

General medical health needs, annual examination, non-psychiatric treatment, special procedures and medical research procedures

Chief Psychiatrist's Guideline

Key message

Public mental health services have a responsibility to assess and, where required, manage the physical and medical health needs of people receiving treatment from their service.

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Purpose

To provide information about the law and clinical policy requirements concerning:

- the physical health needs of people receiving services from public mental health services
- annual examinations
- non-psychiatric treatment
- special procedures
- medical research (including psychiatric research).

Background

People with mental illness are at higher risk of a range of physical problems and illnesses and may be prescribed medications with significant potential for interactions and side effects. Risk factors in this population may include smoking, alcohol and substance use, obesity, poor diet and other lifestyle factors. Additionally, some people may have an itinerant lifestyle, be at increased risk of self-neglect or may misattribute or have difficulty describing physical symptoms. As a result, they are often less likely than the general population to access appropriate healthcare.¹

As opportunities for liaison between mental health services, general medical services, and primary care physicians have increased, in many instances people will be referred to other medical practitioners for examination, investigation, and ongoing management of physical conditions. Providing integrated care can be a challenge when multiple service providers are involved and it is possible an individual's physical health needs may be overlooked. It should not be assumed that a person receives regular physical health checks just because there is a primary care physician identified in the person's clinical record.

¹ Lawrence D, Holman D, Jablensky A 2001, *Duty to care. Preventable physical illness in people with mental illness*, The University of Western Australia, pp.102.

General health

People receiving treatment from public mental health services, whether on a voluntary or involuntary basis, are entitled to access quality care for their mental and physical health needs. Where a person is unable to readily access physical health care due to mental health reasons, the mental health service should facilitate or provide such care.

The authorised psychiatrist maintains a responsibility for the physical as well as the mental health of patients (involuntary, security and forensic) under the *Mental Health Act 1986*, including those people on community treatment orders and restricted community treatment orders.

Identifying medical conditions

Medical conditions may imitate, exacerbate or mask psychiatric symptoms and some treatments for mental illnesses may have significant physical side effects in both the short and long term. Diagnosis and appropriate care of physical illness is therefore essential to prevent deterioration in a person's health and to optimise management of their mental illness. Accordingly, mental health services should ensure people have a comprehensive medical assessment in order to address physical conditions, in particular those that may be impacting on their mental state.

Medical history

A medical history is an essential part of psychiatric assessment. The history should summarise the person's current state of health and identify past medical or surgical treatment, current and recent prescribed medications and their indications, and any use of non-prescribed substances.

The medical practitioner taking the history may refer to previous histories in the person's clinical record, but should confirm the accuracy of key information with the person.

Physical examination

The physical examination is an important diagnostic tool. Medical practitioners need to clearly explain the reason for a physical examination and what it will involve. It is also essential to gain a person's consent or substitute consent before proceeding with the examination (see 'Consent to physical examination or medical treatment').

Consideration should be given to having another health professional of the same gender as the person present for an examination.² Attention should be given to a person's cultural and other needs.³ In the case of a child or adolescent, a parent, guardian or a health professional of the same gender as the young person should be present during a physical examination.

When a person is admitted to a psychiatric inpatient unit, a physical examination should be performed and documented as soon as possible. Where initial physical examination is limited by the mental state of the person, a more complete examination should be performed and documented at the earliest possible opportunity. Appropriate investigations should be ordered and results noted and acted on as required.

In the community, the requirement for a physical examination will depend on the clinical needs of the person and their individual circumstances. If a person has a general practitioner, it would be sufficient for the mental health service to encourage the person to have regular health checks and to liaise with the practitioner about the person's physical health and their needs. If a person does not regularly access other primary health care services, a medical practitioner from the mental health service should physically examine the person periodically.

Emergency departments

People presenting to an emergency department will usually have a general medical evaluation to enable adequate diagnostic assessment or treatment decisions to be made. While this information can contribute to the psychiatric assessment of the person, psychiatric assessments should not be routinely delayed while awaiting medical evaluation.

Issues for aged psychiatry services

The older population has an increased incidence of medical comorbidity including medication interactions and toxicity. It is important to consider delirium in new presentations and in relapse of established illness, and to communicate closely with community practitioners. The possibility of elder abuse is also to be considered in situations of trauma.⁴

² See also *Tailoring services to meet the needs of women*, April 1997, www.health.vic.gov.au/mentalhealth/publications/pubs.htm

³ See also *Use of language services in area mental health services*, October 2006, www.health.vic.gov.au/mentalhealth/pmc/language.htm; *Working with people who are deaf or hard of hearing*, November 2000, www.health.vic.gov.au/mentalhealth/publications/deaf/index.htm *Cultural diversity plan for Victoria's specialist mental health services 2006–2010*, October 2006, www.health.vic.gov.au/mentalhealth/publications/pubs.htm

⁴ For further information see www.health.vic.gov.au/agedcare/policy/elder_abuse.htm

Aged persons mental health residential services

The authorised psychiatrist has a responsibility for ensuring the physical and medical needs of people in aged persons mental health residential services (APMHRS) are met. While the examination, investigation and ongoing management of physical conditions may be performed by geriatricians, medical practitioners employed by the APMHRS and general practitioners, the authorised psychiatrist has a responsibility to ensure that residents in APMHRS receive adequate and appropriate psychiatric and physical care.

The Commonwealth's residential outcome standards specify that all residents are entitled to a general practitioner of their choice.⁵ While most residents will have a listed general practitioner, it cannot be assumed that a person's medical needs are always being actively managed. Further, the possibility of interactions between medications prescribed for physical and psychiatric conditions and the potential for side effects and toxicity associated with psychiatric medications requires specialist knowledge. The authorised psychiatrist should liaise with the general practitioner on a regular basis to ensure resident's physical needs and any possible drug interactions are appropriately assessed and managed. Any disclosure of health information to general practitioners is governed by the confidentiality provisions in the Mental Health Act. See 'Communication with other service providers' for more details.

