

ACT  
Mental Health  
Consumer Network

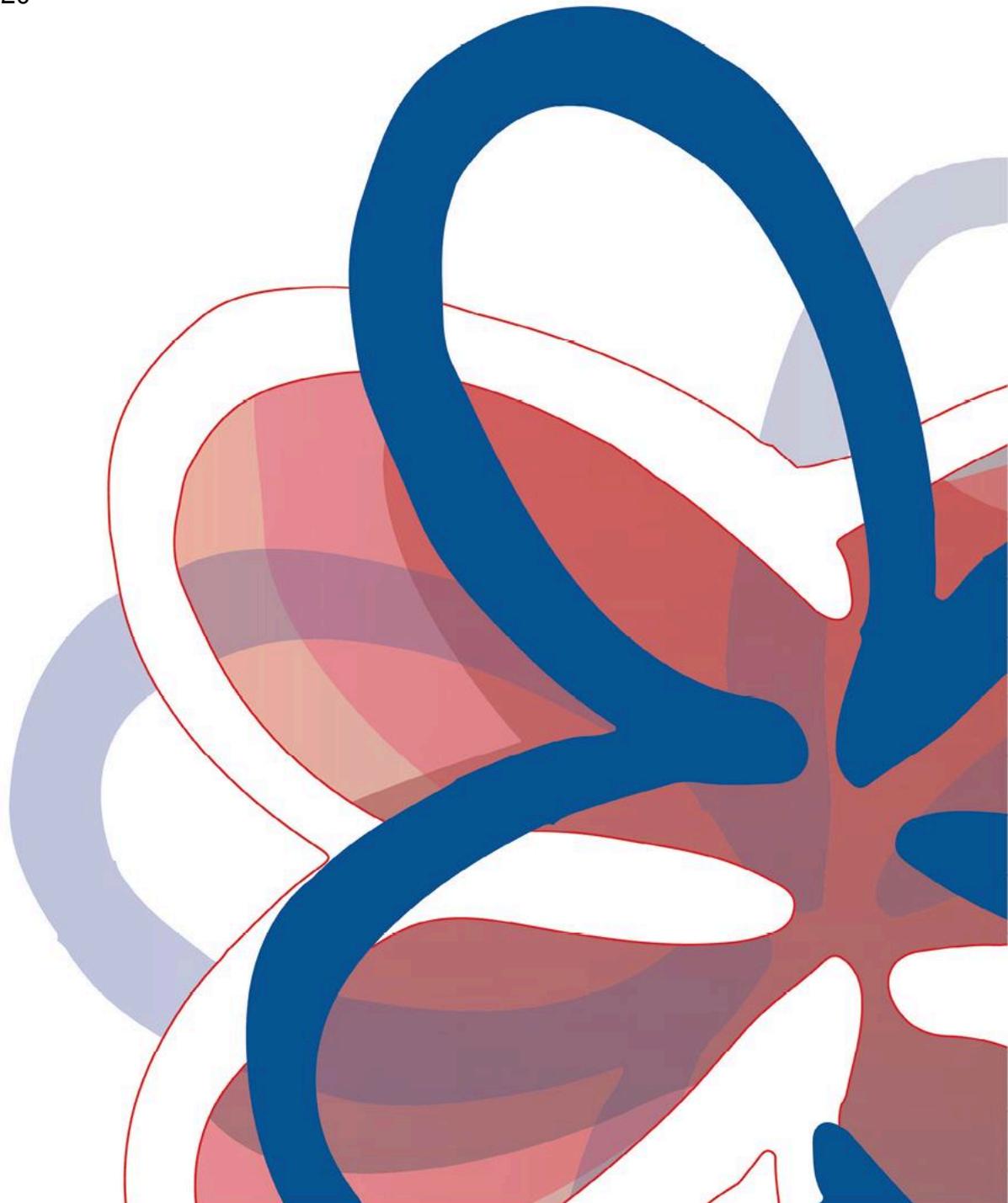
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## Submission: Canberra Health Services

Policy: Consent and Treatment

Submitted by email to: [policyathealth@act.gov.au](mailto:policyathealth@act.gov.au)

13 March 2020



## **Submission: Canberra Health Services, Consent and Treatment Policy**

This submission has been prepared by the ACT Mental Health Consumer Network (the Network) in response to the invitation from the Canberra Health Services (CHS) dated 29 January 2020.

