in the continuation or deterioration of the person's condition) or for the protection of others from harm; and
- the person has impaired decision-making capacity relating to appropriate treatment of the person's mental illness, and
- there is no less restrictive means than the particular treatment order of ensuring appropriate treatment of the person's illness.

Impaired decision-making capacity under the Mental Health Act 2009:

Impaired decision-making capacity is defined (under section 5A of the *Mental Health Act 2009*), as when the patient is not capable of—

- understanding information that may be relevant to the decision (including consequences of making the decision); or
- retaining such information; or
- using such information in the course of making the decision; or
- communicating their decision in any manner; or
- if the person has an advance care directive, the person has set out when they are to be considered to have impaired decision-making capacity and they have satisfied the requirements.

The patient will not be taken to be incapable of understanding or retaining information merely because they do not understand technical or trivial matters or because they can only retain the information for a limited time.

A patient's decision-making capacity may fluctuate between being capable and incapable.

A patient's decision-making capacity will not be taken to be impaired merely because a decision made by the person results or may result in an adverse outcome for the person.

In deciding whether there is no less restrictive means of treatment, the *Mental Health Act 2009* states consideration is to be given, amongst other things, to the prospects of the person receiving all treatment of the illness necessary for the protection of the person and others on a voluntary basis or on a community treatment order.

Schedule 1 of the *Mental Health Act 2009* lists certain types of conduct that may not indicate mental illness (refer to Appendix 1 for a copy of Schedule 1).

Inpatient Treatment Orders:

People who are subject to an inpatient treatment order are required to stay in the treatment centre and receive treatment for a mental illness, even if they do not want to.

They can only be treated for their mental illness or for any other illness that may be causing or contributing to the mental illness.

Medical treatment for other illnesses cannot be involuntarily administered under the *Mental Health Act 2009*. Practitioners will be required to go through the third-party consent process as described at paragraph 7.9 above.

Treatment centre staff may take measures for the confinement of a person subject to an inpatient treatment order and may use such force as is reasonably required in the circumstances, to treat the person according to the inpatient treatment order or to maintain order and security at the centre or to prevent harm or nuisance to others.

Level 1, 2, and 3 inpatient treatment orders:

When a level 1 inpatient treatment order is made:

- the patient needs to be examined by a psychiatrist or authorised medical practitioner within 24 hours of the order being made or, if it is not practicable for this examination to occur within 24 hours, it should occur as soon as practicable thereafter; and
- the psychiatrist or authorised medical practitioner may confirm or revoke the order; and
- the order, if confirmed, is for a period of no longer than 7 days. See section 21 of the *Mental Health Act 2009*.

If a level 1 inpatient treatment order has been made or confirmed by a psychiatrist or medical practitioner, a psychiatrist or authorised medical practitioner may, after further examination of the patient before the 7 day period expires, make a further order for the medical treatment of the patient as an inpatient in an approved treatment centre for a further 42 days. This is a Level 2 inpatient treatment order. See section 25 of the *Mental Health Act 2009*.

Section 29 of the *Mental Health Act 2009* provides that SACAT may make a further order that a person receive treatment as an inpatient in an approved treatment centre if satisfied that:

- the person has a mental illness; and
- because of the mental illness, the person requires medical treatment for the person's own protection from harm (including harm involved in the continuation or deterioration of the person's condition) or for the protection of others from harm; and
- there is no less restrictive means than an inpatient treatment order of ensuring appropriate medical treatment of the person's illness.

An order by SACAT is for a period of up to 12 months for an adult and 6 months for a child and can be revoked by SACAT at any time. This is a Level 3 inpatient treatment order. An application to SACAT for an order can be made by the Public Advocate, the director of an approved treatment centre or an employee in an approved treatment centre authorised by the director of the centre for the purpose.

Application forms are available from the SACAT website at: http://www.sacat.sa.gov.au/application-form.

