Queensland Health

Guideline: Legislative frameworks relevant to the management of COVID-19

Table of Contents

Queensland Government

1. Background

This document was developed by the Mental Health Alcohol and Other Drugs Branch in conjunction with the Communicable Diseases Branch and the Office of the Chief Health Officer.

Acknowledgements are owed to Gold Coast Hospital and Health Service and the Sydney Local Health District Mental Health Service NSW for the development of resources which informed this document.

2. General

On 29 January 2020, a public health emergency was declared under the *Public Health Act 2005* (PHA) due to the COVID-19 pandemic. The public health emergency was extended several times and on 31 October 2022 the temporary legislative framework expired.

On 1 November 2022, amendments to the PHA to include temporary targeted powers to manage COVID-19 as a controlled notifiable condition[1] commenced. These powers are available to the Chief Health Officer until 31 October 2023 to prevent or respond to a serious risk to the public health system or community due to COVID-19 or to implement a national decision on the management of COVID-19.

Under the PHA there was an existing power to declare a public health emergency, irrespective of COVID-19, and this remains unchanged. Where an emergency is declared, or the temporary targeted powers are enacted, there may be an impact on the coordination of treatment and care to patients in hospital.

Respect for a competent person's right to consent to or refuse treatment and provision of care that is least restrictive of their rights and freedoms is fundamental to health care. However, managing COVID-19 under the PHA enlivens complex decision-making regarding community safety, and in some cases, clinicians may need to consider using lawful means to detain and treat patients.

This document provides guidance on the application of the temporary targeted powers to manage COVID-19 under the PHA.

Section 4 of this guideline provides guidance on the application of PHA public health emergency declaration powers, however these are **only applicable if a public health emergency is declared**.

Considerations are also highlighted within this document for the application of the *Mental Health Act 2016* (MHA), *Guardianship and Administration Act 2000,* and *Powers of Attorney Act 1998* in relation to decision making for individuals with impaired capacity to consent.

Related resource: Appendix 1: Flowchart - Managing non-compliance with the *Public Health Act 2005*

[1] As defined in the *Public Health Act 2005* – a Notifiable condition is a medical condition that is a significant risk to public health and has been prescribed under a regulation as a notifiable condition.

A person may be appointed by the chief executive as an **authorised person** for the purpose of exercising powers under the PHA generally, for stated provisions of the PHA or for stated public health risks.

An **authorised person** may be:

- a public service officer or employee, or
- a health service employee, or
- a person prescribed under a regulation.

The person must have the necessary expertise or experience relevant to the appointment and must exercise the powers subject to the directions of the administering executive.

Each Hospital and Health Service retains a list of authorised persons on the Instrument of Appointment for the PHA. A clinical service seeking support from an authorised person should contact their local Public Health Unit.

3. Public Health Directions for COVID-19

The Chief Health Officer may give any of the following public health directions if COVID-19 is a controlled notifiable condition (Chapter 3 Part 5A PHA):

- that persons must wear or carry a face mask in stated circumstances, such as high-risk settings like hospitals and aged care.
- **isolate –** that a person who tests positive for COVID-19 must stay at a stated place (e.g. home or other suitable accommodation) and not otherwise have contact with stated persons for a period of not more than 7 days.
- **quarantine –** that a person who is symptomatic and has had contact of a stated type (e.g. stated duration) with a person who has tested positive for COVID-19 must stay at a stated place (e.g. home or other suitable accommodation) and otherwise avoid contact with stated persons for a period of not more than 7 days.
- that workers at stated places must not enter or remain at the places unless they have been vaccinated against COVID-19 in a stated way.

A public health direction is given by notice published on the department's website or in the Government gazette (section 142G PHA).

Information regarding the Chief Health Officer Public Health Directions is available on the Queensland Health Chief Health Officer Public Health Directions webpage.

Additional information regarding the current traffic light status for COVID-19 is available on the Queensland Government Traffic Light Advice webpage.

3.1. Enforcement of Public Health Directions

A person must comply with a Public Health direction unless they have a reasonable excuse (maximum penalty – 100 penalty units (section 142K PHA)).

An authorised person can direct a person to take certain actions to enforce the public health direction.

While a Public Health Direction is in place, an authorised person can take enforcement action against:

- a person who tests positive for COVID-19, or
- a person who is symptomatic and has had contact with a person who has tested positive for COVID-19, or
- a worker who has entered or remained at a place stated in a public health direction without having been vaccinated against COVID-19 in the way stated in the direction.

This may include by directing the person to go to and stay at a stated place or direct a worker who is unvaccinated to leave a certain place.

