HCASA
Health Consumers Alliance of SA Inc

Consumers at the centre of health in South Australia

Forum Report on the draft Consent to Medical Treatment and Palliative Care Amendment Bill

Thursday 21 September 2017, 1.00-3.00pm

Health Consumers Alliance of SA Inc

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Executive Summary

Health Consumers Alliance of SA Inc (HCA) hosted a forum on the draft Consent to Medical Treatment and Palliative Care Amendment Bill on Thursday 21 September 2017, from 1.00 – 3.00pm. Ten people participated.

The objective of the forum was to gain consumer feedback on the draft Bill.

Ellen Kerrins, Acting Chief Executive HCA, welcomed participants and outlined the forum program.

Lee Wightman, Manager Policy and Legislation, Department for Health and Ageing, presented background on the Act and why the Bill was developed.

The main themes to emerge from the forum were firstly, participants are pleased work is being done on the Consent to Medical Treatment and Palliative Care Amendment Bill, because it allows the Mental Health Act to be used properly and applied only to people with diagnosed mental illness.

Participants indicated that it needs to be clear to clinicians that patients need regular assessment of their decision-making capacity after they have been restrained. Health providers do not have a full 24 hours to restrain or treat without consent, but only until the patient regains decision-making capacity or up to 24 hours, whichever is the lesser.

Consideration for the safety of health service staff was also a priority for the forum participants, who suggested a process be developed for restraint prior to assessment, where it is deemed unsafe for a clinician to undertake an assessment due to violent or threatening behaviour.

Forum participants were clear that the Bill should direct that the "least restrictive practice" should be used.

Participants also identified that clarification is needed in relation to:

- who can undertake assessment of decision-making capacity.
- who can restrain and treat people identified as having reduced decision-making capacity and can these rights be delegated to other staff or other services.
- the process where more than one 24-hour period is required (on weekends).
- the rights and responsibilities of next of kin, the family or carer when a person is assessed as having impaired decision-making capacity.

Recommendations

It is recommended that:

1. this report is provided to SA Health for consideration.
2. that the Amendment Bill and associated guidelines address:
    - the use of minimal restraint.
    - the procedures for working with patients needing more than 24 hours over a weekend period.
    - a process for restraint prior to assessment, where it is deemed unsafe for a clinician to undertake an assessment.
    - training for clinicians to ensure they have a good understanding of assessment of capacity and the guidelines, in order to comply with the Act.

1. Introduction

Health Consumers Alliance of SA Inc (HCA) hosted a Forum on the draft Consent to Medical Treatment and Palliative Care Amendment Bill on Thursday 21 September 2017, with the objective of gaining consumer feedback on the draft Bill.

Ellen Kerrins, Acting Chief Executive, HCA, welcomed forum participants and introduced Lee Wightman, Manager Policy and Legislation, Department for Health and Ageing, who presented the background on the Act and why it is being developed.

Kathy Mickan, Manager Consumer Engagement, HCA, led the participants in round table discussions addressing their thoughts on the draft Bill, including:

Is the Bill balanced in protecting people's rights?

Is anything missing?

Do you have any other comments?

Forum participants

2. Background

The Consent to Medical Treatment Act (Consent Act) provides a definition of impaired decision-making, and sets out who can provide consent. It specifically addresses consent for emergency treatment and treatment of children. The Act provides for the resolution of disputes, reviews and appeals, among other matters.

One problem of the Consent Act is that it does not provide an express power for restrictive practices to be used. There are people using the health system that display challenging behaviours due to delirium caused by intoxication, infection or other factors of unknown cause. Health professionals are sometimes required to restrain the person to prevent harm to themselves or others. This potentially exposes them to legal action, as there is no provision for restrictive practice in the Act.

The draft Consent to Medical Treatment and Palliative Care Amendment Bill aims to provide 'authorised persons' with an express power to use restrictive practices when:

- the patient is displaying behaviour that constitutes a risk of harm; and
- the patient has impaired decision-making capacity; and
- the use of restrictive practices is necessary to prevent the risk of harm or prevent further harm; or
- to enable a medical assessment or examination to be undertaken.