7.12.3 Who is an authorised officer?

Authorised Officers are determined by section 3 of the *Mental Health Act 2009* to be:

- Mental health clinicians: The *Mental Health Act 2009* specifies that a mental health clinician means a person classified as such by the Chief Psychiatrist. The Chief Psychiatrist has issued a determination that classifies the following classes of persons as mental health clinicians for the purposes of the Act (provided they are employed in a public or private mental health service, and are Registered with the Australian Health Practitioner Regulation Agency; or for Social Workers—eligible for membership with the Australian Association of Social Workers).
    - Occupational Therapists,
    - Psychiatrists who are registered with the Royal Australian and New Zealand College of Psychiatrists,
    - Psychologists,

- Registered Nurses with mental health qualifications, and
- Social Workers,
- Ambulance officers
- Royal Flying Doctor Service medical officers or flight nurses
- A person, or a class of person approved by the Chief Psychiatrist by notice in the *Government Gazette* as described in the Chief Psychiatrists *Authorised Officers document*

Police officers, although separately empowered under the *Mental Health Act 2009*, have a range of powers similar to Authorised Officers, with the exception of not being able to administer medication and the addition of being able to use reasonable force to break into a place to take someone into care and control.

An authorised mental health professional is a person named by the Chief Psychiatrist, in the SA Government Gazette, to be an authorised mental health professional, under section 94(1) of the *Mental Health Act 2009* (e.g. their names are published in the Government Gazette by the Chief Psychiatrist).

7.12.4 Consent for Electro-Convulsive Therapy (ECT)

See the ECT Policy Guideline and the ECT Chief Psychiatrist Standard for detailed information about consent requirements in relation to ECT.

Section 42 of the *Mental Health Act 2009* provides specific consent requirements for administering electro-convulsive therapy (ECT).

The Advance Care Directives and Mental Health Treatment Orders Fact Sheet provides information about ACDs and consent for ECT.

7.12.5 Consent for Neurosurgery

In accordance with section 43 of the *Mental Health Act 2009* neurosurgery cannot be carried out on a patient as a treatment for mental illness unless:

- The patient has a mental illness; and
- The neurosurgery has been authorised for treatment of the illness by a person who is to carry it out and by 2 psychiatrists (at least 1 of whom is a senior psychiatrist), each of whom has examined the patient,; and
- The patient is over 16 years of age and written consent to the treatment has been given:
  - by the patient (if they have the Prescribed Psychiatric Treatment Panel decision-making capacity); or
  - if consent cannot be given by the patient, by SACAT.

7.13 SAAS Powers to use force to enter premises

Under section 61 of the *Health Care Act 2008* SAAS staff may use reasonable force to break into any place (in accordance with any SAAS protocols or procedures) if they believe it is necessary to:

- Determine whether a person is in need of medical assistance, or
- To provide a person with medical assistance (noting this does not allow for treatment without valid consent, third-party consent, or legal authority).

7.14 If a person cannot consent because of intoxication.

Is emergency treatment required?

Where the practitioner believes the high level of intoxication poses an imminent threat to life or health, a patient may be provided emergency medical treatment or health care. See paragraph 7.7 and 7.8.

Is the person suffering from a mental illness?

The consumption of drugs or alcohol does not, in and of itself, indicate that a person is suffering from a mental illness. Refer to appendix 1: *Mental Health Act 2009*, Schedule 1—certain conduct may not indicate mental illness.

However, a patient presenting with serious temporary or permanent physiological, biochemical or psychological effects from taking drugs or alcohol may be placed on an inpatient treatment order and treated in accordance with the *Mental Health Act 2009* if the effects of the drugs or alcohol are producing symptoms that appear to be symptoms of a mental illness.

7.15 Can the care and control provision under section 56 of the *Mental Health Act 2009* be used to restrain, transport, or assess people with substance use disorders and/or intoxication?