Prior to taking any enforcement action, the authorised person must give the person or worker an opportunity to voluntarily comply with the direction.

Where a person fails to comply with the instruction of an authorised person, the authorised person may enforce the public health direction with the help and using the force that is reasonable in the circumstances (section 142Q PHA).

Related resource: Appendix 2: Practical guidance for reasonable use of force

4. Declaration of Public Health Emergency

NOTE: Public health emergency declaration powers outlined in this section are **only applicable if a public health emergency is declared**.

A public health emergency may be declared by the Minister for Health and Ambulance Services under section 319 of the PHA, if:

- there is an event or a series of events that has contributed to, or may contribute to, serious adverse effects on the health of persons in Queensland, and
- it is necessary to exercise powers under Chapter 8 of the PHA to prevent or minimise serious adverse effects on human health.

A declared public health emergency will end 7 days after the day it is declared unless the Minister chooses to end it sooner or extend the duration beyond 7 days by regulation.

A declared public health emergency may be for a specific area or the whole of Queensland and should be reviewed to ensure it applies in the location where powers are seeking to be exercised.

4.1. Emergency officers

If a public health emergency is declared under the PHA, the chief executive is responsible for the overall management and control of the response to the emergency and may, by instrument, appoint persons as emergency officers (general) and emergency officers (medical).

Emergency officers may be appointed only if the chief executive considers the person has the necessary expertise and experience and must act in accordance with the conditions stated in the instrument of appointment.

An emergency officer may resign by signed notice of resignation given to the chief executive.

Emergency officer (general)

An emergency officer (general) (EO-G) can be:

- a public service officer or employee
- a health service employee
- a person employed by local government (for the local government's area and any other local government area stated in the appointment)
- an SES member under the *Fire and Emergency Services Act 1990*, or
- another person prescribed under a regulation.

Emergency officer (medical)

An emergency officer (medical) (EO-M) can be:

- a doctor who is a public service officer or employee
- health service employee, or
- another person prescribed under regulation.

Typically, Public Health Physicians, Public Health Medical Officers and potentially Public Health Registrars are appointed.

These positions are predominately based in Hospital and Health Service Public Health Units.

4.1.1. Powers of emergency officers during a Public Health Emergency

All emergency powers of an EO-Gs and EO-Ms can be found under section 345 of the PHA. These include that emergency officers may give a person a direction to, for example:

- not enter or not remain within a place
- stop using a place for a stated purpose, or
- stay at or in a stated place for a stated period.

4.1.2. Enforcement of emergency officer powers

A person must comply with a requirement or direction given by an emergency officer unless the person has a reasonable excuse (maximum penalty – 100 penalty units) (section 346(1) PHA). Where a person fails to comply with a requirement/direction, an emergency officer may enforce the direction with help and using the force that is reasonable in the circumstances (section 345(3) PHA).

A person required to give reasonable help must comply with the requirement, unless the person has a reasonable excuse (maximum penalty – 100 penalty units) (section 348 PHA).

Related resource: Appendix 2: Practical guidance for reasonable use of force

4.2. Detention order (EO-Ms) during public health emergency

Detention Orders are used in rare circumstances and should be considered only as a **last resort**.

An EO-M may order detention of a person under section 349 of the PHA, if:

- a person in a public health emergency area has or may have a serious disease or illness, and
- the serious disease or illness, or the serious disease or illness and the person's likely behaviour, constitutes an immediate risk to public health, and
- it is necessary to detain the person to effectively respond to the declared public health emergency.

The place at which a person may be detained includes the person's home, or another place decided by the EO-M, for example a hospital or isolation area established under section 352 of the PHA.

A detention order ends—

- 96 hours from the time it is given to the person the subject of the order, or
- if a lesser period is stated in the order, at the end of the lesser period.

However, the person must be released before the detention order ends if—

- an EO-M is satisfied the person is no longer an immediate risk to public health, or
- if the person has been examined by a doctor chosen by the person—both the doctor and the EO-M are satisfied the person is no longer an immediate risk to public health.

If the EO-M determines it is necessary to detain the person beyond the time the detention order was made, they may apply to a magistrate to extend the order (before the order ends).

Related resource: Form: Magistrate's extension of a detention order by an Emergency Officer Medical (Queensland Health staff access only)

4.2.1. Medical examination under a detention order

As soon as practicable after a person is detained, an EO-M must request that the person be medically examined (including a test such as a nasal swab) for the purpose of:

- diagnosing and treating COVID-19, and
- to decide whether the person is an immediate risk to public health.

A person retains the right to refuse the examination (section 354(2)(b) PHA).

