# Preliminary submission to the NSW Law Reform Commission on the Review of the Guardianship Act 1987

This is the response of the NSW Mental Health Review Tribunal (MHRT) to the call for preliminary submissions by the NSW Law Reform Commission (LRC). The MHRT anticipates making a significant contribution to the LRC review with respect to the interaction between the *Guardianship Act* and the *Mental Health Act 2007* (NSW).

## Some general comments about the review

The MHRT supports an in principle preference for supported decision making. The Tribunal's support for such an approach in relation to its own jurisdiction was made clear in its response to the Discussion Paper relating to the review of the Mental *Health Act 2007*. The Tribunal in answer to whether it supported the further exploration of supported decision making gave it in principle support, noting that

> "One reason is that such an approach is critical for the successful implementation of a plan that the patient is involved in the development of the treatment plan and in exploring options for treatment".

In 2015, comprehensive amendments to the *Mental Health Act* were proclaimed. They emphasised a person centred, recovery approach with the s 68 principles of care and treatment stating:

> (h) every effort that is reasonably practicable should be made to involve persons with a mental illness or mental disorder in the development of treatment plans and recovery plans and to consider their views and expressed wishes in that development,
>
> (h1) every effort that is reasonably practicable should be made to obtain the consent of people with a mental illness or mental disorder when developing treatment plans and recovery plans for their care, to monitor their capacity to consent and to *support people who lack that capacity to understand treatment plans and recovery plans (emphasis added)…*
>
> (j) the role of carers for people with mental illness or mental disorder and their rights under this Act to be kept informed, to be involved and to have information provided by them considered, should be given effect.

The MHRT considers that supported decision making is generally preferable because it empowers consumers in their recovery and is consistent with the protection of their human rights and relevant international principles and instruments. Supported decision making may also lead to more effective decisions and plans as consumers are more likely to embrace and follow decisions and plans that they themselves have had a major role in developing. Substituted decision making is generally regarded as less desirable as it is viewed as a paternalistic approach that impedes consumer empowerment and restricts consumers' human rights.

However, there may be individual circumstances where supported decision making may be inappropriate for a variety of reasons such as that a consumer patently lacks the capacity to fulfil such a role in a manner that protects their best interests, a consumer does not want such a role, and/or where there are likely risks of serious financial loss or exploitation which clearly outweigh the benefits of supported decision making.

Moreover, there are complex questions as to how to frame the decision making process in legislation including how much statutory guidance should be given, for example, the inclusion of an exhaustive list of mandatory factors to consider or merely non mandatory matters in a non-exhaustive list, and the level of discretion left for tribunals and other decision makers to deal with individual circumstances.

In practical terms, supported decision making raises issues about what level of support and assistance will be given, particularly when many consumers and their families and friends will have no, or little, knowledge about the new model and some people may have real problems in adapting to the new approach. The NSW Family and Community Services document 'Supported Decision Making Pilot – background and learnings which occurred in the context of transitioning to the NDIS shows how complex and demanding these changes may well be. The pilot found for example, that people with disability and their supporters often need time and assistance to understand supported decision making and to put it into practice. There were barriers to supported decision making which depended on the general life circumstances of people with disability. Trust between the person and the disability and his or her supporter is critical to building decision making capacity. Some people with disability will need additional help from volunteers, advocates and disability service workers. Other issues that arose in the pilot were power dynamics and imbalances, conflicts of interest and concerns about possible breaches of duty of care and legal actions.

A further issue is that with the NDIS being introduced with its own supported decision making model in NSW, some consumers, their advisors and practitioners may be faced with a confusing level of change and complexity, having to dealing with multiple institutions, different legislation and different decision making models: for example, the NDIS, the *Guardianship Act* and the *Mental Health Act*. It is anticipated that a cohort of hospital and community based patients with complex needs who are subject to orders under the *Mental Health Act* will become eligible for the NDIS.

Each legislative and decision making model may be different in either obvious or subtle ways and there is a concern that some people will fall through the administrative cracks or make mistakes that cause serious consequences. There will need to be clear guidelines and protocols on the nature and interaction of different systems and different legislation, appropriate information sharing, and also effective training, education and information sources for users and professionals. These requirements will involve a variety of State Acts (e.g. *National Disability Insurance Scheme (NSW Enabling) Act 2013*, *Disability Inclusion Act 2014*, *Guardianship Act 1987*, *Children and Young Persons (Care and Protection) Act 1998*; *Community Services (Complaints, Reviews and Monitoring Act) 1993*, *Privacy and Personal Information Protection Act 1998* and *Health Records and Information Privacy Act 2002*).

Another issue to consider is the resource implications of respective decision making processes also referred to in the LRC's terms of reference.