Treatment may be provided for the conditions underlying the risk of harm and injuries arising from the harm in order to reduce the risk of further harm. This would include treatments such as managing an infection or dressing serious wounds.

Treatment and the restrictive practices may continue as long as is reasonably necessary or for up to 24 hours, whichever is the lesser.

Protections for patients would include providing patients with the statement of rights, publishing guidelines under clause 14G of the draft Bill and recording of all use of restrictive practices. After 24 hours, if restrictive practices and treatment are required, an application must be made to South Australian Civil and Administrative Tribunal (SACAT) for a guardianship order and special powers under s32 of the *Guardianship and Administration Act 1993* (the GAA Act) if necessary.

3. Forum Presentations

Lee Wightman, Manager Policy and Legislation, Department for Health and Ageing, presented background on the Act and why the draft Bill was developed. She detailed the draft Bill and what treatment and protections would look like under the new Bill.

Presentation by Lee Wightman on behalf of the Department for Health and Ageing

4. Panel Discussion

Kathy Mickan, Manager Consumer Engagement, HCA, then invited the participants to engage in round table discussions addressing their thoughts on the draft Bill, including:

Is the Bill balanced in protecting people's rights?

Is anything missing?

Do you have any other comments?

Key points from the discussions were recorded at each table, and reported back to the whole group at the conclusion of the forum.

Forum participants

5. Emerging Themes

The main themes to emerge from the forum were firstly, participants are really pleased work is being done on the Consent to Medical Treatment and Palliative Care Amendment Bill, because it allows the Mental Health Act to be used properly and applied only to people with diagnosed mental illness.

Participants indicated that it needs to be clear to clinicians that patients need regular assessment of their decision-making capacity after they have been restrained. Health providers do not have a full 24 hours to restrain or treat without consent, but only until the patient regains decision-making capacity or up to 24 hours, whichever is the lesser.

Consideration for the safety of health service staff was also a priority for the forum participants, who suggested a process be developed for restraint prior to assessment, where it is deemed unsafe for a clinician to undertake an assessment due to violent or threatening behaviour.

Forum participants were clear that the Bill should direct that the "least restrictive practice" should be used.

Participants also identified that clarification is needed in relation to:

- who can undertake assessment of decision-making capacity.
- who can restrain and treat people identified as having reduced decision-making capacity and can these rights be delegated to other staff or other services.
- the process where more than one 24-hour period is required (on weekends).
- the rights and responsibilities of next of kin, the family or carer when a person is assessed as having impaired decision-making capacity.

6. Conclusion

Forum participants were pleased work is being done on the Consent to Medical Treatment and Palliative Care Amendment Bill through the draft Amendment Bill because it allows the Mental Health Act to be used properly and applied only to people with diagnosed mental illness. They understand the need for restrictive practices to be used from time to time, when patients present a risk to themselves or others and when mental illness is not a factor. They agree that the Bill provides protections for patients and health workers.

The detail of the Bill and its implementation were of particular interest to forum participants who were clear that health professionals are, or should be trained to ensure they understand decision-making capacity, and that patients need regular assessment of decision-making capacity after they have been restrained. The right to use restrictive practice and treat is for a maximum of 24 hours or until the patient regains decision-making capacity, whichever is the lesser.

Further clarity around who has rights to assess, detain or provide treatment, as well the rights and responsibilities of family members, is needed.

Appendix One: Round table discussion notes

Tell us your thoughts on the draft Consent to Medical Treatment and Palliative Care Amendment Bill.

Is the Bill balanced in protecting people's rights?

- The Act should say "least restrictive practices" Have it as a guideline in the Act or a principle in the Act.
- There is a need to treat without consent, but do we need to have appropriate processes in place and ensure these processes are properly followed?
- The 24-hour limit does not properly fill the gap in getting the s32 of the GAA Act put in place. A second period would be reasonable provided there were appropriate safeguards. How does this work in remote areas where getting hold of doctors is difficult, provided there is a second, may not need a second independent doctor?
- Protections seem ok.
- Concern there may be an element of 'creep' with the authority to restrain.
- Non-understanding by clinicians of capacity, and how to assess capacity (good opportunity to educate).
- Put the decision-making test for capacity on the form.
- Needs resources for education.
- Adding in stricter provisions explaining the reliance on the lack of capacity.