If agreement cannot be reached with the patient, the examination should not be completed. Instead, an EO-M may consider detaining the person in isolation for all or part of the period of detention.

See Testing and treatment of COVID-19 section of this document for further information.

4.2.2. Enforcement of a detention order during public health emergency

A person must comply with a detention order made by an EO-M unless the person has a reasonable excuse (maximum penalty – 200 penalty units) (section 351(4) PHA).

Before taking steps to enforce a detention order, a person must be given the opportunity to voluntarily comply with the order.

Use of force

If a person fails to willingly comply with a detention order, an EO-M may take action to enforce the order with the help, and using the force, that is reasonable and necessary in the circumstances (section 351(5) PHA).

- These powers apply **only** to EO-Ms.
- Clinicians, including doctors not appointed as an EO-M have **no general powers to enforce or assist** with enforcing a detention order unless nominated to do so by an EO-M.
- A detention order may be enforced by the EO-M or a person nominated by the EO-M.

Related resource: Appendix 2: Practical guidance for reasonable use of force

5. Testing and treatment of COVID-19

NOTE: Guidance in this section applies in relation to persons subject to a public health direction for COVID-19 and/or requirements under the PHA Public health emergency declaration powers.

Wherever possible, obtaining patient consent (including consent provided with the assistance of someone else) for testing and treatment of COVID-19 should occur.

Refer to the Queensland Health Guide to informed decision making in healthcare[2] for guidance on the ethical and legal requirements surrounding informed decision-making about health care.

As highlighted in the Queensland Health Guide, in circumstances where an adult patient does not have capacity to provide consent, consideration should be given to alternative consent mechanisms under the *Guardianship and Administration Act 2000* and *Powers of Attorney Act 1998* in relation to decision making for individuals with impaired capacity (see the Office of the Public Guardian Health Care Decision Making Framework (Adult)).

Related resource: Appendix 3: Pathway for patients with impaired capacity to consent

[2] The Queensland Health Guide to informed decision making in healthcare is currently under review by Queensland Health Patient Safety and Quality.

5.1. Medical examination under the *Public Health Act 2005*

There are powers under the PHA to enforce a requirement for a person to be tested or receive treatment for a controlled notifiable condition (including COVID-19). Under section 116 of the PHA, the Chief Executive (or delegate) may apply to a magistrate for a controlled notifiable condition order (initial examination order) if a person has or is believed to have COVID-19 and requires a medical examination to ascertain whether they have the condition.

The use of Magistrates Orders to enforce testing and treatment is **not the preferred position of Queensland Health** due to the invasive nature of this approach, therefore every attempt should be made to obtain consent from the patient for necessary testing and treatment.

The magistrate may make the initial examination order if they believe the person's condition and/or behaviour **presents an immediate risk to public health** and the person has been satisfactorily counselled about the condition and its possible effect on their health and on public health.

The initial examination order may provide for any or all of the following:

- that the person be detained at a stated place
- that the person be detained in isolation for part or all of the period of detention
- that the person is not detained for more than 72 hours
- that if the person is not at the place where they are to be detained, that the person be taken to and detained at that place
- that the person undergoes the medical examination stated in the order by a doctor nominated by the chief executive to ascertain whether the person has the controlled notifiable condition.

5.1.1. Enforcement of an initial examination order

The person detained under an initial examination order must remain at the place of detention for the period stated in the order and undergo the stated medical examination, unless the chief executive is satisfied that the reason for the order no longer exists (maximum penalty – 400 penalty units (section 121 PHA)).

An authorised person may exercise powers under the initial examination order with the help and using the force that is reasonable in the circumstances.

The doctor undertaking the medical examination of the person under the initial examination order must if practicable –

- give an explanation to the person of the examination to be undertaken in a way that is likely to be readily understood by the person, and
- allow the person an opportunity to submit to the examination voluntarily.
    - If the person does not submit to the examination voluntarily, the doctor may undertake the examination with the help, and using the force, that is reasonable in the circumstances.

Related resource: Appendix 2: Practical guidance for reasonable use of force

5.2. Behavioural disturbance

An assessment of factors contributing to disturbed behaviour is necessary to determine how a patient is to be managed. Factors may, for example, include medical illness (e.g., causing delirium), mental illness, situational or personality factors. Where appropriate, mental health consultation is available to facilitate assessment and advice on behavioural disturbance.

Involuntary treatment of mental illness under the MHA only applies if:

- the person meets defined treatment criteria including the presence of a mental illness, and
- there is no less restrictive way to obtain consent for the person's mental health treatment and care.

