NSW Law Reform Commission Review of the Guardianship Act 1987 NSW Health Response

Overview

The NSW Ministry of Health comment will examine the following issues:

- There are inconsistencies between the Guardianship Act and the Mental Health Act in relation to obtaining consent for non-mental health treatment for mental health patients
- There are practical and clinical issues arising from the current drafting of Part 5 of the Guardianship Act which impact on end of life care
- Recent issues with clinical trial provisions
- Practical impact of the current Act, including resource issues.

The Guardianship Act and the Mental Health Act

The Mental Health Act 2007 provides the legislative framework for the voluntary and involuntary treatment of persons with a mental illness or mental condition in NSW. The objectives of the Mental Health Act are found in section 3 which provides that the objects of the Act are:

(a) *to provide for the care, treatment and control of persons who are mentally ill or mentally disordered, and*

(b) *to facilitate the care, treatment and control of those persons through community care facilities, and*

(c) *to facilitate the provision of hospital care for those persons on a voluntary basis where appropriate and, in a limited number of situations, on an involuntary basis, and*

(d) *while protecting the civil rights of those persons, to give an opportunity for those persons to have access to appropriate care, and*

(e) *to facilitate the involvement of those persons, and persons caring for them, in decisions involving appropriate care, treatment and control.*

The Mental Health Act intersects with the Guardianship Act in many respects. In particular, in relation to persons who are admitted as involuntary patients under the mental health legislation, and who also require treatment and care for conditions and illnesses unrelated to their mental illness. The provision of general medical care and treatment for mental health patients detained in a mental health facility often raises issues relating to consent to treatment: who should provide consent when the patient is not competent to consent to his/her own treatment; and in what circumstances, if any, should a competent person who is involuntarily detained be able to refuse medical or dental treatment unrelated to their mental illness or condition. This is an important area of law that deserves careful consideration to ensure that all persons with a mental illness receive appropriate care and treatment while respecting, so far as is safe and appropriate, a mental health patient's right to self-determination.

People who have a mental illness have the same right to expect appropriate medical care – both for their mental health condition and general health state - at the same standard and with the same rights as any other patient. For most people who live with a mental illness, access to general medical and dental treatment is a largely uncontentious issue with individuals being able to seek and be offered appropriate treatment and having the capacity to consent to such treatment. However, for some, access to general medical treatment can be complicated due to a range of factors, particularly when a person's mental illness or disorder has impacted on their capacity to consent or when they have been detained in a mental health facility.

In 2009, the NSW's Legislative Council's Standing Committee on Social Issues conducted an Inquiry into substituted decision making for persons lacking the capacity to consent. The Standing Committee on Social Issues noted that this was an area in need of reform and clarification and recommended that:

> *That the NSW Government consider the need for amendments to the Mental Health Act 2007 and the Guardianship Act 1987 in relation to the authority of medical officers to authorise medical treatment for a person detained in a mental health facility and the manner in which substitute consent for the termination of pregnancy is determined.*

Persons detained under mental health legislation can be provided with involuntary treatment for a mental illness or mental condition in accordance with the terms of the Mental Health Act. Section 84 of the Mental Health Act allows the authorised medical officer to authorise the giving of mental health treatment[1] to a patient detained in a mental health facility.

When it comes to medical or dental treatment that is unrelated to the person's mental illness or condition, the law is not so clear, and regard must be had to either the Mental Health Act or the Guardianship Act. Which regime applies will depend on the status of the patient and whether the treatment being sought is surgical or non-surgical in nature or a special medical procedure.

There are also some major differences between the substituted decision making regimes found in the Mental Health Act and Part 5 of the Guardianship Act. The differences between the Guardianship Act and the Mental Health Act may lead to a number of differences in outcomes for patients requiring the same treatment depending on whether the person is a detained mental health patient under the Mental Health Act or whether the person falls under the Guardianship Act. The outcomes can be anomalous.