One other general point is that the MHRT would suggest that the terms of reference will require a significant consideration of overseas developments and other Australian jurisdictions to properly evaluate options and approaches.

## Some preliminary comments on the interaction between the Guardianship Act and the Mental Health Act

It is clear as indicated by the LRC's terms of reference that the interaction between the *Guardianship Act* and the *Mental Health Act* is of fundamental importance. From that key interaction it follows that the relationship between the Guardianship Division of NCAT and the MHRT is also especially important.

Changes to the *Guardianship Act* in many cases will have significant consequences for the *Mental Health Act* and the role of the MHRT. The MHRT is confident that the LRC is already aware that it will need to assess how any proposed changes might affect other legislation and other organizations.

The MHRT operates in two key areas – the civil jurisdiction and the forensic jurisdiction. It is the civil jurisdiction that clearly is most relevant for the Law Reform Commission inquiry.

In performing its role the Tribunal actively seeks to pursue the objectives of the *Mental Health Act*, including delivery of the best possible kind of care to each patient in the least restrictive environment and the requirements of the *United Nations Principles for the Protection of Persons with Mental illness and the Improvement of Mental Health Care* as well the *National Mental Health Service Standards*. The Tribunal seeks to maintain the balance between the Act's objectives while minimising the risk to the individual and the community.

### *Similarities and differences between the Tribunals*

Both tribunals are independent quasi- judicial bodies with specified statutory decision making powers and both are concerned with persons who, in the broad use of the term, suffer from a 'disability'. Both are intended to be protectionist, beneficent bodies that are to place a premium on protection of human rights and to limit paternalism. Both are intended to accord with international principles on the rights of those with a disability. Both are intended to provide fair, quick, efficient and relatively informal decision making. Neither is bound by the formal rules of evidence. However, there are also significant differences.

The primary function of the MHRT is to make and review orders about the treatment, care and detention of people with a mental illness who need to be treated involuntarily, whether within mental health facilities or in the community. The Tribunal must also hear appeals against the refusal by the authorised medical officer to discharge a detained or involuntary patient. In addition, the MHRT also determines applications for Electro Convulsive Therapy for voluntary and involuntary patients, and for certain patients decide issues as to consent to surgery (including sterilization, defined as "special medical treatment'. The MHRT also deals with matters pertaining to the financial management of people with incapacity as does the Guardianship Division, NCAT. In particular, the MHRT hears applications made under the *NSW Trustee and Guardianship Act 2009.*

The Guardianship Division is a specialist legal tribunal whose key role is the protection and empowerment of people living with a decision-making disability. It exercises a protective jurisdiction and facilitates substitute decision making by hearing and determining applications for the appointment of guardians and financial managers for adults with decision-making disabilities.

The *Mental Health Act* allows for involuntary detention of patients in special cases where, for example, there is a risk of serious physical harm to the person or to

others. Because such circumstances are often very urgent, the scheme for involuntary admission allows compulsory detention, containment and even treatment without any form of hearing until after the event.

The *Guardianship Act*, on the other hand, requires a hearing to take place and an order to be made before any coercive action can be taken. The Guardianship Division's focus is not on balancing public interest with private rights but rather its sole concern is with the welfare, interests and rights of the person with the disability.

There is an overlap between the provisions of the *Guardianship Act* and *Mental Health Act* in that in some instances a person may be subject to guardianship orders and the provisions of the Guardianship Act as well as the jurisdiction of the MHRT.

It is not uncommon for a person subject to a guardianship order to be detained in a mental health facility and therefore subject to care and treatment under the mental health legislation, or living in the community subject to a community treatment order approved by the MHRT.

***Treatment under the Mental Health Act***

One important example of overlap between the two Acts is in relation to medical treatments. Generally, consent to medical treatment unrelated to a person's mental illness is to be found in the *Mental Health Act* or the *Guardianship Act* depending on the person's status. This can lead to anomalies and confusion for practitioners and consumers.

The *Mental Health Act* has a substituted consent regime for specific non-mental health decisions, i.e. surgery and special medical treatment depending on the patient's status. All other treatments fall to be decided under the *Guardianship Act*, if the subject person lacks capacity to make decisions.

As the *Guardianship Act* also has a legislative regime for surgery and special medical treatment many clinicians working in mental health facilities have difficulty determining which regime applies and frequently seek advice from the MHRT.

The MHRT submitted in relation to the review of the *Mental Health Act* 2007 that "for ease and consistency" it would be preferable if the whole of the legislative regime governing medical decisions about a person detained in a mental health facility was governed by the *Mental Health Act*. The *Mental Health Act* review identified this as an issue which required further investigation and consideration.