In urgent circumstances, provisions for urgent health care under section 63 of the *Guardianship and Administration Act 2000* may apply.

Related resources:

Appendix 4: Urgent health care under the Guardianship and Administration Act 2000

Office of the Public Guardian Health Care Decision Making Framework (Adult)

5.2.1. Behavioural order (magistrate)

Under the PHA, the chief executive may apply to a magistrate for a controlled notifiable conditions order (behavioural order). The magistrate may make a behavioural order for the person if the magistrate is satisfied that the person has COVID-19 and the person may constitute an immediate risk to public health, either by way of the person's condition or the person's condition and likely behaviour.

- Prior to applying for a behavioural order, if it is practicable, reasonable attempts must have been made to counsel the person, about the condition and its possible effect on the person's health and on public health.

The behavioural order may provide that the person do any or all of the following for the period stated in the order –

- undergo counselling by a stated person or persons
- refrain from stated conduct
- refrain from visiting stated places
- submit to supervision and monitoring by another person (be by a particular person, or a person nominated by the chief executive, and be done in a stated way), also
- the order may be made subject to the conditions the magistrate considers appropriate.

5.2.2. Enforcement of behavioural order

Once a behavioural order has been made for a person and the person has been given a copy of the order, they must comply with the order (maximum penalty – 400 penalty units (section 128 PHA)).

An authorised person may exercise powers under the behavioural order with the help and using the force that is reasonable in the circumstances.

Related resource: Appendix 2: Practical guidance for reasonable use of force

5.3. Detention order (magistrate)

Detention Orders are used in rare circumstances and should be considered only as a **last resort**.

Under the PHA, the chief executive may apply to a magistrate for a controlled notifiable conditions order (detention order). The magistrate may make a detention order for the person if the magistrate is satisfied that:

- the person has COVID-19, and
- the person may constitute an immediate risk to public health, either by way of the person's condition or the person's condition and likely behaviour.

Prior to applying for a detention order, if it is practicable, reasonable attempts must have been made to counsel the person, about the condition and its possible effect on the person's health and on public health.

The detention order may provide that the person do any or all of the following for the period stated in the order:

- that the person be detained at a stated place for a stated period of not more than 28 days
- that the person be detained in isolation for part or all of the period of detention
- if the person is not at the place where they are to be detained, that the person be taken to and detained at that place
- that the person undergoes the medical examination or treatment stated in the order by a doctor nominated by the chief executive
- the order may be made subject to the conditions that the magistrate considers appropriate.

As soon as practicable after a detention order is made for a person, an authorised person must:

- give the person a copy of the order, and
- explain the terms and effect of the order (including that they must remain at the place of detention and undergo medical examination or treatment), and the penalty for not complying with the order, and
- if the person is not at the place where they are to be detained, give the person an opportunity to voluntarily accompany the authorised person to the place, and
- give the person notice about the right of appeal against the order and how to appeal.

Related resource: Procedure: Public Health Act – Detention order for a controlled notifiable condition - Queensland Health Communicable Diseases Branch (Queensland Health staff access only)

5.3.1. Enforcement of detention order

The person detained under a detention order must remain at the place of detention for the period stated in the order and undergo the stated medical examination, unless the chief executive is satisfied that the reason for the order no longer exists (maximum penalty – 400 penalty units (section 132 PHA)).

An authorised person may exercise powers under the detention order with the help and using the force that is reasonable in the circumstances.

Related resource: Appendix 2: Practical guidance for reasonable use of force

6. Considerations for patients of mental health services

6.1. Isolation and quarantine

The circumstances surrounding isolation and quarantine can act as a stressor which can exacerbate an individual's mental illness. Where appropriate, both the MHA and PHA may need to be considered having regard to the individual circumstances and treatment and care needs. Consultation with the relevant authorised doctor in addition to the clinical director of the mental health service where appropriate, is required to determine the appropriate management strategy.

Where a patient can be safely and effectively managed using the powers under the PHA (i.e., quarantine, isolation or detention), the PHA will apply.

Where the individual's clinical presentation necessitates, and the person meets the relevant treatment criteria under the MHA, provisions under the MHA may apply.

The MHA provides a range of powers and associated safeguards to enable treatment of mental illness including powers to detain and seclude a person in an authorised mental health service. This includes circumstances where the person is or may otherwise be subject to a direction under the PHA.

Related resource: Appendix 1: Flowchart - Managing non-compliance with the *Public Health Act 2005*

6.2. Seclusion under the *Mental Health Act 2016*

Seclusion significantly affects patient rights and liberty and therefore can only be authorised as a last resort to prevent imminent and serious risk of harm to patients or others, where less restrictive interventions have been unsuccessful or are not feasible. Imminent and serious risk of harm may include risk of infecting others with a controlled notifiable condition (including COVID-19).