Management of an identified physical health problem

If a person is an inpatient at the time of diagnosis of a medical condition, referral may be made to the appropriate medical, surgical or specialist unit. Other options include referral to outpatient services after discharge or referral back to the person's community medical practitioner. The person's nominated community medical practitioner should be informed in a timely manner about any findings and referrals made (see 'Communication with other service providers').

Most people in the community will receive medical health care through a general practitioner or other health care provider. If a person is not accessing medical health care, the mental health service should refer the person to an appropriate health care provider and offer the necessary support to help the person engage with the provider. Where this is not achievable, for example when a person is paranoid and refuses to access services, this should be documented in the clinical record and the person's condition monitored for an opportunity to successfully refer them.

Where a mental health service believes that a person is at significant risk due to their medical condition, reasonable steps should be taken to ensure prompt physical assessment, either by a medical practitioner from the mental health service or at an emergency department.

If a patient under the Mental Health Act requires medical treatment and is unable to consent to the treatment, the authorised psychiatrist should consider using the powers for authorising non-psychiatric treatment in ss. 83–85 of that Act (see 'Non-psychiatric treatment').

People should be educated and encouraged to minimise long-term health risks, with attention to issues such as smoking, obesity and exercise levels.

Psychiatric treatment

The authorised psychiatrist should consider a person's medical needs in selecting psychiatric treatment options, preferentially selecting treatments that will not be affected by, nor affect, any known medical conditions.

People should be actively monitored for side effects of treatment.

Consent to physical examination or medical treatment

Informed consent

A person's informed consent should be sought before any physical examination is performed or medical treatment is given. The common law requirements for full, free and informed consent generally apply. However, if the person is a patient (involuntary, security and forensic) under the Mental Health Act, the requirements for informed consent to non-psychiatric treatment in that Act apply (see 'Non-psychiatric treatment').

Issues for child and adolescent mental health services

It is essential to gain consent or substitute consent (see below) before proceeding with a physical examination and any subsequent treatment involving a child or adolescent.

People below the age of 18 years may be legally able to give consent, provided the young person has sufficient intelligence and maturity to understand the nature and consequences of the examination or treatment and to make a decision. Wherever possible, parents and guardians should be involved in the decision. However, if a medical practitioner decides that a young person is competent to consent to an examination or treatment on his or her own behalf, the person's right to confidentiality should be respected and permission should be obtained before these matters are discussed with a parent or guardian.

5 For further information about the Commonwealth's standards for clinical care in aged care facilities see www.health.gov.au/internet/wcms/publishing.nsf/content/ageing-standard-facility-sacfindx.htm

Substitute consent

If a person is unable to give informed consent to medical treatment, the laws governing substitute consent differ, depending on whether or not the person is a patient under the Mental Health Act and whether the person is an adult or a minor.

Substitute consent for patients under the Mental Health Act

If a patient under the Mental Health Act is unable to consent to non-psychiatric treatment (including both adults and minors), s. 85 of that Act governs the process and lists the categories of people able to give substitute consent (see 'Non-psychiatric treatment').

Substitute consent for other people

If a person over the age of 18 years is unable to consent to medical treatment, substitute consent can be given by a medical treatment agent appointed under the *Medical Treatment Act 1988* or a guardian or an enduring guardian appointed under the *Guardianship and Administration Act 1986*, where the agent or guardian has the power to make decisions about the proposed treatment. If the person does not have a medical treatment agent or guardian, part 4A of the *Guardianship and Administration Act* provides a substitute consent regime for medical and dental treatment. Generally, a spouse, primary carer or close relative can give consent to medical or dental treatment on their behalf if the treatment will be in the person's best interests. Information explaining these provisions is available from the Public Advocate's website www.publicadvocate.vic.gov.au

If a person under the age of 18 years is unable to consent to medical treatment, a parent or an appointed guardian or custodian who has the power to make decisions about the proposed treatment may generally give consent.

Consent in urgent situations

Consent is not required where medical or dental treatment (in the case of a patient under the *Guardianship and Administration Act*⁶) or non-psychiatric treatment (in the case of a patient under the Mental Health Act) is necessary, as a matter of urgency:

- to save a person's life
- to prevent serious damage to a person's health

- to prevent a person from suffering or continuing to suffer significant pain or distress.⁷

Communication with other service providers

Mental health services should communicate with providers of physical health care to optimise management of a person's mental and physical health care needs. Generally, the service should seek the person's consent for the disclosure of information. Most people will agree to giving information to other treating clinicians or services if time is taken to discuss the reasons and the benefits, although they may wish to place limits on the disclosure of some information, particularly sensitive information. These wishes should generally be respected.

Section 120A(3)(e)(i) of the Mental Health Act permits disclosing information without consent where this is required for the 'further treatment' of a person with a mental disorder.⁸

The purpose of this exception to confidentiality is to facilitate continuity of treatment between different agencies or services that provide treatment and services to an individual. Examples include the disclosure of information to a general practitioner who is supervising the treatment of a person subject to a community treatment order and the disclosure of information to an organisation providing psychiatric disability and rehabilitation support services (PDRSS) to a person.

Only information that is necessary for the continuing treatment of the person's mental disorder should be disclosed under this exception. In particular, discharge summaries should not be routinely sent to general practitioners or other service providers unless the person consents or it is necessary to facilitate continuity of treatment and the requirements of s. 120A(3)(e)(i) are met.

Where a clinician decides to disclose information to another clinician or service under this provision, it would be good clinical practice to inform the person. Generally, only where this would pose a risk to the health or welfare of any individual should the person not be informed.

Mental health services should generally liaise with the community practitioner when:

- a person is admitted to or discharged from an inpatient unit
- the mental status of a person significantly alters
- the physical health of a person significantly alters

⁶ 'Patient' is defined in s. 36 of the *Guardianship and Administration Act* as a person with a disability (intellectual impairment, mental disorder, brain injury, physical disability or dementia) who is aged 18 years or over and is incapable of giving consent to the carrying out of a medical or dental procedure.