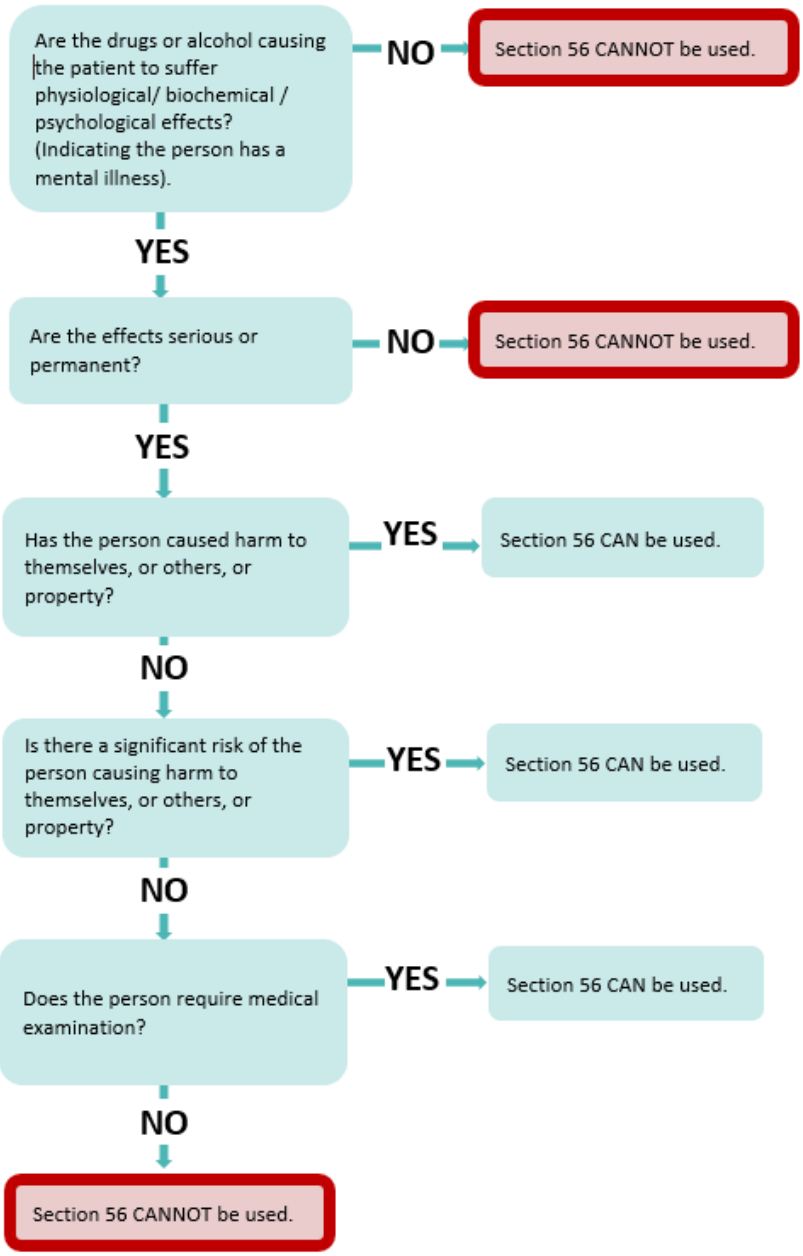
Substance use disorder or intoxication alone (without otherwise appearing to have a mental illness) do not allow for the use of section 56 of the *Mental Health Act 2009*.

The *Mental Health Act 2009* specifically states that “a person does not have a mental illness merely because the person takes or has taken alcohol or any other drug” but recognises that taking alcohol or any other drugs may cause serious or permanent effects that could be regarded as a mental illness.

Section 56 can only be used to transport or assess people with substance use disorders (SUD) and/or intoxication if the below criteria are met:

- the patient is suffering serious, or permanent, physiological, or biochemical, or psychological effects because of taking drug/s or alcohol (thus indicating the person has a mental illness) and,
- the patient has caused or is at significant risk of causing harm to self or others or property, or the person requires medical examination.

Figure 2: Flowchart for assessing whether section 56 can be used for patients with SUD or who are intoxicated:



The use of section 56 powers to restrain, transport, and assess a patient who is intoxicated or suffering from SUD is appropriate where the person meets the above thresholds.

See paragraph 7.12.3 in relation to the powers of authorised officers under section 56.

7.16 Dispute Resolution under the Consent Act and the ACD Act

Part 3A of the Consent Act legislates a dispute resolution scheme in relation to decisions administer or not administer medical treatment or health care to a person without decision-making capacity.

Part 7 of the ACD Act legislates a dispute resolution scheme in relation to the provision or medical treatment and/or health care to a person who has given an ACD and any decisions or proposed decisions under an ACD.

1. Local processes:

In the first instance steps to resolve the dispute should be undertaken consistent with LHN or local procedures. This could include:

- a case conference,
- a second medical opinion,
- referral to the Clinical Risk Manager/Divisional Director,
- referral to the Patient Care Ethics Committee.

2. Office of the Public Advocate:

If disputes regarding consent to medical treatment or health care or ACDs cannot be resolved at the local level, the Office of the Public Advocate (OPA) may assist with on-site advice or mediation, and can make declarations in respect of the operation of an ACD at:

- 1800 066 969 or email *opa@agd.sa.gov.au* (24/7 service)

3. SA Civil and Administrative Tribunal:

SACAT can review matters dealt with by the OPA and make declarations or directions in relation to the matter. SACAT usually only review or make a declaration if the Public Advocate has previously tried to resolve the matter or mediate the issue.