If a patient subject to a treatment authority, forensic order or treatment support order is unwilling or unable to voluntarily comply with a PHA direction because of lack of capacity, and they require acute mental health inpatient treatment and care, this may include seclusion in an authorised mental health service under the MHA where the requirements under the MHA are met. This is on the basis that:

- they are a risk of physical harm to others (including of infecting others)
- seclusion is necessary to prevent this harm
- seclusion under the MHA is subject to mandatory oversight and monitoring requirements.

Clinical judgement of the patient's medical and psychiatric risk of harm to themselves and others should be used in deciding the most appropriate location of seclusion. The use of seclusion in the patient's room may be considered where appropriate.

While seclusion under the MHA is most appropriately applied within specialist mental health units, it may be applied in any ward of an authorised mental health service. All public sector hospitals with acute mental health units are authorised mental health services (i.e. all clinical areas of the hospital are designated). MHA legislative and Chief Psychiatrist policy requirements relating to seclusion apply and arrangements must ensure appropriate mental health clinical oversight in compliance with the Chief Psychiatrist Policy Seclusion.

6.3. Voluntary patients of mental health services

Voluntary patients (including classified patients – voluntary) receiving treatment and care in an authorised mental health service cannot be secluded under the MHA. This includes patients who are subject to involuntary assessment.

If a voluntary patient does not willingly comply with a PHA direction and this non-compliance is suspected to be related to the person's mental illness, an assessment should be made as to whether the patient meets the involuntary treatment criteria under the MHA.

Related resource: Appendix 1: Flowchart - Managing non-compliance with the *Public Health Act 2005*

6.4. Transfer considerations for patients of mental health services

If a patient receiving inpatient care under the MHA requires admission to a health service for the treatment of COVID-19 outside their current authorised mental health service, staff must ensure the necessary approvals are in place for patient transfer, limited community treatment or temporary absence in accordance with the MHA.

In urgent circumstances, the Chief Psychiatrist may approve a temporary absence from an authorised mental health service for patient's subject to forensic orders, detained under a judicial order or admitted as classified patients to facilitate a patient receiving medical treatment.

Related resource: Chief Psychiatrist Policy Temporary absences

7. Further information

Referenced documents and resources

Chief Psychiatrist Policy: Seclusion

Chief Psychiatrist Policy: Temporary absences

Flowchart: Managing non-compliance with directions given under the *Public Health Act 2005*

Flowchart: Pathway for patients with impaired capacity to consent

Resource: Queensland Health Guide to informed decision-making in health care (UNDER REVIEW)

Resource: Office of the Public Guardian Health Care Decision Making Framework (Adult)

Procedure: Public Health Act – Detention order for a controlled notifiable condition (Queensland Health staff access only)

Form: Magistrate's extension of a detention order by an Emergency Officer Medical (Queensland Health staff access only)

Related links and information

Legislation: Public Health Act 2005

Legislation: Mental Health Act 2016

Queensland Government website: Public Health Act 2005

Queensland Government website: Chief Health Officer public health directions

Queensland Government website: COVID-19 information for Queensland clinicians

QHEPS: Queensland Occupational Violence Strategy Unit (Queensland Health staff access only)