⁷ Section 42A, *Guardianship and Administration Act* (in the case of a patient under that Act) and s. 84(3), *Mental Health Act* (in the case of a patient under that Act)

⁸ Section 120A(3)(e)(i) only applies to disclosing information for further treatment to external organisations or practitioners. Note that under s. 120A(2B), the giving and sharing of information between employees of a 'relevant psychiatric service' to provide treatment to an individual, including sharing information between inpatient and community-based clinicians of the same service, is regulated by the *Health Privacy Principles of the Health Records Act 2001*.

- medication is significantly altered, especially where there is a significant risk of physical side effects (for example, Clozapine)
- physical treatment such as electroconvulsive therapy (ECT) is being considered.

Annual examination

Section 87 of the Mental Health Act provides that:

- every patient (involuntary, security or forensic) must be examined at least once a year to assess their mental and general health
- the authorised psychiatrist must submit a report of the annual examination to the Chief Psychiatrist.

The examination has two components: the psychiatric examination and the physical examination. Different medical practitioners may complete the different parts, for example, the person's general practitioner may perform the physical examination.

The authorised psychiatrist is responsible to ensure both the psychiatric and physical examinations are comprehensive and that any issues concerning the person's health that are raised by the examinations are addressed.

Consent issues

The annual examination is required by the Mental Health Act and is integral to the patient's psychiatric treatment. In particular, the requirement for a physical examination provides an opportunity to identify any medical conditions that may be affected by or might affect the patient's mental illness. It also ensures any side effects of treatment can be identified and appropriately managed.

If the person is unable to consent to the examination or unreasonably refuses to give consent, the authorised psychiatrist may consent on their behalf. Sometimes, patients on community treatment orders question the need for a physical examination and refuse to cooperate. In these circumstances, a patient should not be forcibly physically examined if they are strongly opposed to the examination. The reasons for the examination should be explained and reasonable efforts made to obtain the person's cooperation. If a patient refuses to be physically examined, the relevant practitioner should summarise the person's physical health to the extent that is possible and also document the circumstances of the refusal.

If a patient refuses to be physically examined, this subject should be revisited from time to time to see if the person has changed their mind and to encourage the person's cooperation.

Documentation

The results of the examinations should be recorded on the *Annual examination of patient* (MHA 32) form and promptly sent to the Chief Psychiatrist, usually within four weeks of the date of the annual examination.⁹ A copy of the person's treatment plan (in the case of patient under the Mental Health Act) or equivalent plan should be attached.

Service management should ensure a reminder system is developed and implemented to ensure annual reports are performed in a timely manner. An 'annual examination report' is available through the CMI/ODS¹⁰ to assist service providers to monitor the due dates for annual examinations.

Non-psychiatric treatment

Introduction and scope

The Mental Health Act establishes a regime for consent to non-psychiatric treatment for patients (involuntary, security and forensic) under that Act. The term 'patient' is used in this part of the guideline for this reason.

The non-psychiatric treatment regime does not apply to people receiving mental health services on a voluntary basis. The common law requirements for full, free and informed consent to medical treatment apply to this group. If such a person is unable to consent to medical treatment, part 4A of the Guardianship and Administration Act provides a substitute consent regime for medical and dental treatment. If the person is under the age of 18 years and unable to consent to non-psychiatric treatment, a parent or an appointed guardian or custodian who has the power to make decisions about the proposed treatment may generally give consent.

Definitions

The Mental Health Act makes a distinction between 'major non-psychiatric treatment' and other types of 'non-psychiatric treatment'. The requirements for informed consent for the two categories are different.

Non-psychiatric treatment

Non-psychiatric treatments are any of the following procedures where the primary purpose of the procedure is not the treatment of any mental disorder or the effects of mental disorder:

- any surgical operation or procedure or series of related surgical operations or procedures
- the administration of an anaesthetic for the purpose of medical investigation
- the administration of any course of treatment or course of medication requiring a prescription or medical supervision.¹¹

⁹ Copies of the MHA 32 can be viewed or downloaded from www.health.vic.gov.au/mentalhealth/mh-act/forms.htm

¹⁰ The CMI/ODS is the Victorian public mental health client information management system.

¹¹ Section 83(1), Mental Health Act

Non-psychiatric treatment does not include ‘special procedures’ or ‘medical research procedures’. These procedures are discussed later in this guideline.

Major non-psychiatric treatment

The Chief Psychiatrist defines the following non-psychiatric treatments to be ‘major non-psychiatric treatments’:

- any surgery performed under a general or regional anaesthetic
- the use of general or regional block anaesthetic for any purpose
- chemotherapy
- radiotherapy.¹²

Informed consent to non-psychiatric treatment

A patient’s informed consent should be sought before any non-psychiatric treatment is performed. The requirements differ according to whether the non-psychiatric treatment is major or not.

Major non-psychiatric treatment

The requirements for informed consent to ‘major non-psychiatric treatments’ are that the person gives full, free and informed written consent after:

- the person has been given a clear explanation containing sufficient information to enable him or her to make a balanced judgement
- the person has been given an adequate description of benefits, discomforts and risks without exaggeration or concealment
- the person has been advised of any beneficial alternative treatments
- any relevant questions asked by the person have been answered and the person has understood the answers
- a full disclosure has been made of any financial relationship between the person seeking informed consent or the registered medical practitioner who proposes to perform the treatment, or both, and the service, hospital or clinic in which it is proposed to perform the treatment.¹³

In addition, the person must be given the patients’ rights booklet *Major non-psychiatric treatment* and the information explained.¹⁴ If the person appears not to have understood the explanation, arrangements must be made to convey the information to the person in the language, mode of communication or terms that the person is most likely to understand.

Other non-psychiatric treatment

There are many minor procedures, investigations and courses of medication that do not fall within the definition of ‘major non-psychiatric treatment’, but which still fall within the definition of non-psychiatric treatment.