Is anything missing?

- Make sure S32 of GAA Act interacts appropriately with the amendments.
- The meaning of restraint differs depending on the clinical circumstances.
- The guidelines need to be specific and the Act needs to support this.
- What are the rules around medical practitioners authorising others to provide restrictive practices or treatment?
- Can they authorise over the phone? Do they have to sight the patient?
- Who needs to do the assessment? It would be good to have this explicitly clarified in the Bill.
- Are 'authorised officers' broad enough to allow everyone who needs to exercise restraint? eg ambulance officers.
- Do we need to distinguish the need for restraint, the decision to restrain, who does the restraint, and the type of restraint? Is this needed in the Act?
- Is there a need to provide for immediate power to restrain before assessment and evaluation?
- Add to clause 14J 6 (c) of the draft Bill 'and while decision-making capacity is not there.'
- Impaired decision-making or risk of harm persist.
- Check up/ debrief patients after seclusion or restraint to minimise trauma.
- Test of reasonable assessment of capacity.

Other comments

- Need processes to manage the handover of information – eg transfer between departments or from aged care facilities (relevant to power to make and order is providing power?) This may not need to be in the Act but in guidelines – when does the restraint start?
- Pleased to see this is being done.
- Clause 14J and 14K – reads as if the medical practitioner only can administer treatment – can this be delegated to nurses etc? At the moment it reads as if the Authorised Officer is the only one able to use the restrictive practices – it does not say or specify that they can authorise. Clause 14J (8) may answer this but it may need to be clarified to ensure restrictive practices can be authorised and what needs to happen to authorise.
- Offers the opportunity to use the mental health act properly.
- Emergency Departments need to be able to deal with challenging behaviours.
- What happens when people are regularly presenting in this situation? Need prevention or management strategies.
- Protections "reasonable" what does that mean for clinicians? Is there a legal determination of reasonable in assessing a patient's capacity?
- What are the rights of family carers where their family member is assessed as having impaired decision-making capacity? Would like to avoid the situation where families are asked for information but not given information about their family member's condition or treatment, but are then given responsibility for taking over care on discharge.
- Really good that this is being done.

Appendix 2: Draft Consent to Medical Treatment and Palliative Care (Restrictive Practices) Amendment Bill 2017

Consent to Medical Treatment and Palliative Care (Restrictive Practices) Amendment Bill 2017

A BILL FOR

An Act to amend the *Consent to Medical Treatment and Palliative Care Act 1995*.

Contents

The Parliament of South Australia enacts as follows:

Part 1—Preliminary

1—Short title

This Act may be cited as the *Consent to Medical Treatment and Palliative Care (Restrictive Practices) Amendment Act 2017*.

2—Commencement

This Act will come into operation on a day to be fixed by proclamation.

3—Amendment provisions

In this Act, a provision under a heading referring to the amendment of a specified Act amends the Act so specified.

Part 2—Amendment of *Consent to Medical Treatment and Palliative Care Act 1995*

4—Amendment of section 4—Interpretation

Section 4(1)—after the definition of ***representative*** insert:

restrictive practices—see section 14H;

5—Insertion of Part 2B

After section 14D insert:

Part 2B—Restrictive practices

14E—Interpretation

(1) In this Part—

authorised person means a person authorised to use restrictive practices under section 14I;

risk of harm—see subsection (2);

use of restrictive practices or to ***use restrictive practices*** means the use of restrictive practices in accordance with the requirements of this Part.