Resource: Hospital in the home: During a pandemic

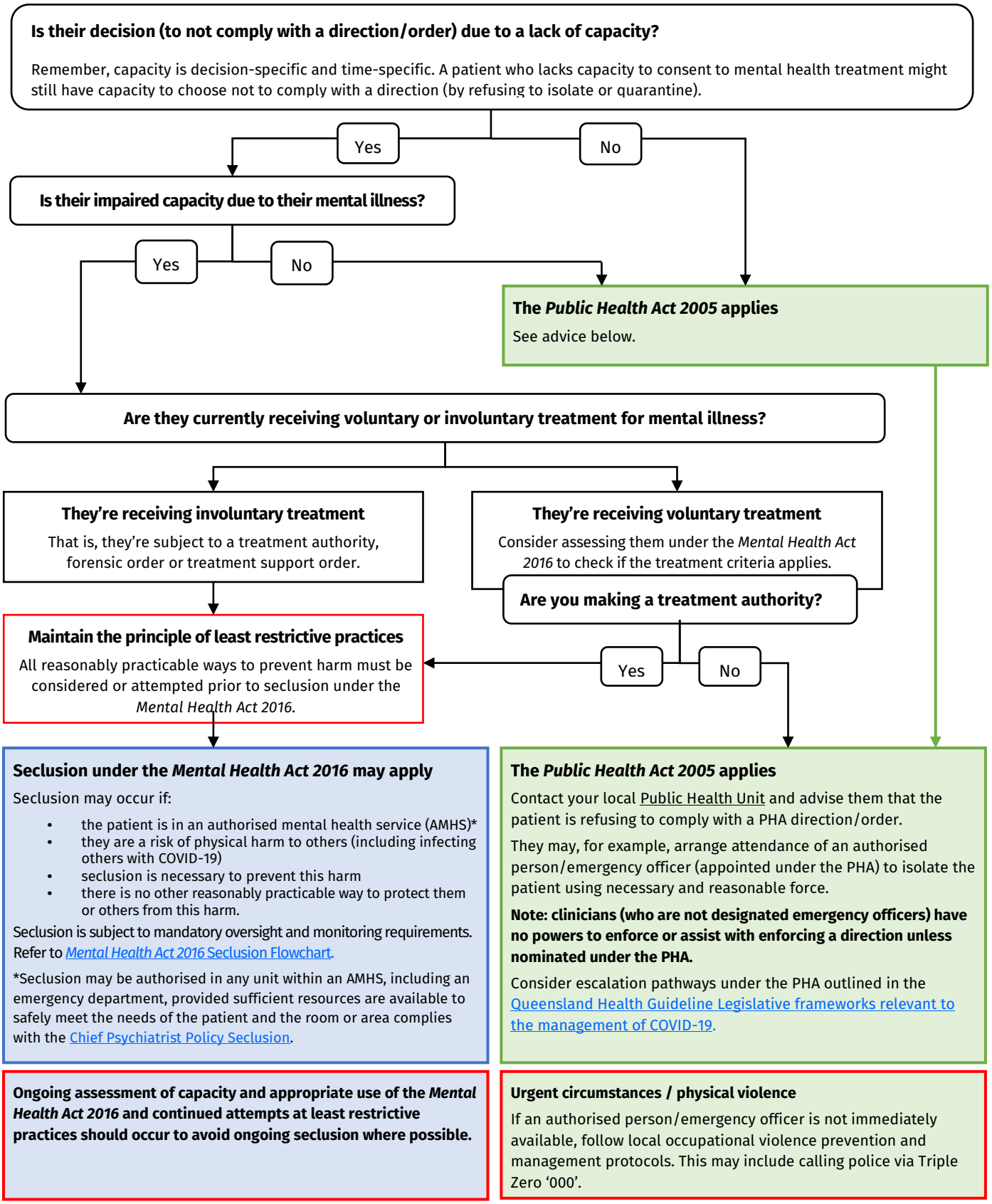
Website: www.health.qld.gov.au/mental-health-act

Document status summary	
Date approved:	5 April 2023
Supersedes version that took effect on:	29 November 2021

Appendix 1: Managing non-compliance with the *Public Health Act 2005*

Patients not complying with a public health direction/order

If repeated attempts to explain why the patient must follow the direction are unsuccessful, clinicians may need to consider lawful means to detain patients (to manage their treatment needs or risk of infecting others):



Appendix 2: Practical guidance for reasonable use of force

Before taking steps to enforce a direction/order made under the *Public Health Act 2005*, a person must be given the opportunity to voluntarily comply with the direction/order.

The urgency of the situation should be considered when determining action required to enforce a direction/order.

Where a person fails to comply with the instruction of an authorised person or emergency officer, the direction/order may be enforced with the help and using the force that is reasonable in the circumstances. For example:

Person unwilling to comply with a direction/order but is not physically trying to leave the facility

Public Health Direction:
Maximum penalty – 100 penalty units (section 142K PHA)

- The authorised person may consider if a request should be escalated to the Chief Executive (or delegate) to apply to a Magistrate for a controlled notifiable conditions order to be put in place (if not already).
  Maximum penalty – 400 penalty units

Public Health Emergency:

- **Direction made by an emergency officer**
  Maximum penalty – 100 penalty units (section 346(1) PHA)

  The local Public health unit may be called to request attendance by the EO-M to have a detention order put in place (if not already) or to have the direction enforced.
- **Detention order made by an EO-M**
  Maximum penalty – 200 penalty units (section 351(4) PHA)

  Staff of the health service should explain the requirements of the order and the necessary action to be taken and/or penalties for the person if they do not comply with the order.

Person has attempted to abscond or is actively trying to leave the facility

- An authorised person/emergency officer (or person nominated by an EO-M (including police if required)) should immediately be called to enforce the direction/order, including with necessary and reasonable force if required.