The requirements for informed consent to these other non-psychiatric treatments, which are not ‘major non-psychiatric treatments’, are that the person gives full, free and informed consent after:

- the person has been given a clear explanation of the proposed non-psychiatric treatment
- the person has been advised as to the reason why the non-psychiatric treatment is necessary.¹⁵

Informed consent by patients under 18 years of age

Patients below the age of 18 years may be legally able to give consent to non-psychiatric treatment, provided the young patient has sufficient intelligence and maturity to understand the information that must be given under the requirements for informed consent above and make a decision about the treatment.

Wherever possible, parents and guardians should be involved in the decision. However, if a medical practitioner decides that a young patient is competent to consent to treatment on his or her own behalf, the patient’s right to confidentiality should be respected and permission should be obtained before the proposed treatment is discussed with a parent or guardian.

Consent to non-psychiatric treatment where a patient is incapable of giving informed consent

If a patient is incapable of giving informed consent, the Mental Health Act sets out a process and lists the categories of people able to give substitute consent on behalf of the patient.¹⁶

¹² This definition of ‘major non-psychiatric treatment’ is issued by the Chief Psychiatrist in accordance with s. 83(1A), Mental Health Act.

¹³ Section 53B, Mental Health Act

¹⁴ Copies of the booklet can be viewed, downloaded or ordered from the mental health website: www.health.vic.gov.au/mentalhealth/patientrights/index.htm

¹⁵ Section 83(2), Mental Health Act

¹⁶ A non-psychiatric treatment may be performed without consent if it is necessary, as a matter of urgency, to save a patient’s life, prevent serious damage to a patient’s health, or prevent a patient from suffering or continuing to suffer significant pain or distress (see ‘Consent in urgent situations’).

Substitute consent for a patient 18 years of age or over

If an adult patient is incapable of giving informed consent to any non-psychiatric treatment (including 'major non-psychiatric treatment'), consent may be given by the **first** person listed below who is reasonably available, willing and able to make a decision about the proposed treatment:

- a person who is the patient's medical enduring power of attorney appointed under the *Medical Treatment Act 1988* (a 'medical treatment agent')
- a person appointed by the Victorian Civil and Administrative Tribunal (VCAT) to make decisions about the proposed treatment
- a guardian appointed by VCAT under the Guardianship and Administration Act who has the power to make decisions about the proposed treatment
- an enduring guardian appointed by the patient under the Guardianship and Administration Act with power to make decisions about the proposed treatment
- the authorised psychiatrist.¹⁷

Substitute consent for a patient under 18 years of age

If a patient under the age of 18 years is incapable of giving informed consent to any non-psychiatric treatment (including 'major non-psychiatric treatment'), consent may be given by any of the persons listed below who is reasonably available, willing and able to make a decision about the proposed treatment:

- a person with parental responsibility within the meaning of the *Family Law Act 1975* (Cwth)
- a guardian appointed under an Australian law
- a person appointed under s. 597 of the *Children, Youth and Families Act 2005* who can consent to the performance of the proposed treatment
- the authorised psychiatrist – but only if there is no parent, guardian or custodian who is reasonably available, willing and able to make the decision about the proposed treatment.¹⁸

Consent by the authorised psychiatrist

Where the authorised psychiatrist proposes to consent to a non-psychiatric treatment on behalf of a patient, he or she should be satisfied that the treatment is in the best interests of the patient. Some matters that the authorised psychiatrist could take into account when deciding whether a non-psychiatric treatment would be in the best interests of a patient include:

- the wishes of the patient
- the wishes of any nearest relative or other family members, but only if the patient does not object to the family members or relatives being involved in the decision
- the consequences to the patient if the treatment is not carried out
- any alternative treatment available
- the nature and degree of any significant risks associated with the treatment or any alternative treatment
- whether the treatment is only to promote and maintain the health and wellbeing of the patient.

In order to protect the personal autonomy of the patient, the authorised psychiatrist should always consider whether the proposed non-psychiatric treatment could await the person's recovery so that the patient can decide whether or not to consent to the proposed treatment.

The authorised psychiatrist should obtain a second opinion where a proposed non-psychiatric treatment involves significant risk or where the patient or a family member strongly objects to the proposed treatment.

Non-psychiatric treatment if an appointed substitute decision maker refuses consent

If an appointed agent or guardian refuses to give consent to a necessary non-psychiatric treatment, the authorised psychiatrist may consider making an application to the Guardianship List of VCAT for a review of the decision to refuse the treatment, and of the relevant guardianship order or enduring power of attorney (medical treatment). The authorised psychiatrist should only consider making an application if he or she believes on reasonable grounds that the proposed treatment is necessary and in the best interests of the patient.

If a parent, guardian or custodian of a patient under the age of 18 years refuses to consent to a necessary non-psychiatric treatment, the authorised psychiatrist may seek advice and referral from the Office of the Public Advocate. There is a power to challenge the decision in a court where it is believed the parent, guardian or custodian is not acting in the best interests of the child.

Consent in urgent situations

Consent is not required where a non-psychiatric treatment is necessary, as a matter of urgency:

- to save the patient's life
- to prevent serious damage to the patient's health
- to prevent the patient from suffering or continuing to suffer significant pain or distress.¹⁹

17 Section 85(1)(a), Mental Health Act

18 Section 85(1)(b), Mental Health Act

19 Section 84(3), Mental Health Act

Non-psychiatric treatment after an involuntary treatment order is made

When an involuntary treatment order is made for a person, the authorised psychiatrist must examine the person within 24 hours to decide whether or not to confirm the order. During this period the authorised psychiatrist should not consent to any non-psychiatric treatment without first having examined the person.

If a person is incapable of consenting to non-psychiatric treatment during this period, a medical treatment agent, guardian, enduring guardian or other appointed substitute decision maker may consent, as described above.