However, if the matter is urgent (there is a serious risk to the person or to others) the practitioner may contact SACAT directly to arrange an urgent hearing.

SACAT contact details are:

- 1800 723 767 or *sacat@sacat.sa.gov.au*

Further information is available at: Dispute resolution | Office of the Public Advocate (opa.sa.gov.au)

It is not appropriate for SACAT to be the first point of contact to resolve disputes. SACAT should be the last resort to assist in resolving disputes. Applications can be made to SACAT, or disputes can be referred to SACAT by the Office of the Public Advocate, on the grounds that it is more appropriate for the matter to be dealt with by SACAT, or if certain persons are dissatisfied with a decision by the Office of the Public Advocate.

If a decision cannot be made, or problems arise with decisions made under an ACD and/or by a Substitute Decision-Maker, or there are concerns about the decision of a Person Responsible, the wishes (whether expressed or implied) of the person who gave the ACD are of paramount importance and should, as far as is reasonably practicable, be given effect.

If required, advice can be sought through the Clinical Risk Management Team.

7.17 When can Restrictive Practices be used?

Where a patient has impaired decision-making capacity, is exhibiting challenging behaviours, and de-escalation techniques have limited or no effect, the use of restrictive practices may need to be considered to allow a more detailed assessment and medical treatment or health care to take place.

(Note the requirements for use of section 56 of the *Mental Health Act 2009* are that a patient appears to have a mental illness and is presenting a significant risk to themselves or others, not that they have impaired decision-making capacity, see paragraph 7.12.1 for further detail.)

Practitioners are required to report specified restrictive practices in SLS in accordance with the Minimising Restrictive Practice in Public Health Care Services Policy.

For information about restrictive practices and dealing with challenging behaviours refer to:

- Minimising Restrictive Practices in Public Health Care Services Policy
- Minimising Restrictive Practices in Public Health Care Services Clinical Guideline
- Preventing and Responding to Challenging Behaviour Policy

Third Party consent to restrictive practices for medical treatment or health care under the supervision of a health or medical practitioner:

Substitute Decision-Makers or Persons Responsible can consent to some very limited restrictive practices when they form part of health or medical treatment. Refer to the Minimising Restrictive Practices in Public Health Care Services Policy and Clinical Guideline for more information.

Carers cannot consent to the use of chemical restraint:

The *Consent to Medical Treatment and Palliative Care Regulations 2014* specify that a person who is charged with overseeing the ongoing day-to-day supervision, care and wellbeing of a patient (paragraph (d) of the definition of Person Responsible in section 14(1) of the Consent Act) cannot consent to or authorise the administration of drugs for the purpose of controlling the behaviour of the patient (chemical restraint).

Legal authority to use restrictive practices is contained in the:

- *Mental Health Act 2009*:
  - Section 56 provides care and control powers which can be used by Authorised Officers (or Police Officers).
  - If a patient is subject to an Inpatient Treatment Order then treatment centre staff may use section 34 and 34A care and control powers.
- *Guardianship and Administration Act 1993*:
  - A substitute decision-maker, guardian or applicant for guardianship can apply to SACAT for special powers (under s 32 of the *Guardianship and Administration Act 1993*) which can:
    - Direct someone to live in a particular place.
    - Authorise someone to be detained in a particular place.
    - Authorise the use of force so that medical or dental treatment can be provided.
  - Special powers orders can only be made if there is a risk to the health or safety of the person or the safety of others would be seriously at risk.
    - A Person Responsible (not including an appointed guardian or SACAT) cannot apply to SACAT for extra powers without first (or at the same time) applying to be appointed as a guardian of the patient.
    - Following an order from SACAT, if a Substitute Decision-Maker appointed under an ACD, or a guardian, or medical practitioner, is uncertain of what restrictive practices can be consented to under that order, they should be advised to contact the Office of the Public Advocate.
    - When acting in anticipation of guardianship orders, it is vital that the health practitioner ensures that the medical records of the patient reflect the issues and support the decision to seek special powers to use restrictive practices under section 32 of the *Guardianship and Administration Act 1993*, and that this is formally supported (with notes signed) by another medical practitioner and is clearly documented in the patient's medical record.