After hours

- A request to police via Triple Zero '000' in the first instance may be necessary to ensure an immediate response.

Urgent circumstances/physical violence

- Where an authorised person/emergency officer (or person nominated by an EO-M) is not immediately available, local occupational violence prevention and management protocols should be followed.

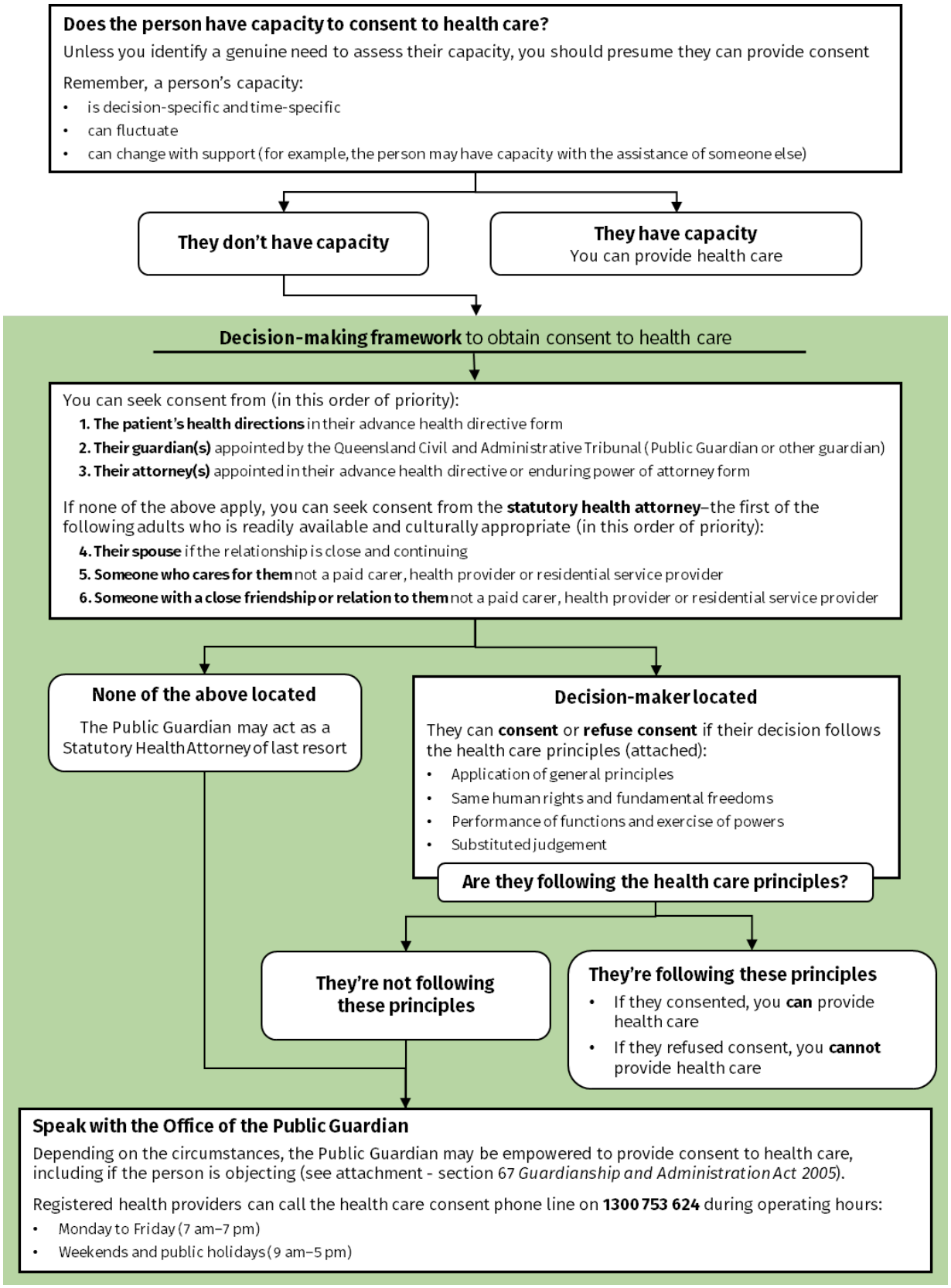
Note: If there is a physical confrontation element, the authorised person/emergency officer would likely call the police via Triple Zero '000' to apply reasonable use of force.

Appendix 3: Pathway for patients with impaired capacity to consent to health care

This document must be read in conjunction with the Queensland Health Guide to informed decision making in health care.