If any non-psychiatric treatment is necessary as a matter of urgency, no consent is required and the treatment may be given as described in 'Consent in urgent situations' above.

Medical Treatment Act continues to apply

A medical practitioner must not carry out any non-psychiatric treatment, including any urgent treatment (see 'Consent in urgent situations' above), if the medical practitioner knows that a 'Refusal of treatment certificate' has been completed and is in force in accordance with the Medical Treatment Act.

Further information is available from the Office of the Public Advocate on 9603 9500, 1300 309 337 (toll free) or www.publicadvocate.vic.gov.au

Documentation

Consent forms²⁰

Informed consent for a 'major non-psychiatric treatment' is recorded on an *Informed consent to major non-psychiatric treatment* (MHA 26) form.

Informed consent for any non-psychiatric treatment that is not 'major' does not need to be in writing. However, the rationale for the decision to prescribe a non-psychiatric treatment and the details of the process for obtaining informed consent must be recorded in the patient's clinical record. Where service providers wish to obtain written consent to these non-psychiatric treatments, locally developed consent forms may be used.

Substitute consent for any non-psychiatric treatment (including 'major non-psychiatric treatment') is recorded on a *Substitute consent to non-psychiatric treatment* (MHA 27) form.

Register of major non-psychiatric treatment

The authorised psychiatrist of each approved mental health service must establish and maintain a register of each 'major non-psychiatric treatment' performed on a patient of the service (*Register of major non-psychiatric treatment* (Schedule 22)²¹). A copy of each written consent to a 'major non-psychiatric treatment' must be attached to the register.

The register should be retained at the mental health service and be available for inspection on request by the Chief Psychiatrist or delegate.

General documentation requirements

In addition to the statutory requirements for documentation, good clinical practice requires that the clinical record show documentation of the requirements of professional standards of practice, guidelines and relevant local policy and procedures, including:

- a treatment plan
- the rationale for the proposed non-psychiatric treatment
- details of the process of gaining consent
- details of any second opinions, where applicable
- details of the registered medical practitioner who performed the non-psychiatric treatment
- where a substitute decision maker has given consent to the non-psychiatric treatment, a copy of the relevant document or order giving authority for the person to consent to the treatment (for example, a guardianship order or some other evidence of the person's power to give consent) should be in the clinical record
- the person's response to the treatment.

Appointed substitute decision makers

At the time when a patient requires non-psychiatric treatment, it is sometimes unclear whether the person has a substitute decision maker who can make a decision about the proposed treatment. Mental health service providers should routinely record at the time of admission or intake whether a patient has a guardian or has appointed any person to be their enduring power of attorney (medical treatment) or their enduring guardian.

²¹ Copies of forms can be viewed or downloaded from www.health.vic.gov.au/mentalhealth/mh-act/forms.htm

²² Copies of the register can be viewed or downloaded from www.health.vic.gov.au/mentalhealth/mh-act/forms.htm

Special procedures

Special procedures are medical treatments that by their nature are so intrusive or serious that they require special regulation by legislation.

The Guardianship and Administration Act governs consent to special procedures for 'patients' within the meaning of the Guardianship and Administration Act.²²

In this part of the guideline, the term 'patient' refers to patients under the Guardianship and Administration Act.

Definition

'Special procedures' are defined in the Guardianship and Administration Act as:

- any procedure that is intended, or is reasonably likely, to have the effect of rendering permanently infertile the person on whom it is carried out
- termination of pregnancy
- any removal of tissue for the purposes of transplantation to another person.²³

Consent to a special procedure for a patient 18 years of age or over

A person must give informed consent to the performance of a special procedure. The authorised psychiatrist may seek a second psychiatric opinion if there is any doubt about whether a person has the capacity to give informed consent to a special procedure.

If a patient is incapable of giving informed consent to a special procedure, the procedure may be performed with the consent of VCAT.²⁴ A guardian, agent or authorised psychiatrist cannot consent on the person's behalf.

A person is considered to be incapable of giving consent if the person is either:

- incapable of understanding the general nature and effect of the proposed special procedure
- incapable of indicating whether or not he or she consents or does not consent to the carrying out of the proposed special procedure.²⁵

The 'person responsible'²⁶ for a patient, or any person who has a special interest in the affairs of the patient, can make an application to VCAT for consent to carry out a special procedure.²⁷ Application forms and advice are available from the VCAT website www.vcat.vic.gov.au or by calling 9628 9911 or 1800 133 055 and asking to speak to the Guardianship List Registrar.

VCAT may only consent to the carrying out of a special procedure if it is satisfied that:

- the patient is incapable of giving consent
- it is not likely the patient will be capable within a reasonable time to give consent to the procedure
- the special procedure would be in the patient's best interests.²⁸

If VCAT gives consent to a special procedure, it may authorise the 'person responsible' to consent to continuing the special procedure or carrying out any further special procedures of a similar nature.²⁹

Consent in urgent situations

A special procedure may be performed without consent if the procedure is necessary, as a matter of urgency:

- to save a patient's life
- to prevent serious damage to a patient's health.³⁰

Register of major non-psychiatric treatment

The Chief Psychiatrist requires that the authorised psychiatrist enter the details of any special procedures performed in relation to patients (involuntary, security and forensic) under the Mental Health Act in the *Register of major non-psychiatric treatment* (Schedule 22³¹).

Special medical procedures for children

The Guardianship and Administration Act, and the procedures for obtaining consent to a special procedure, do not apply to children (up to 18 years of age).

Some medical procedures proposed for children require the approval of the Family Court of Australia. These procedures include non-therapeutic sterilisation,

²² 'Patient' is defined in s. 36 of the Guardianship and Administration Act as a person with a disability (intellectual impairment, mental disorder, brain injury, physical disability or dementia) who is aged 18 years or over and is incapable of giving consent to the carrying out of the special procedure.