The Network is funded by the ACT Health Directorate to be the peak systemic advocacy body for mental health consumers in the ACT. We represent the interests of mental health consumers in the ACT in policy and decision-making forums. The Network is committed to social justice and the inclusion of people with lived experience of mental illness. Run by consumers for consumers, our aim is to advocate for services and supports for mental health consumers which better enable them to live fuller, healthier and more valued lives in the community.

The Network hosted a policy consultation to seek the input of consumers with lived experience of mental health and this submission is based on their comments.

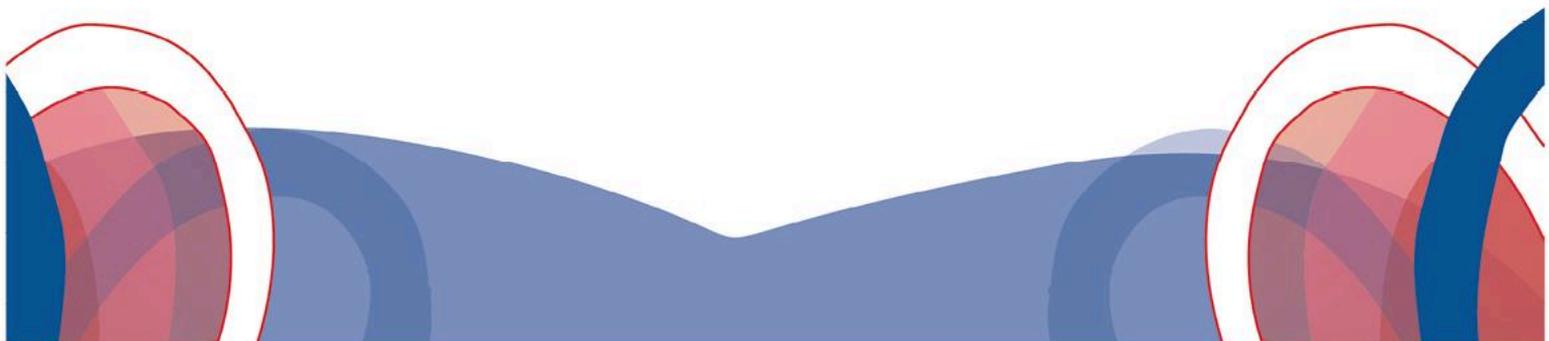
We note that the policy covers the consent sought from all consumers, not just mental health consumers. While we are responding from the standpoint of mental health consumers, we feel that many of the points we raise are applicable more broadly. This is especially the case for consumers from diverse cultural or religious backgrounds and those who identify as non-binary.

### **General Comments**

It appears to us that the policy's focus is on consent **for** treatment as it does not address treatment independently of consent. Therefore, we would recommend renaming the policy "Consent for treatment".

The policy is very long, which may deter staff from reading and becoming familiar with it. The Network believes that a set of overarching principles would guide staff behaviour. This is discussed in more detail below.

In some places the text refers the reader to other sections, but in many it does not, so it is not always easy to locate a section of interest. It is also inconsistent in places. See example provided in Section 4. The document needs to provide consistent information without being repetitive. This could be achieved by consistent referencing throughout.



## Principles underpinning the policy

The principles underpinning the *Mental Health ACT 2015* (ACT) appear unreferenced in the policy statement, particularly the elements of consent and the definition of capacity to make decisions (page 3). The Network would like to see a clearer statement of the principles so that health professionals understand their importance and, indeed, their legal foundation. We recommend the policy include a statement of principles drawn largely from the *Mental Health ACT 2015* (ACT), which references the Act. We highlight some important principles below.