(2) For the purposes of this Part, a reference to behaviour of a person that constitutes a ***risk of harm*** will be taken to be a reference to any of the following behaviours, or any combination of the following behaviours:

(a) the use of force against another person, or a direct or implied threat that force will be used against another person;

(b) self-harm, or a direct or implied threat of self-harm;

(c) behaviour that substantially increases the likelihood that physical or mental harm will be caused to the person or to

any other person (whether intentionally or unintentionally);

(d) damage to the property of another person or body, or direct or implied threats to damage such property;

(e) any other behaviour of a kind prescribed by the regulations.

(3) For the purposes of this Part, a reference to a ***medical practitioner*** will be taken not to include a reference to a dentist.

14F—Application of Part

(1) This Part is in addition to, and does not derogate from, the *Mental Health Act 2009*.

(2) Nothing in this Part limits the operation of the *Controlled Substances Act 1984* (and, in particular, a drug may only be administered in the course of a restrictive practice or administration of medical treatment by a person authorised to do so in accordance with that Act).

14G—Minister to publish guidelines

(1) The Minister must, by notice in the Gazette, publish guidelines for the purposes of this Part.

(2) The Minister may, by subsequent notice in the Gazette, vary, substitute or revoke guidelines published under subsection (1).

(3) The Minister must cause guidelines published under subsection (1) to be published on a website determined by the Minister.

14H—Restrictive practices

(1) For the purposes of this Part, a reference to ***restrictive practices*** will be taken to be a reference to any of the following (or a combination of any of the following):

(a) the use of physical, mechanical or chemical to restrain or sedate a person;

(b) the confinement of a person in an area from which the person cannot leave of the person's own volition;

(c) the seclusion of a person on their own in an area from which the person cannot leave of the person's own volition;

(d) the transportation of a person from place to place;

(e) any other act or omission of a kind prescribed by the regulations,

in each case being an act or omission done without the consent of the person.

(2) For the purposes of this Part, an act or omission used as a restrictive practice will be taken not to constitute medical treatment (whether or not the act or omission also has a therapeutic effect).

14I—Persons authorised to use restrictive practices

(1) For the purposes of this Part, the following persons are authorised to use restrictive practices:

(a) medical practitioners;

(b) any other person, or a person of a class, authorised by the Minister for the purposes of this Part.

(2) An authorisation under subsection (1)(b)—

(a) must be by instrument in writing;

(b) may be conditional or unconditional;

(c) has effect for—

(i) if a period is specified in the instrument of authorisation—that period; or

(ii) if no such period is specified—until it is revoked under this section.

(3) The Minister may, by notice in writing, vary or revoke an authorisation under subsection (1)(b).

14J—Use of restrictive practices authorised in certain circumstances

(1) Subject to this section, an authorised person may use restrictive practices in relation to a person (the ***patient***) if the authorised person believes on reasonable grounds that—

(a) the patient is displaying behaviour that constitutes a risk of harm; and

(b) the patient has impaired decision-making capacity in respect of—

(i) a decision to submit to any medical assessment or examination that the authorised person considers reasonably necessary; or

(ii) a decision to consent to the administration of any medical treatment that may, in the opinion of the authorised person, be reasonably required as a consequence of, or that relates to, the behaviour that constitutes a risk of harm; and

(c) the use of restrictive practices is necessary—

(i) to minimise the risk of harm, or to prevent further harm from being caused; or

(ii) to enable a medical assessment or examination of the patient to be undertaken.

(2) An authorised person must, in using restrictive practices, comply with the guidelines published under section 14G.

(3) An authorised person may, in the relation to the use of restrictive practices in relation to a patient—

(a) enter and remain in a place where the authorised person reasonably suspects the patient may be found;

(b) search the patient's clothing or possessions and take possession of anything in the patient's possession that the patient may use to cause harm to themself or others, or to damage property;

(c) retain anything so taken from the possession of the patient for as long as is necessary for reasons of safety (and then return the thing to the patient or otherwise deal with the thing according to law).

(4) To avoid doubt, an authorised person may use restrictive practices in relation to a patient—

(a) without the consent of the patient; or

(b) despite a refusal of the patient to consent to the use of restrictive practices.

(5) To avoid doubt, an authorised person may use restrictive practices in relation to a patient who is a child.