²³ Section 3, Guardianship and Administration Act

²⁴ A special procedure may be performed without consent if it is necessary, as a matter of urgency, to save a patient's life or to prevent serious damage to a patient's health (see 'Consent in urgent situations').

²⁵ Section 36(2), Guardianship and Administration Act

²⁶ See definition of 'person responsible' in s. 37, Guardianship and Administration Act.

²⁷ Section 42B, Guardianship and Administration Act

²⁸ Section 42E, Guardianship and Administration Act

²⁹ Section 42F, Guardianship and Administration Act

³⁰ Section 42A, Guardianship and Administration Act

³¹ Copies of the register can be viewed or downloaded from www.health.vic.gov.au/mentalhealth/mh-act/forms.htm

gender reassignment and donation of non-regenerative tissue. A parent or guardian cannot consent to these special medical procedures.

If a special medical procedure is being considered for a child, information and assistance should be obtained from the Office of the Public Advocate. A guideline titled *Special medical procedures for children* is available on the Public Advocate's website at www.publicadvocate.vic.gov.au

Medical and psychiatric research

Introduction

Part 4A of the Guardianship and Administration Act establishes the regime governing the carrying out of 'medical research procedures' (including psychiatric research) on people who are incapable of consenting to these procedures.³² It provides a four-step process for authorising the carrying out of medical research procedures on 'patients' within the meaning of that Act. A 'patient' is a person with a disability (intellectual impairment, mental disorder, brain injury, physical disability or dementia) who is 18 years of age or over and is **incapable of giving consent** to the carrying out of a medical research procedure.³³ In this part of the guideline, the term 'patient' refers to patients under the Guardianship and Administration Act.

A person is considered to be incapable of giving consent if the person is either:

- incapable of understanding the general nature and effect of the proposed procedure
- incapable of indicating whether or not he or she consents or does not consent to the carrying out of the proposed procedure.³⁴

The authorised psychiatrist may seek a second psychiatric opinion if there is any doubt about whether a person has the capacity to give informed consent to the performance of a medical research procedure.

Definition of medical research procedure

Any **procedure** carried out for the purposes of medical research, including clinical trials that involve the administration of medication or the use of equipment or devices, is considered to be a 'medical research procedure'.³⁵ The following are not medical research procedures and are therefore not regulated by part 4A of the Guardianship and Administration Act:

- any non-intrusive examination (including a visual examination of the mouth, throat, nasal cavity, eyes or ears or the measuring of a person's height, weight or vision)
- observing a person's activities or undertaking a survey (because these are not physically invasive)
- collecting or using information, including personal or health information (because such activities are already separately regulated by privacy and confidentiality laws including the *Health Records Act 2001*, the *Information Privacy Act 2000*, s. 141 of the *Health Services Act 1988* and s. 120A of the *Mental Health Act*)
- any other procedure that is prescribed by regulations not to be a medical research procedure – there are no such regulations at this stage.

Researchers may contact the relevant human research ethics committee or the Office of the Public Advocate for further guidance about the definition of medical research procedures.

Consent to research for a patient 18 years and over

A person must give informed consent for a medical research procedure to be performed.

If an adult patient is incapable of giving consent to any research that is a medical research procedure, the research may be performed in accordance with a 'four-step process' outlined in the Guardianship and Administration Act.³⁶

The authorised psychiatrist cannot consent to the research on behalf of the patient, even where the research procedure or clinical trial might be thought of as being treatment of a mental disorder.

³² In addition, guidance about the ethical considerations for involving people who are incapable of consenting to medical research procedures because of cognitive impairment, intellectual disability or mental illness is given in the National statement on ethical conduct in human research, Commonwealth of Australia, 2007, p. 65, www.nhmrc.gov.au/publications/synopses/e72syn.htm

³³ Section 36(1), Guardianship and Administration Act

³⁴ Section 36(2), Guardianship and Administration Act

³⁵ See definition in s. 3, Guardianship and Administration Act.

³⁶ A medical research procedure may be performed without consent if it is necessary, as a matter of urgency, to save a patient's life, prevent serious damage to a patient's health, or prevent a patient from suffering or continuing to suffer significant pain or distress. However, a human research ethics committee must still have approved the relevant research project (see 'Emergency treatment' section of this guideline below).

Four step process

The 'four-step process' is prescribed in division 6 of part 4A of the Guardianship and Administration Act. In summary, researchers must:

Step 1: Determine whether an ethics committee has approved the project (s. 42Q Guardianship and Administration Act).

and

Step 2: Determine whether the patient is likely to recover capacity within a reasonable time to give consent to the procedure. If the patient is likely to recover capacity within a reasonable time, the researchers must wait and seek the patient's own consent (s. 42R Guardianship and Administration Act).

or

Step 3: If the patient is not likely to recover capacity within a reasonable time, seek the consent of the 'person responsible' (s. 42S Guardianship and Administration Act).³⁷

or

Step 4: If the 'person responsible' cannot be identified or contacted, consider procedural authorisation. Section 42T of the Guardianship and Administration Act provides a scheme to enable procedural authorisation for carrying out medical research procedures on patients in certain circumstances.

The 'four-step process' is explained in detail in the guideline *Guardianship and Administration Act 1986 - Medical research procedures involving patients under a legal incapacity*, Department of Human Services, July 2006, and has not been repeated in this guideline. Researchers and other interested clinicians can see appendix 2 of this document or view the guideline at www.health.vic.gov.au/legislation/medicalresearch.htm

Additional information is available on the Public Advocate's website at www.publicadvocate.vic.gov.au

Best interests and confidentiality

Steps 3 and 4 of the four-step process require the 'person responsible' or a registered medical practitioner (as the case requires) to make a judgement about whether the proposed medical research procedure would be contrary to the best interests of the patient. Section 42U of the Guardianship and Administration Act lists the matters that must be taken into account in deciding whether any medical research procedure would, or would not, be contrary to the best interests of a patient. One of the matters that must be taken into account is the wishes of any nearest relative or any other family members.³⁸ However, the Guardianship and Administration Act does not require the wishes of certain relatives or other family members to be taken into account if the patient:

- is likely to be capable of giving consent to the research, but not within a reasonable time
- objects to that relative (a child, parent, sibling, grandparent, grandchild, uncle, aunt, nephew or niece of the patient) or family member (other than the patient's spouse or domestic partner) being involved in the decision.³⁹

This means that where a patient's inability to consent to research is temporary, the person is entitled to object to any of the listed family members being consulted about or involved in the decision about the research. This provision is intended to prevent the disclosure of information to and the involvement of these categories of family members without the agreement of the patient.