Considerations include:

- obligations to record decisions on the person's health record
- a person may withdraw consent at any time



Guardianship and Administration Act 2000

Section 67 Effect of adult's objection to health care

(1) Generally, the exercise of power for a health matter or special health matter is ineffective to give consent to health care of an adult if the health provider knows, or ought reasonably to know, the adult objects to the health care.

Note—the Powers of Attorney Act 1998, section 35(2)(a) (Advance health directives) provides that 'by an advance health directive [a] principal may give a direction—

(a) consenting, in the circumstances specified, to particular future health care of the principal when necessary and despite objection by the principal when the health care is provided'.

(2) However, the exercise of power for a health matter or special health matter is effective to give consent to the health care despite an objection by the adult to the health care if—

(a) (a) the adult has minimal or no understanding of 1 of the following—

(i) what the health care involves

(ii) why the health care is required, and

(b) (b) the health care is likely to cause the adult—

(iii) no distress, or

(iv) temporary distress that is outweighed by the benefit to the adult of the proposed health care.

(3) Subsection (2) does not apply to the following health care—

(a) removal of tissue for donation

(b) participation in special medical research or experimental health care or approved clinical research.

Health Care Principles

Anyone who exercises a function or power under the *Guardianship and Administration Act 2000* in relation to a health matter must apply the Health Care Principles (section 11C).

1. Apply the general principles

This principle recognises that both the general principles and the health care principles must be applied when any person or entity performs a function or exercises a power in relation to health care or special health care under Queensland's guardianship legislation.

2. Same human rights and fundamental freedoms

This principle provides further guidance about applying general principle 2 in relation to health matters or special health matters.

In recognising and taking into account **non-discrimination**, all adults, regardless of whether or not they have impaired capacity, must be offered appropriate health care, including preventative care. When consenting to or refusing health care for an adult the principles of **respect for inherent dignity and worth**, individual autonomy (including the freedom to make one's own choices) and **independence of persons** must be taken into account.

3. Performance of functions or exercise of powers

This principle provides further guidance about applying general principles 9 and 10 in relation to health matters or special health matters. When making a decision or exercising a power about an adult's health care or special health care, the following must be taken into account:

- information given by the adult's health care provider
- the nature of the adult's medical condition and prognosis
- any available alternative health care treatments
- significant risks of the proposed health care or alternative health care
- whether the health care could be postponed because a better option may become available within a reasonable time or the adult is likely to become capable of making their own decision about the health care
- the consequences if the proposed health care is not carried out
- the advantages and disadvantages of the proposed health care
- the effect of the health care on the adult's dignity and autonomy.

4. Substituted judgement

This principle provides further guidance about applying general principle 10 in relation to health matters or special health matters, when it is not possible to determine the adult's views and wishes at the time. It clarifies that the adult's **views, wishes or preferences expressed** when the adult had capacity, may also have been expressed in their advance health directive; or any previous decision by the adult to consent to or refuse health care

Contact us

t. 1300 653 187
e. publicguardian@publicguardian.qld.gov.au
w. www.publicguardian.qld.gov.au

If you need translation services, contact the Translating and Interpreting Service on 131 450.

SOURCE: www.publicguardian.qld.gov.au/__data/assets/pdf_file/0007/572353/OPG-Factsheet_Health-Care-Principles.pdf

Appendix 4: Urgent health care under the *Guardianship and Administration Act 2000*

Section 63 Urgent health care

(1) Health care, other than special health care, of an adult may be carried out without consent if the adult's health provider reasonably considers—

(a) the adult has impaired capacity for the health matter concerned, and

(b) either—

(i) the health care should be carried out urgently to meet imminent risk to the adult's life or health, or

(ii) the health care should be carried out urgently to prevent significant pain or distress to the adult and it is not reasonably practicable to get consent from a person who may give it under this Act or the *Powers of Attorney Act 1998*.

(2) However, the health care mentioned in subsection (1)(b)(i) may not be carried out without consent if the health provider knows the adult objects to the health care in an advance health directive.

(3) However, the health care mentioned in subsection (1)(b)(ii) may not be carried out without consent if the health provider knows the adult objects to the health care unless —

(a) the adult has minimal or no understanding of 1 or both of the following —

(i) what the health care involves

(ii) why the health care is required, and

(b) the health care is likely to cause the adult —

(i) no distress, or

(ii) temporary distress that is outweighed by the benefit to the adult of the health care.

(4) The health provider must certify in the adult's clinical records as to the various things enabling the health care to be carried out because of this section.

(5) In this section — ***health care***, of an adult, does not include withholding or withdrawal of a life-sustaining measure for the adult.