(6) Subject to section 14K(3), restrictive practices may be used in relation to a patient—

(a) for as long as is reasonably necessary to enable or facilitate the medical assessment or examination of the patient; or

(b) for a period of 24 hours,

whichever is the lesser.

(7) An authorised person who uses restrictive practices in relation to a patient must cause a written notice setting out the information required by the regulations to be given to the patient.

(8) An authorised person may be assisted in the use of restrictive practices by such other persons as the authorised person thinks fit.

(9) Nothing in this section authorises the use of restrictive practices—

(a) as a punishment or for the convenience of others; or

(b) to address inadequate levels of staffing, equipment or facilities.

14K—Medical treatment may be provided without consent in certain circumstances

(1) Despite any other provision of this Act, or any other Act or law, a medical practitioner may lawfully administer medical treatment (not being prescribed treatment) to a person (the ***patient***) without consent if—

(a) restrictive practices are being used in relation to the patient in accordance with section 14J; and

(b) either—

(i) the medical treatment is reasonably necessary to treat an injury arising out of the behaviour constituting the risk of harm to which the use of restrictive practices relates; or

(ii) the medical practitioner believes on reasonable grounds that—

(A) the risk of harm to which the use of restrictive practices relates is wholly or partly caused by a particular medical condition or conditions; and

(B) the treatment of the medical condition or conditions is reasonably necessary to minimise the risk of harm, or to prevent further harm from being caused; and

(c) the patient has impaired decision-making capacity in respect of a decision to consent to the administration of such medical treatment.

(2) To avoid doubt, subsection (1) applies—

(a) whether the patient is a child or is of or over 16 years of age;

(b) whether or not the patient has given an advance care directive;

(c) whether or not a substitute decision-maker, guardian or person responsible for the patient has been appointed or is available;

(d) whether or not the patient, or a substitute decision-maker, guardian or person responsible for the patient, has refused consent to the proposed medical treatment.

(3) A medical practitioner proposing to administer medical treatment to a patient under this section may continue to use restrictive practices in relation to the patient—

(a) for as long as is reasonably necessary to enable the medical treatment to be administered; or

(b) for a period of 24 hours,

whichever is the lesser.

(4) A medical practitioner must, in relation to the administration of medical treatment to a patient under this section, comply with the guidelines published under section 14G.

(5) A medical practitioner who administers medical treatment to a patient under this section must cause a written notice setting out the information required by the regulations to be given to the patient.

(6) In this section—

medical condition includes intoxication by a drug or alcohol or both;

prescribed psychiatric treatment means—

(a) prescribed psychiatric treatment within the meaning of the *Mental Health Act 2009*; and

(b) any other treatment of a kind prescribed by the regulations;

prescribed treatment means—

(a) prescribed psychiatric treatment; or

(b) prescribed treatment within the meaning of the *Guardianship and Administration Act 1993*.

14L—Limitation of liability

(1) An authorised person, or a person assisting an authorised person, incurs no civil or criminal liability for an act or omission relating to the use of restrictive practices (being an act or omission done or made in good faith and without negligence).

(2) A medical practitioner who administers medical treatment to a patient in accordance with section 14K, 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) in accordance with that section; and

(b) in good faith and without negligence; and

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

14M—Offence to hinder or obstruct authorised person

A person who hinders or obstructs an authorised person in relation to the use of restrictive practices is guilty of an offence.

Maximum penalty: $25 000.

14N—Reporting

(1) An authorised person who uses restrictive practices in relation to a patient must make such records as may be required by the regulations.

Maximum penalty: $25 000.

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Prepared by Parliamentary Counsel

(2) An authorised person must keep the records referred to in subsection (1) in accordance with the requirements set out in the regulations.

Maximum penalty: $25 000.

Part 1—Amendment of *Advance Care Directives Act 2013*

1—Amendment of section 12—Provisions that cannot be included in advance care directives

Section 12(1)—after paragraph (b) insert:

(ba) a provision that comprises a refusal of medical treatment forming part of a restrictive practice used in accordance with Part 2B of the *Consent to Medical Treatment and Palliative Care Act 1995*;