It is suggested that the LRC review of the *Guardianship Act* could be widened to consider more broadly whether amendments should be made to allow the MHRT to be the decision maker for all medical decisions in circumstances where a person is detained in a mental health facility.

Another area of overlap and inconsistency relates to definitions in the two Acts. For example, in the *Guardianship Act*, a termination of pregnancy is defined (in cl. 9 of the Regs) as special medical treatment, and so requiring the authorisation of the Guardianship Division. However, a termination is considered to be "surgery" under the *Mental Health Act*. This means that, for involuntary patients *(which does not include assessable persons or detained persons) consent may be given by the Secretary of the Ministry of Health, if the patient's designated carer agrees with it, the patient is unable to give informed consent and it is "desirable, having regard to the interests of the patient" (* s 100(3)).

The MHRT considers that the *Guardianship Act* definition should be adopted, which means that only the MHRT could make such decisions, following a hearing. Such a legislative amendment would bring the *Mental Health Act* in better alignment with the *Guardianship Act*.

The *Mental Health Act* provides that an authorised medical officer may authorise the giving of any treatment, including medication to an involuntary patient *(s 84 involuntary patient is defined in s 82 to include 'a forensic patient, correctional patient and a person detained in a mental health facility) or assessable person detained in a mental health facility. Although the issue is not beyond doubt the MHRT has now for many years interpreted this to mean treatment in connection with the person's mental health condition. Accordingly, mental health treatment can be given to certain patients, without their consent even in circumstances where the patient has capacity to give consent but refuses.

In policy terms the rationale for overriding a competent person's decision is clear; the mental illness or condition is causing serious harm to the person or others and the treatment is necessary to mitigate the harm.

There is a fundamental tension between the objectives of the guardianship provisions and the mental health provisions in that the former focuses on the best interests and welfare of the subject person whereas under the mental health provisions there is a need to balance the interests of the subject person with the need to protect the safety of the patient and the general community.

***Financial management***

The MHRT also deals with matters pertaining to the financial management of people with incapacity as does the Guardianship Division. In particular, the MHRT hears applications made under the *NSW Trustee and Guardianship Act 2009* for the appointment of financial managers for persons who are unable to make competent financial decisions for themselves, usually because of mental illness or cognitive impairment. The MHRT is limited to making such orders for 'patients' who are voluntary or detained in a mental health facility.

Both the *Guardianship Act* and the *NSW Trustee and Guardianship Act* enunciate a set of guiding principles that emphasise the subject person's right to personal autonomy; freedom of unnecessary interference in decisions or freedom of action; that their welfare and interests are the paramount considerations; that they should be encouraged to be self-reliant in personal domestic and financial matters; and take into account the views of subject person. However, neither makes reference to supported decision making. If supported decision making is introduced as a major concept in the *Guardianship Act*, then amendment may be necessary to the *NSW Trustee and Guardianship Act*.

***Voluntary patients***

An area of overlap between the *Mental Health Act 2007* and the *Guardianship Act* relates to the powers of guardians in respect of voluntary patients. Section 7 of the *Mental Health Act* provides for the admission of voluntary patients to a mental health facility at the request of a guardian. In addition, the person must not be admitted as a voluntary patient if the person's guardian objects and they must be discharged, if so requested by the guardian. Section 8 of the *Mental Health Act* also provides that an authorised medical officer may discharge the patient at their request but must give notice of discharge to the guardian. The MHRT has a review function in respect of such patients, and must consider whether they consent to continuing as a voluntary patient and whether they are likely to benefit from ongoing care and treatment.

Commonly private or public 'guardians' appointed under the *Guardianship Act* seek to have a person admitted to a mental health facility.

The MHRT is aware of at least one matter in which the Public Guardian has submitted at a review of a voluntary patient order that they could override a patient's decision to discharge themselves. Whilst the MHRT did not accept that argument (the reasons are outlined in the Official Report of Richard Peters (2015 NSW MHRT 1) it continues to be an area of confusion for patients, guardians, carers and clinicians. The MHRT recommends that the *Guardianship Act* be amended to include a clear statement as to the limits of guardian's powers in relation to voluntary patients. The statement should prohibit a guardian from making decisions about a patient's discharge that override a patient's right to be discharged. Similarly, a guardian should be prohibited from re- admitting a patient who has discharged themselves. The latter issue was raised in the decision of Sarah White v The Local Health Authority & Anor [2015] NSWSC 417.