The differences between the Guardianship Act and the Mental Health Act requires clinicians in the mental health field to be aware of two different substituted decision making regimes that are dependent on a patient's status and the nature of the treatment required and not necessarily on the needs or interests of the individual patient themselves. This means that different documentation will have to be prepared and consent sought from different substituted decision makers depending on whether a person is living in the community, is an assessable person, involuntary patient, forensic patient or correctional patient and whether the treatment being sought is surgical in nature or non-surgical. Moreover, the differences have the potential to lead to different outcomes for similar patients requiring the same types of treatment.

NSW Health considers that the following questions on these issues are worthy of further consideration:

- Should there be only one substituted decision making regime for providing consent to medical and dental treatment (unrelated to a mental health patient's mental illness or condition)?

- Should there continue to be different regimes depending on the legal status of the patient under the mental health legislation and the type of treatment being sought?

- If only one substituted decision making regime is to apply to mental health patients who require medical or dental treatment unrelated to their mental illness or condition, should the regime be based on:
    a. the provision of Part 5 of the Guardianship Act,
    b. the provision currently found in the Mental Health Act, or
    c. a hybrid model incorporating provisions from both the Guardianship Act and the Mental Health Act?

[1] This does not include electro-convulsive therapy for which the Mental Health Review Tribunal must consent and does not include prohibited treatment, being deep sleep therapy, insulin coma therapy and psychosurgery.

- What is the most appropriate external body to make decisions – the Mental Health Review Tribunal or the Guardianship Tribunal?
- Should a detained mental health patient who is capable of consenting, or refusing to consent, to medical or dental treatment unrelated to their mental illness, be able to refuse necessary medical or dental treatment?
- If so, should such a right be open ended or restricted?
- What factors should the substitute decision maker have to consider before authorising treatment that a competent detained mental health patient has refused?

Substitute consent and end of life care

The arrangements in the Guardianship Act for obtaining substitute consent for withdrawing treatment in the end of life context require careful consideration. The substitute consent arrangements must have appropriate safeguards to ensure that all decisions made by substitute decisions makers are made in the best interests of the patient. The provisions must also operate clearly and able to be applied in a hospital setting without delay or confusion.

The current arrangements are set out in Part 5 of the Act. Section 36 of the Guardianship Act allows a 'person responsible' to consent to 'the carrying out of medical or dental treatment' on a patient to whom this Part 5 of the Act applies. The objects of Part 5 are set out in section 32 which requires any medical or dental treatment to be carried out for the purpose of 'promoting the health and wellbeing of the patient'.

NSW public health services and staff can find it challenging to interpret and implement these arrangements in the end of life context. They have raised concerns that the wording in the legislation, in particular the terms 'carrying out' and 'promoting and maintaining health and wellbeing' may be unduly restrictive and are also confusing. The issues have arisen in a series of cases.

WK v Public Guardian (No 2) [2006] NSWADT 121

In WK v Public Guardian (No 2) [2006] NSWADT 121, the NSW Administrative Decisions Tribunal (NSW ADT) found that a guardian could not make a decision to withdraw treatment which would result in the patient's death, as this would not promote the patient's health and wellbeing.

WK was a person with an interest in the welfare of X, a protected person. X was 73 years old, had end stage kidney disease and was suffering from dementia. WK applied to the Tribunal to prevent the Public Guardian implementing a palliative care management plan to which the Public Guardian had agreed on X's behalf. The plan included two elements dealing with withdrawal of treatment in end of life circumstances: withdrawal of dialysis treatment, and no further aggressive treatments, including cardio-pulmonary resuscitation or intubation. It was expected that if dialysis was withdrawn, WK would die within two weeks. The plan had been developed in consultation with immediate family members and the renal and palliative care team at the hospital. The objector was a friend and business associate of X.