### *Consent*

**Consent is a process**, not a single event. An individual's capacity to provide consent may change over time, as may their decision about that consent. An adequate process includes repeatedly checking an individual's capacity to consent to participation, as well as their decision about consent for the duration of their treatment.<sup>1</sup> The Network recommends that the concept of consent changing over time is included as a principle that underpins the entire policy.

### *Assent*

Where it is not possible to get the consent of an individual and consent is required from the individual's Power of Attorney, the individual's assent should still be sought. We feel that the need to seek assent, or firmly establish the absence of dissent, adds a valuable level of protection for consumers.<sup>1</sup> Once again, we would like this spelt out as a principle.

### *Communication*

The need for good communication skills is central to the successful implementation of this policy and its role in securing consumer consent needs to be understood by staff. Without training and regular assessment it is unlikely that health professionals across Canberra Health Services will have the necessary communication skills to ensure

- that consent is 'free and voluntary', or
- that the information they provided adequately conveys the treatment and the consequences of treatment or non-treatment in a 'in a way that the person is most likely to understand, to allow the person to make decisions or maximise the person's contribution to decision-making'.<sup>2</sup>

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<sup>1</sup> This statement has been made previously in the Network's submission to Amendments to the *Powers of Attorney Act 2006* (ACT), 11 September 2019.

<sup>2</sup> *Mental Health Act 2015* (ACT), 'Principles applying to the Act'. Chapter Two, Section Six.

We recommend that expectations about good communication, including compassion for the individual concerned, is included in the principles.

### *Recovery*

The notion of recovery “means gaining and retaining hope, understanding of one’s abilities and disabilities, engagement in an active life, personal autonomy, social identity, meaning and purpose in life, and a positive sense of self”.<sup>3</sup> While it is applicable to people with mental illness it is equally applicable to all health care consumers, who when unwell also may feel that their personal autonomy, social identity and sense of self is challenged. However, the policy could indicate that this principle specifically applies to people with mental illness.

### **Staff training**

As noted above, unless health professionals across CHS are adequately trained in a variety of areas relating to consent, consumers may not be in a position to give their free and voluntary consent. The Network feels that training in communication skills is essential to all staff who approach consumers for consent.

Given that people with mental illness may be admitted for treatment of their physical health, health professional across CHS also need to be aware of My Rights My Decisions and to establish whether the consumer has it in place. While not all staff will require training in how to determine capacity, they do need to be aware of what procedure to follow should capacity be in question.

We strongly recommend that CHS involve consumers as part of staff training in communication skills and in seeking consent.

### **My Rights My Decisions**

My Rights, My Decisions supports consumers to express their views and preferences about their mental health treatment, care and support. Based on the *Mental Health Act 2015 (ACT)*, the program helps consumers to be empowered and express themselves while they have decision-making capacity, so that their views are taken into account by their treating team if they have reduced decision-making capacity in the future. The My Rights My Decisions Kit comprises three forms

- Nominated persons
- Advanced Agreement
- Advance Consent Direction

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<sup>3</sup> National Standards for Mental Health Services 2010. Principles of recovery oriented mental health practice. <https://www1.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-i-nongov-toc~mental-pubs-i-nongov-pri>



The kit, and the training available to CHS staff, should be highlighted in this policy.

### **Accompanying procedures**

The Network acknowledges that in the absence of an accompanying procedure document, some of the issues we raise may be more appropriately addressed in the procedure.

### **Specific comments**

#### **Policy statement**

The policy states (page 3) that health professionals should

*[take] into account a person's personal circumstances, beliefs, and priorities including:*

- *temperament, attitude and level of understanding”*

Mental health consumers consider the term ‘temperament’ insulting and more appropriately applied by a vet to a domestic animal, than by a health professional to a human. Additionally, it is unclear

- **what** is meant by temperament;
- **who** assesses the person's temperament; and
- **how** that assessment takes place.

The notion that someone else could make a judgement about an individual's lived experience is abhorrent to many mental health consumers.