- More information can be found on the SACAT website at the following link: Special powers | South Australian Civil and Administrative Tribunal (sacat.sa.gov.au).
- Non urgent applications to SACAT should be in writing and will be considered by SACAT before a hearing. Applications can be made:
  1) online at the following link: MCMS OLS (sacat.sa.gov.au)
  2) over the phone 1800 723 767
  3) in person in the Adelaide CBD: Level 4, 100 Pirie Street, Adelaide, 5000.
- Urgent applications to SACAT can be made over the phone on 1800 066 969.

> *South Australian Public Health Act 2011*

- Under section 73 - 75, and 77 the use of reasonable force is allowed in certain circumstances to facilitate medical procedures.

> *Disability Inclusion Act 2018*

- Part 6A establishes an authorisation scheme for restrictive practices by registered NDIS providers for NDIS participants.
- An SA Health provider that is a registered NDIS provider may use restrictive practices under this scheme provided they register with the Restrictive Practices Authorisation scheme and nominate the proposed Authorised Program Officer (APO). The APO or the senior authorising officer will review applications and make decisions about use of restrictive practices.
- All decisions under the Restrictive Practices Authorisation scheme are required to be recorded in the Department for Human Services Restrictive Practices Unit's restrictive practices system (RPS) which is an online platform available to registered organisations.
- Further information is available at SA.GOV.AU - Restrictive Practices Authorisation scheme (www.sa.gov.au)
- Unauthorised use of restrictive practices not in accordance with a behaviour support plan is a serious reportable incident. See the Clinical Incident Management Policy .

Use of Restrictive Practices without direct legal authority:

Circumstances may arise where practitioners need to use restrictive practices without express legal authority (e.g. before a section 32 guardianship order with special powers is granted, in an emergency where medical treatment is required to prevent death or permanent harm). Refer to the *Minimising Restrictive Practices in Public Health Care Services Clinical Guideline* for further information.

7.18 Treatments that third parties cannot consent to – Prescribed treatments.

Prescribed treatments under the *Guardianship and Administration Act 1993*:

Medical practitioners cannot provide the following treatments to patients without decision-making capacity, without the consent of SACAT. The Consent Act does not apply in relation to third party consent for (except in circumstances where emergency treatment is required):

> Sterilisation
> Termination of pregnancy

Prescribed psychiatric treatments under the *Mental Health Act 2009*:

Sections 42 and 43 of the *Mental Health Act 2009*provide detail about the requirements for carrying out the below treatments.

- Electroconvulsive therapy (ECT) (refer to paragraph 7.13.4)
- Neurosurgery for mental illness (refer to paragraph 7.13.5)

7.19 Pain relief for persons unable to consent

Substitute Decision-Makers and Persons Responsible cannot refuse the administration of drugs to relieve pain or distress.

Where there is no one available to consent on behalf of the patient the medical practitioner will need to seek an urgent guardianship order from SACAT. Refer to paragraph 7.12.

CASE STUDY

A patient with advanced metastatic cancer in a Palliative Care Unit without any Persons Responsible deteriorates over the weekend due to cerebral bleed associated with his disease. The patient does not have decision-making capacity. The treating medical team need to administer pain relief as part of end-of-life care.

Medical practitioners should contact the OPA and SACAT to seek an urgent guardianship order.

In these circumstances pain relief can also be provided as part of emergency treatment under section 13 of the Consent Act, provided that the patient is incapable of consenting and the medical practitioner who administers the treatment is of the opinion that the treatment is necessary to meet an imminent risk to life or health. This opinion should be supported by another medical practitioner who has personally examined the patient if practicable.

7.20 Civil claims regarding alleged unlawful health or medical treatment, detainment, or other restrictive practices

See paragraph 5.30 Indemnity.

7.21 Criminal proceedings regarding alleged unlawful imprisonment or assault

See paragraph 5.31.

7.22 Disciplinary Proceedings by a Professional Body/Statutory Authority

Medical and health practitioners are entitled to seek their own legal and/or industrial representation in the case of any disciplinary proceedings.

As with medical malpractice, disciplinary proceedings in relation to false imprisonment and assault will not be covered by the Department for Health and Wellbeing. Refer to the Guidelines for the Department for health and Wellbeing Professional Indemnity (Medical Malpractice) Program.

7.23 Where to get further information and advice

If an employee requires further information or advice they are encouraged to contact their Local Health Network Clinical Risk Managers in the first instance.