In WK, the ADT held that:

> *'A decision to withdraw life sustaining medical treatment is not a decision carried out for the purpose of promoting and maintaining the health and wellbeing of a person. These objects and the definition of 'medical treatment' in s33, lead to the conclusion that while the Public Guardian may consent to treatment which will prolong the life of a person, there is no power to consent to the withdrawal of treatment that will result in a person's death.'*

This decision left the patient to continue to receive burdensome treatment until death, rather than palliative care. This interpretation of promoting health and wellbeing implies that palliative and pain relief care cannot promote a patient's wellbeing.

Re AG [2007] NSWGT 1

In Re AG [2007] NSWGT 1 (5 February 2007), the NSW Guardianship Tribunal reviewed the findings in the WK matter, reaching a different conclusion.

The patient was a 56 year old woman with mild intellectual disability. AG had been diagnosed with a renal tumour. There was also the possibility that she had secondary brain tumours and her prognosis was very poor. She refused to acknowledge the existence of the kidney tumour, although she had accepted that she had cancer. The Public Guardian had previously been appointed to manage AG's care but was now faced with a decision concerning a palliative care plan which included decisions to forego CPR and dialysis. The Public Guardian approached the Guardianship Tribunal for directions on the care plan, given that the WK decision seemed to conclude that it was not possible for the Public Guardian to consent to such a plan.

The Tribunal decided that, generally, consent could be given or refused for medical treatment under the Guardianship Act, which included palliative care. Palliative care could include treatment limitations, such as the non-provision of treatment, on the proviso that the palliative care promoted and maintained the patient's health and wellbeing. The Tribunal stated that the weight of authority supported the notion that treatment limitation can promote and maintain a person's health and wellbeing, if it prevents futile treatment and if it allows the person to die with comfort and dignity.

FI v Public Guardian [2008] NSWADT 263

The subsequent decision of FI v Public Guardian [2008] NSWADT 263 went some way in clarifying the previous inconsistent decisions. The Applicant, FI was the mother of a protected person (DFI). The Public Guardian managed DFI's affairs, including the health care guardianship function and the function of consenting to medical and dental treatment pursuant to the Guardianship Act.

In February 2008, FI asked the Public Guardian to prepare an advance care plan for her daughter. The Public Guardian refused, as the daughter's health was stable. FI applied to the ADT for review of the Public Guardian's decision not to enter into an advance care plan. In particular, FI wanted the Public Guardian to authorise no life sustaining treatment or drugs for DFI.

DFI was 24 years old. She had sustained severe traumatic brain injury in a car accident that occurred on 31 December 1999. Her mother describes her state as a 'permanent vegetative state'. An officer of the Public Guardian described her state to the Tribunal as 'post-coma unresponsiveness'. She was a resident in a nursing home. FI said that, 'in layman's terms [DFI] is brain dead and kept physically alive by a brain shunt, breathing tube, feeding tube, catheter. She has no awareness or ability to communicate, suffers severe spasticity so that her body and limbs are severely twisted and rigid like steel rods.' She went on to refer to the vulnerability of her condition to assault and mistreatment, and her inability to lead any kind of life involving social activity, communication or going on outings.

An expert assessment dated 4 April 2008 stated that DFI 'remains completely dependent in all self-care and mobility, requiring feeding gastrostomy and tracheostomy. She continues to have deformity of lower limbs and limited upper limb function with flexion posturing more marked on the right'. However, the expert also said that staff had noted her 'to respond and smile to different stimuli and to orient and apparently remain attentive to television'. She had also responded 'positively with staff to events in cricket telecasts'. She responded positively 'to vocal tone and touch in being comforted when distressed'. On the other hand, '[n]o utility had been observed with Yes/No cards or specific requests'. He estimated her life expectancy was 25 to 30 years.

In the decision, the ADT considered whether there are limitations imposed by the Guardianship Act which prevent a guardian from entering into advance care plans or palliative care plans that involve the withdrawal of life-sustaining treatment.