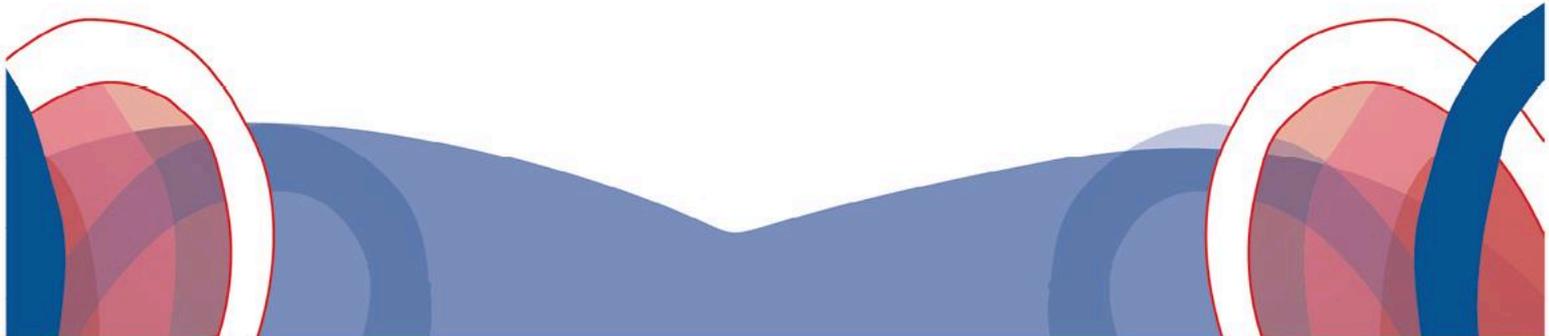
At a broader level, it should be noted that one's attitude may be influenced by the manner in which they are being treated. Furthermore, one's level of understanding may change with circumstances and as a result of treatment or non-treatment.

#### **Documentation of consent**

The policy states that (page 4)

*Consent and the information provided to the person at the time consent is obtained must be documented in the clinical record*

As per our statements on consent, attempts to secure consent should also be documented, as should any changes in consent. Our position is consistent with the Principle of decision-making capacity (1)(g) *Mental Health Act 2015 (ACT)*.



## **Scope**

The statement of scope states (page 4)

*Compliance with this policy is mandatory.*

The Network recommends that this statement is expanded to refer staff and students to their responsibilities under the *Mental Health Act 2015 (ACT)*.

## **Roles and responsibilities**

The following terms are used (page 5) but not defined:

- principles of consent
- rights of people seeking treatment
- legal and ethical considerations and risks

They need to be clearly defined.

The Network assumes that the accompanying procedure will cover, for instance, how training and/or orientation will address the policy.

## **Levels of consent**

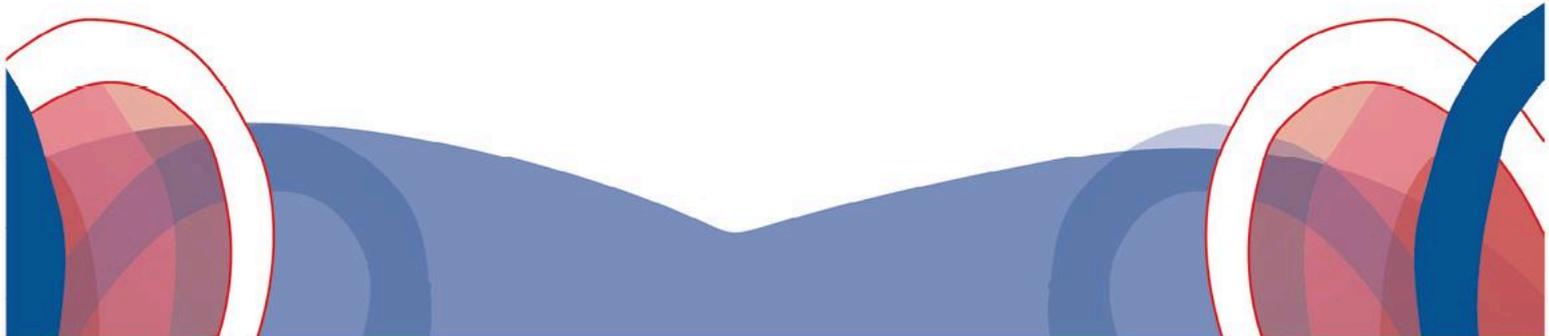
The term 'levels of consent' (page 5) suggests a hierarchy.