Further information on consent matters can be obtained from the Office of the Public Advocate (Internet site: *www.opa.sa.gov.au*),

8. Supporting information

Advance Care Directives Act 2013

Advance Care Directives and Mental Health Treatment Orders Fact Sheet

Advance Care Directives Policy

Australian Commission on Safety and Quality in Health Care - Informed Consent Fact Sheet

Child harm – identifying and responding where medical neglect or fabricated or induced illness is suspected Policy Guideline

Child Safe Environments (Child Protection) Policy

Children and Young People (Safety) Act 2017

Collection of Forensic Blood for Drug and Alcohol Testing Policy

Consent to Medical Treatment and Healthcare flowchart

Consent to Medical Treatment and Palliative Care Act 1995

Crown Solicitor's Office - Legal Bulletin 5

Department for Child Protection's – Who can say OK?

ECT Chief Psychiatrist Standard

ECT Policy Guideline

Guardianship and Administration Act 1993

Guidelines for the Department for Health and Wellbeing Professional Indemnity (Medical Malpractice) Program

Impaired Decision-Making Fact Sheet

Mandatory Reporting of Suspicion that a Child or Young Person is or may be at Risk Policy

Mental Health Act 2009

Mental Health Act 2009 - Authorised Officers

Minimising Restrictive Practices in Public Health Care Services Clinical Guideline

Minimising Restrictive Practices in Public Health Care Services Policy

Office of the Public Advocate Fact Sheet – Consent to Medical Treatment

People in Custody – Care and Treatment in Public Hospitals and Health Care Services Policy

Preventing and Responding to Challenging Behaviour Policy

Privacy policy

Research Ethics and Governance Policy

Section 56 – Care and Control Fact Sheet

Surrogacy in SA Public Health Services Patient Information Brochure

South Australian Interpreting and Translating Policy

South Australian Public Health Act 2011

Voluntary Assisted Dying Policy

Who can Consent? poster

9. Definitions

- **Ambulance Clinician**: means all clinical levels including assist, ambulance responder, ambulance officer, paramedic, Intensive care paramedic, extended care paramedic, paramedic telehealth clinician.
- **Chemical restraint:** means the use of medication or chemical substance for the primary purpose of influencing a person's behaviour. It does not include the use of medication prescribed by a medical practitioner for the treatment of, or to enable treatment of, a diagnosed mental disorder, a physical illness, or a physical condition**.**
- **Disciplinary proceedings:** means internal proceedings, disciplinary proceedings of a National Board and the Australian Health Practitioner Regulation Authority (AHPRA), and/or investigation and actions under the *Health and Community Services Complaints Act 2004*
- **Environmental restraint:** means a practice or intervention that restricts or involves restricting a person's free access to all parts of their environment, including items or activities, for the purpose of influencing their behaviour.
- **Guardian**: means a person acting or appointed under any Act or law as the guardian of another.
- **Health practitioner:** means all individuals practicing a health profession within the meaning of the *Health Practitioner Regulation National Law (South Australia) Act 2010* and any other health professional with direct or indirect clinical contact who are credentialed by the relevant health service within SA Health.
- **Health care:** means any care, service, procedure or treatment provided by, or under the supervision of, a health practitioner for the purpose of diagnosing, maintaining or treating a physical or mental condition of a person.
- **Mechanical restraint:** means the use of device to prevent, restrict, or subdue a person's movement for the primary purpose of influencing the person's behaviour but does not include the use of devices for therapeutic or noon-behavioural purposes.
- **Medical practitioner:** means a person who is registered under the *Health Practitioner Regulations National Law (South Australia) Act 2010* in the medical profession.
- **Medical record:** means the composition of all information collected about a consumer during interactions with the health system (also known as the health record). A medical record applies to both paper-based records, electronic recording systems and a hybrid of both.
- **Medical treatment**: means the provision by a medical practitioner of physical, surgical or psychological therapy to a person (including the provision of such therapy for the purposes of preventing disease, restoring or replacing bodily function in the face of disease or injury or improving comfort and quality of life) and includes the prescription or supply of drugs.
- **Person Responsible:** means a person responsible for a patient as defined under section 14 of the *Consent to Medical Treatment and Palliative Care Act 1995* and in the following legal hierarchy:
    1. a guardian
    2. a prescribed relative (being a person who is legally married to the patient, an adult domestic partner, an adult related by blood or marriage, a relation by adoption, an adult of aboriginal or Torres Strait Islander descent who is related to the patient according to kinship rules)
    3. an adult friend with a close and continuing relationship with the patient
    4. an adult who is charged with overseeing the ongoing day-to-day supervision care and wellbeing of the patient
    5. the South Australian Civil and Administrative Tribunal on application of a prescribed relative, the medical practitioner proposing to provide treatment or any other person who the Tribunal is satisfied has a proper interest in the matter.