The Public Guardian's submission in FI was that the Part 5 regime is only concerned with the performance of medical (or dental) procedures which involve proactive intrusions into the bodily integrity of the patient and that it is not concerned with the making of choices not to give treatment or to cease treatment. Reference was made to section 34 which states that that Part of the Act applies to a patient who is incapable of giving consent to the 'carrying out of medical or dental treatment' and section 33, which defines medical treatment as medical treatment (including any medical or surgical procedure, operation or examination and any prophylactic, palliative or rehabilitative care) normally carried out by or under the supervision of a medical practitioner and various other categories of treatment, none of which, it was submitted, takes the form of cessation of treatment or removal of physical connections to the body (such as tubes). The object provisions of Part 5 of the Guardianship Act are found in section 32 which includes at 32(b) 'to ensure that any medical or dental treatment that is carried out on such people is carried out for the purpose of promoting and maintaining their health and well-being.'

Judge O'Connor noted that advance care plans or palliative care plans will often have a mix of proactive treatment elements and elements involving cessation of medical treatments in particular circumstances. He held that the inclusion within an advance care plan or a palliative care plan of an element which provides for the withdrawal of treatment in certain circumstances is not unlawful because of any of the provisions of Part 5, accepting the submissions that these provisions are directed to proactive medical interventions.

Judge O'Connor then considered whether there is anything in the general provisions of the Guardianship Act which precludes a guardian granted a health care function from exercising that function in a way that involves the making of advance care plans or palliative care plans. He noted that the Guardianship Act makes no attempt to define the 'functions of a guardian' and concludes that these words therefore should be given a breadth of interpretation consistent with the general law's historical understanding of the scope and role of the guardian. The object of guardianship is to enable the making of decisions that the subject would have been able to make had he or she had legal capacity to do so, therefore, there is no reason to limit the power of an appointed guardian – an appointed guardian can exercise any right which a competent person has to make decisions affecting their own health care, including in relation to end of life decision-making, on behalf of the protected person.

The Judge referred to case law which establishes a competent person's right to refuse to consent to medical treatment, even if the treatment is objectively in the person's best interests, including if the treatment may be necessary to save or sustain that person's life: *Airedale National Health Service Trust v Bland* [1993] AC 789 at 891 per Lord Mustill; In *Re C (Adult Refusal of Treatment)* [1994] 1 WLR 290; and cases establishing that it is unlawful to treat patients without consent: *Secretary of Department of Health and Community Services v B (Marion's Case)* (1992) 175 CLR 219 at 309-310. He also noted that, in the case of unconscious or incompetent patients, the duties imposed on medical practitioners to provide treatment (including life-sustaining treatment) rest on consideration of what is in the patient's best interests for the purpose of preservation of life and that the law recognises that clinical judgements are involved, and that there is no need to continue treatments which are therapeutically ineffective, or are extraordinary, excessively burdensome, intrusive or futile. *Northbridge v Central Sydney Area Health Service* (2000) 50 NSWLR 549 at 553-554; *Airedale National Health Service; Auckland Area Health Board v Attorney General* [1993] 1 NZLR 235 at 252-253; Re G [1997] 2 NZLR 201; *Messiha v South East Health* [2004] NSWSC 1061 at [22]-[28]; *Hunter Area Health Service v Marchlewski* (2000) 51 NSWLR 264 at 268 [91].

Judge O'Connor concluded that the Guardianship Act does not seek to fetter a guardian in a way that is inconsistent with the ordinary law. Therefore, a specified function in a limited guardianship order should be interpreted in accordance with what is permitted by law or in

equity in relation to the kind of conduct that is the subject of the specified function. The only difference between the rights enjoyed under the law as between an autonomous individual with capacity, and a guardian responsible for a person without capacity, is that the guardian must always act according to best interests considerations whereas the autonomous individual, in the exercise of free will, may make decisions which, objectively, appear to be against his or her best interests.

A guardian has the same power as the Supreme Court, exercising its parens patriae jurisdiction, to make decisions about the health care of incompetent persons (guided by their best interests, which may be for life sustaining treatment to be withdrawn).