Consent to research for a patient under 18 years

Medical or psychiatric research involving children or young people requires a decision to be made about who will consent to the child or young person participating in the research. Guidance about this issue is given in the *National statement on ethical conduct in human research*.⁴⁰

A young person may have capacity to give informed consent to research if they have enough intelligence and maturity to understand the nature and expected outcomes of the research. It is necessary to look at the individual young person's capacity and maturity as well as the character and complexity of the research.

³⁷ See definition of 'person responsible' in s. 37 of the Guardianship and Administration Act. The 'person responsible' includes the person's spouse, primary carer and close relatives. Note that if a patient objects to certain family members (a child, parent, sibling, grandparent, grandchild, uncle, aunt, nephew or niece of the patient) being involved in the decision about a medical research procedure, that family member cannot be the 'person responsible' and therefore cannot give consent (s. 37(7) Guardianship and Administration Act).

³⁸ Section 42U(1)(b), Guardianship and Administration Act

³⁹ Section 42U(2), Guardianship and Administration Act

⁴⁰ *National statement on ethical conduct in human research*, Commonwealth of Australia, 2007, p. 55, www.nhmrc.gov.au/publications/synopses/e72syn.htm

Where a young person can give valid consent to research, the consent of the parents or guardian is not strictly necessary. However, parents and guardians should be involved in the decision wherever possible.

If a patient under the age of 18 years has capacity to make a decision about research and refuses consent, the research cannot be performed.

Where a patient under the age of 18 years does not have capacity to consent to research, in general, the parent or an appointed guardian who has the power to make decisions about the proposed research may give consent on their behalf. The authorised psychiatrist should seek advice from the Office of the Public Advocate if there is any doubt about whether a parent or guardian has the power to give consent to research on behalf of a child or there is disagreement between the parents and the child.

Where a young person is incapable of consenting to research and there is no parent or guardian who is reasonably available, willing and able to make a decision, the research cannot be performed. If the research is considered necessary, the authorised psychiatrist might consider making an application for a guardian to be appointed under the Children, Youth and Families Act. Advice should be sought from the Office of the Public Advocate.

The authorised psychiatrist cannot consent to research, even when the research may be considered to be a psychiatric treatment, for example, a drug trial intended to treat the young person's mental illness.

Medical Treatment Act continues to apply

A medical practitioner must not carry out any medical research procedure, including any emergency treatment (see below), if the medical practitioner knows that a 'Refusal of treatment certificate' has been completed and is in force in accordance with the Medical Treatment Act.

Further information is available from the Office of the Public Advocate on 9 603 9500, 1300 309 337 (toll free) or www.publicadvocate.vic.gov.au

Emergency treatment

A medical research procedure (which is part of a research project that has been approved by a human research ethics committee⁴¹) may be carried out without consent, if a registered medical practitioner believes on reasonable grounds that the procedure is **necessary**, as a matter of urgency, to:

- save a patient's life
- prevent serious damage to a patient's health
- prevent a patient from suffering or continuing to suffer significant pain or distress.⁴²

However, in the context of research, it is anticipated that this source of authority would be rarely exercised. The practitioner would need to have reasonable grounds for believing that the medical research procedure is necessary on the basis that available conventional treatment would not meet the patient's urgent clinical needs.

41 Section 42P(3), Guardianship and Administration Act

42 Section 42A, Guardianship and Administration Act

About Chief Psychiatrist's Guidelines

The information provided in this guideline is intended as general information and not as legal advice.

Mental health service management should ensure that policies and procedures are developed and implemented to enable staff to assess and manage the physical and medical needs of people and, where required, to obtain and document valid consent for medical treatment, non-psychiatric treatment, special procedures and medical research procedures.

If mental health staff have queries about individual cases or their obligations under the Mental Health Act or the Guardianship and Administration Act, service providers should obtain independent legal advice.

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The flowchart in Appendix 2 is reproduced from the Public Advocate's website at www.publicadvocate.vic.gov.au

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Further information

For further information about general health and non-psychiatric treatment contact the Chief Psychiatrist on 1300 767 299 or 9096 7571.

For information about special procedures contact the Guardianship List on 9628 9911, 1800 133 055 (toll free) or www.vcat.vic.gov.au, or the Office of the Public Advocate on 9603 9500, 1300 309 337 (toll free) or www.publicadvocate.vic.gov.au

For information about medical research procedures visit the Public Advocate's website or contact your local human research ethics committee. Additional information is available on the Department of Human Services' website at www.health.vic.gov.au/legislation/medicalresearch.htm

Electronic copies of the Mental Health Act and the Guardianship and Administration Act can be viewed or downloaded from the legislation and parliamentary documents website www.legislation.vic.gov.au



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Appendix 1

Self-assessment tool

The following indicators are provided to assist services in developing and implementing policies and procedures to enable staff to assess and manage the physical and medical needs of people and, where required, to obtain and document valid consent for medical or non-psychiatric treatment.

Standard 1: Each area mental health service has local policies and procedures for timely and appropriate attention to the physical health care needs of people. These include protocols with relevant services to promote access to general and specialist health services, including dental services.