- **Physical restraint:** means the use or action of physical force to prevent, restrict or subdue movement of a person's body, or part of their body, for the primary purpose of influencing their behaviour. Physical restraint does not include the use of a hands-on technique in a reflexive way to guide or redirect a person away from potential harm or injury, consistent with what could reasonably be considered the exercise of care towards a person.
- **State-wide services**: means State-wide Clinical Support Services, Prison Health, SA Dental Service, BreastScreen SA and any other state-wide services that fall under the governance of the Local Health Networks.
- **Substitute decision-maker:** means a substitute decision-maker appointed in an advance care directive under the *Advance Care Directives Act 2013*.

10. Document ownership

Guideline owner: Domain Custodian for the Legal and Governance Policy Domain

Title: Consent Guideline

Objective reference number: A4162028

Review date: 29/03/2029

Contact for enquiries: healthpolicylegislation@sa.gov.au

11. Document history

Version	Date approved	Approved by	Amendment notes
1.0	28/03/2024	Chief Executive, DHW	Replaces the Providing medical assessment and/or treatment where patient consent cannot be obtained Policy Directive in accordance with the requirements of the SA Health Policy Framework.

Appendix 1 – Schedule 1 of the Mental Health Act 2009 – Certain conduct may not indicate mental illness.

Schedule 1—Certain conduct may not indicate mental illness

A person does not have a mental illness merely because of any 1 or more of the following:

(a) the person expresses or refuses or fails to express, or has expressed or refused or failed to express, a particular political opinion or belief;

(b) the person expresses or refuses or fails to express, or has expressed or refused or failed to express, a particular religious opinion or belief;

(c) the person expresses or refuses or fails to express, or has expressed or refused or failed to express, a particular philosophy;

(d) the person expresses or refuses or fails to express, or has expressed or refused or failed to express, a particular sexual preference or sexual orientation;

(e) the person engages in or refuses or fails to engage in, or has engaged in or refused or failed to engage in, a particular political activity;

(f) the person engages in or refuses or fails to engage in, or has engaged in or refused or failed to engage in, a particular religious activity;

(g) the person engages in or has engaged in a particular sexual activity or sexual promiscuity;

(h) the person engages in or has engaged in immoral conduct;

(i) the person engages in or has engaged in illegal conduct;

(j) the person has developmental disability of mind;

(k) the person takes or has taken alcohol or any other drug;

(l) the person engages in or has engaged in anti-social behaviour;

(m) the person has a particular economic or social status or is a member of a particular cultural or racial group.

However, nothing prevents, in relation to a person who takes or has taken alcohol or any other drug, the serious or permanent physiological, biochemical or psychological effects of drug taking from being regarded as an indication that a person is suffering from mental illness.

References

[i] (Marion's case) Secretary, Department of Health & Community Services v JWB and SMB (1992) 175 CLR 218 at 240, 278, 295 and 316.

[ii] Marion's Case at 240, 249-50, 252-3.

[iii] *Guardianship and Administration Act 1993* s61.

[iv] In the Marriage of GWW and CMW (1997) 21 Fam LR 612; *Transplantation and Anatomy Act 1983* s13.

[v] *Mental Health Act 2009* s42. and 43.

[vi] Case law re in loco parentis – Nash v Commissioner for Railways; Hunt v National & General Insurance Co Ltd [1974] Qd R 157 at 158; Re Schneider and Secretary to the Department of Social Security (1966 ASSC 92-085.

[vii] See for example Re C (a minor) (medical treatment) [1998] 1 FLR 384; and Re J (a minor) (wardship: medical treatment) [1991] 2 WLR 140.

[viii] Women's and Children's Health Network Inc. v M, CN & Ors (2013) SASC 16 [15], Women's and Children's Health Network Inc v JC, JC, and KC (by her litigation guardiuan) (2012) SASC 104, [33]; Children, Youth & Women's Health Services Inc v YJL, MHL and TL (by his next friend) (2010) SASC 175, [38].