- Implied consent for minor or routine procedures
- Verbal consent for non-routine procedures
- Written for procedures carrying significant risk, etc.

However, these definitions do not take into consideration the perspective of consumers. For instance, many consumers would not consider the insertion of an intravenous line or a urinary catheter as a minor event, even though these are routine procedures for nursing and medical staff. The risk is that some mental health consumers, people who have experienced trauma, and certain cultural groups may well find such procedures confronting, if not abusive and traumatising. Therefore, implied consent such as extending one's arm when requested or swallowing the medication provided is not consent unless it has been preceded by adequate communication with the individual.

## **Section 4 Substitute Decision Makers**

We recommend that this section mention My Rights My Decisions, particularly in the section on "Advance Agreements and Advance Consent Directions for a mental disorder or illness" (page 17).



Sections 4 and 5 need to be rewritten to clarify the precedence of legal documents – Enduring Power of Attorney, Health Direction, Advance Agreement and Advance Consent Direction. For instance, the section entitled “Health Direction” (page 15) suggests that Enduring Power of Attorney take precedence over Health Directions.

*This direction will not be valid if it is inconsistent with an Enduring Power of Attorney for healthcare matters previously given by the person.*

*It will also be revoked if a person later makes an Enduring Power of Attorney for healthcare matters or the person clearly expresses to a health professional or someone else that it no longer represents their wishes. (page 15)*

However, the section on Advance Agreements and Advance Consent Directions (page 18) does not mention what happens when either is inconsistent with an Enduring Power of Attorney, but does state that Health Direction takes precedence over both an Advance Agreement and an Advance Consent Direction. Furthermore, it does not mention what happens if a person clearly expresses to a health professional or someone else that it no longer represents their wishes.

*Even if a Power of Attorney or Guardian has been appointed, if there is an Advance Agreement or an Advance Consent Direction which deals with the relevant issue, consent of the Power of Attorney or Guardian is not required.*

*Where the person has made an Advance Consent Direction and then makes a Health Direction, the Advance Consent Direction has no effect to the extent that is inconsistent with the Health Direction. (page 18)*

The final sentence in Paragraph 1, Page 18 should read

An Advance Consent Direction only comes into effect if the person is deemed not have decision-making capacity at the time.

## **Section 5 Treatment under the Mental Health Act 2015**

The text as it stands is not easily understood. For clarity, we recommend that the policy include excerpts from the Plain English version of the *Mental Health Act 2015* (ACT), especially when referring to assessment and decision making capacity.<sup>4</sup> In addition, it contains only three elements to determine decision making on page 15, whereas seven are listed on page 3.

In the opinion of consumers, Attachment 3 offers no new information and does not aid understanding.

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<sup>4</sup> The Plain Language Guide for the Mental Health Act 2015 (Australian Capital Territory) , February 2016 [https://health.act.gov.au/sites/default/files/2018-09/Plain%20Language%20Guide\\_MH%20ACT.pdf](https://health.act.gov.au/sites/default/files/2018-09/Plain%20Language%20Guide_MH%20ACT.pdf)

## **Section 6 Treatment of minors**

This section should include a clear statement of the Gillick Principle or Competence, which holds that “as children grow and develop in maturity, their views and wishes must be given greater weight”.<sup>5</sup> This means that a child (under 16 years of age) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

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<sup>5</sup> Griffin Richard. “What is Gillick competence?” *Human Vaccines & Immunotherapeutics*. 2016 Jan; Volume 12(Issue 1): Pages 244–247. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4962726/>