Indicators:

- The clinical record shows evidence that each person's physical health care needs are appropriately assessed and considered in clinical management, discharge planning and in recommendations for treatment and management.
 - Services develop and implement protocols for liaison with general health physicians regarding ongoing monitoring, results of recent investigations and care of specific medical health needs.
 - The clinical record shows evidence of the person's and, where appropriate, family involvement in decisions and discussions regarding management of the person's physical health care needs.
 - All involuntary, security and forensic patients are examined with regard to their physical and mental health at least once a year, as required under section 87 of the Mental Health Act, and the authorised psychiatrist submits a completed *Annual examination of patient* (MHA 32) form to the Chief Psychiatrist within four weeks of the examination.
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Standard 2: Each area mental health service has an established policy and procedure concerning non-psychiatric treatment.

Indicators:

- There is a written policy and procedure concerning non-psychiatric treatment based on, or advised by, these guidelines.
 - Clinical staff are able to articulate a working knowledge of the key principles, statutory requirements and issues about the classes of non-psychiatric treatment and relevant local policy and procedures.
 - A register of major non-psychiatric treatment is maintained and regularly updated.
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Standard 3: That where a person who is in receipt of treatment for a mental disorder has a non-psychiatric treatment, that the clinical record demonstrates sound clinical practice and that the requirements of these guidelines have been met.

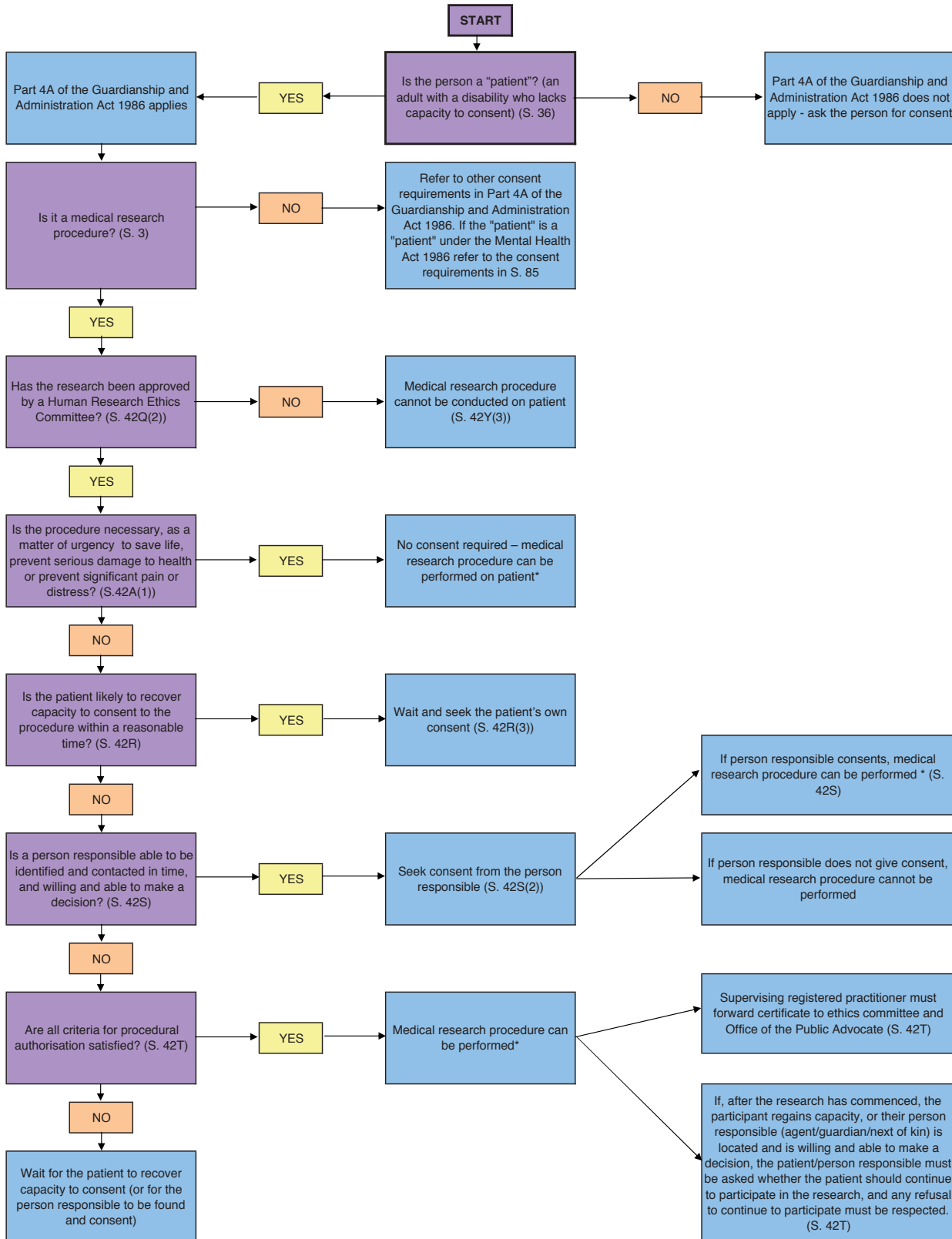
Indicators:

- Clinical record documentation contains the requirements of these guidelines and local policy and procedures.
 - Each person has a documented treatment and care plan that includes identification of the non-psychiatric condition, related clinical needs and strategies for their management.
 - The rationale for the decision to provide a non-psychiatric treatment is detailed in the clinical record.
 - Details of the process of obtaining informed consent or substitute consent are recorded and a copy of the consent form is in the clinical record.
 - Details of second opinions, where applicable, are recorded.
 - Where a guardian, agent or custodian gives consent to the non-psychiatric treatment, that a copy of the relevant authorisation (guardianship order, enduring power of attorney) is clearly identified in the clinical record.
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Appendix 2

Approval process for medical research procedures to be performed in Victoria on adults with a disability who lack capacity to consent (*Guardianship and Administration Act 1986*)

Available at www.health.vic.gov.au/legislation/flowchart.pdf



* Medical research procedure cannot be conducted if there is a relevant refusal of medical treatment under *Medical Treatment Act (S. 42P(5))*.