***A major issue about inconsistencies***

One major issue that can arise is where there is a conflict in the objectives, terms or conditions of an order made with respect to the same person by the respective tribunals. Section 3C of the Guardianship Act deals with inconsistencies between guardianship orders and mental health determinations. Section 3C provides the following with respect to the relationship with the *Mental Health Act 2007*:

> '(1) A guardianship order may be made in respect of a patient within the meaning of the Mental Health Act 2007.
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> (2) The fact that a person under guardianship becomes a patient within the meaning of the Mental Health Act 2007 does not operate to suspend or revoke the guardianship.
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> (3) However:
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> (a) a guardianship order made, or
>
> (b) an instrument appointing an enduring guardian,
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> in respect of a person who is, or becomes, a patient within the meaning of the Mental Health Act 2007 is effective only to the extent that the terms of the order or instrument are consistent with any determination or order made under the Mental Health Act 2007 in respect of the patient.'

Thus, the mere fact that a person becomes a patient under the *Mental Health Act* does not preclude the making of a guardianship order with respect to that person; nor does it suspend or revoke a current guardianship order. However, 3(C) (3) indicates that in the event of any inconsistency between the terms of a guardianship order and any order under the *Mental Health Act* the latter is to prevail.

There are very strong grounds for supporting a provision that is intended to give precedence to the operation of the MHRT order. There is fundamental tension between the objectives of the guardianship provisions and the mental health provisions in that the former focuses on the best interests and welfare of the subject person whereas under the mental health provisions there is a need to balance the interests of the subject person with the need to protect the safety of the patient and the general community.

Whilst there is clearly an obligation to protect and foster the best interests of the individual, protection of the individual and the community must prevail. Given that forensic patients by definition have been brought to the attention of the criminal justice system the need to ensure the primacy of mental health orders over guardianship orders is obvious. For example, there is a clear issue of community

safety as many forensic patients have been involved in serious index events such as murder, manslaughter, arson and serious assault.

There are also a number of issues that arise from section 3C.

1. First, the provision refers only to 'patients' which is defined under s 4(i) of the *Mental Health Act 2007* as a person who is admitted to a mental health facility in accordance with that Act and who is in the mental health facility following the person's admission. Because the MHRT determines forensic patients under Part 5 of the *Mental Health (Forensic Provisions) Act 1990* it may be argued that forensic and correctional patients might never become patients within the meaning of the 2007 Act.

   As it stands there is no clear answer to the question as to whether s 3C does so apply to those categories of persons. It seems clear that the new drafting with the failure to specify applicability to forensic and correctional patients is the consequence of a legislative oversight and that there should be an amendment to s 3C to clearly provide for a person to be a forensic patient or a correctional patient as those terms are defined under Part 5 of the *Mental Health (Forensic Provisions) Act 1990* and come within the terms of s 3C.

2. A second issue is what tests should be used to determine inconsistency under s 3C. Section 3C refers to a consideration of the terms of the guardianship order but does not refer to the terms of the mental health determination or order. A reference to the terms of the guardianship order could mean that a textual test should be used to evaluate inconsistency. There is considerable anecdotal evidence that the wording of s 3C is opaque and that practitioners, parties and clinicians are unable to resolve the question of the applicable jurisdictions by reference to it. The MHRT suggests that s 3C should be amended to clearly provide that in the event of an inconsistency the Mental Health Act prevails.

Another area of clarification relates to s 34 of the *Guardianship Act* which provides, in relation to medical and dental treatment in Part 5, that in the event of any inconsistency between the provisions of that Part and the provisions of the *Mental Health Act 2007* or the *Mental Health (Forensic Provisions) Act 1990*, the provisions of the *Mental Health Act 2007* or the *Mental Health (Forensic Provisions) Act 1990* prevail.

For the reasons outlines above it is submitted that a textual test should be used to evaluate the inconsistency.

***Supported decision making and the MHRT***

Another issue for consideration is the impact that a formal model of supported decision making would have on the operation of the Mental Health Act and the functions of the MHRT. There has been considerable debate about the preferred models of decision making and the MHRT is aware as discussed above that the trial of supported decision making in NSW highlighted potential problems and concerns. Any formal supported decision making model will stand in contrast to the 'informal' support model adopted in the *Mental Health Act* (see s 68(h)). Notably the *Mental Health Act* does not specifically provide for the use of advanced care directives nor is there a mechanism to resolve disputes if, for example, designated carers disagree about a proposed course of treatment; nor is there an appeal process.

Should the *Guardianship Act* adopt a supported decision making model, it would be necessary to consider whether this should be reflected in the *NSW Trustee & Guardianship Act*. It would be anomalous for persons who, merely because of their status as patients in a mental health facility, had the consideration of whether they needed their financial affairs by the MHRT to not have the benefit of supported decision making.

Maria Bisogni
Deputy President
Mental Health Review Tribunal

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