Judge O'Connor concluded that a guardian invested with the authority to perform health care functions on behalf of a protected person is not prevented by the Guardianship Act or the general law from making decisions that involve the withdrawal of life-sustaining treatment, provided such decisions are made consistently with the principles articulated in the leading cases (i.e. consideration of the protected person's best interests).

LE and LF v Public Guardian [2009] NSW ADT 78

After FI, the NSW ADT considered withdrawal of artificial feeding and hydration in LE and LF v Public Guardian [2009] NSW ADT 78. In this case the patient was a 47 year old man with post coma unresponsiveness (vegetative state). The Public Guardian had been appointed to take care of the patient's treatment and had decided to not unblock the patient's feeding tube the next time it became blocked. The wife and son of the patient agreed with this decision but the patient's niece and her husband objected.

The Judge confirmed the Public Guardian's decisions. This made it clear that guardians have the power to refuse treatment, as long as the decision is made in the patient's best interests. However, as with the decision in FI, the case did not decide whether persons responsible have the same power.

Comment

NSW Health currently advises clinicians on the basis of these cases that:

- a person responsible can consent to active treatment on behalf of the patient (including palliative care);
- only appointed Guardians (including Enduring Guardians) can consent to treatment being withheld or withdrawn, and then only if they have been expressly given such a power in their appointment;
- where the treating team considers life-sustaining treatment to be of negligible clinical benefit, consent to withhold or withdraw treatment is not required from the patient or their person responsible (including Enduring Guardians). However, consultation with the patient and/or their person responsible is important in determining what is in a patient's best interests; and
- while other persons responsible do not have the express power to consent to withholding or withdrawing treatment, they should still be consulted when an end of life treatment decision is being made because they will be able to help the treatment team make a better assessment of the patient's best interests.

This position involves significant complexity. In practice the substitute decision maker for most people without capacity is their person responsible. However, if consent is required to withdraw treatment a guardian would need to be appointed, and this process can take some time.

The review should consider whether it is appropriate that the powers and functions of substitute decision makers should differ from the powers and functions of appointed guardians, in light of the issues raised by NSW public health services and staff. Other options that could be considered include:

- clarifying that persons responsible can consent to treatment being withheld or withdrawn, as long as the decision is made in the patient's best interests;
- replacing the wording in Part 5 of 'promote and maintain health and wellbeing' with 'promote the best interests of the person' and expand on the references to 'carrying out' treatment so as to include treatment limitation decisions. The best interests test is employed in most other Australian jurisdictions, and is the common law test; and
- whether it would be desirable to establish a register or other mechanism for lodging enduring guardian appointments. At present, if a person comes into hospital at the end of life, clinical staff may have no means of ascertaining whether the they have an appointed guardian which could mean that the patient's wishes concerning who should consent to treatment on their behalf are not honoured.

Clinical Trials

- The *Guardianship Act 1997* (NSW) (**the Act**) requires the Guardianship Division (**GD**) of the NSW Civil and Administrative Tribunal (**NCAT**) approval of any clinical trial on people who cannot consent to their own medical treatment. Once approved, the GD may make an order regarding who can consent to an individual's recruitment to a trial. Only 'persons responsible' (a defined hierarchy) or the GD can consent to trials conducted under the Act.

- Part 5, Division 5A Act states that the Guardianship Division of the NSW Civil and Administrative Tribunal may approve any clinical trial which is to be conducted on people who cannot consent to their own medical treatment. A 'clinical trial' is defined in section 33 as *'a trial of drugs or techniques that necessarily involves the carrying out of medical or dental treatment on the participants in the trial'.*

- Under section 45AB of the Act, once a clinical trial is approved, the GD may make an order with respect to who can consent to individual participants being recruited to the trial. This section is limited to consent being given or withheld by the 'persons responsible' for the patients or the GD itself. For a person other than a child, section 33A defines the hierarchy of 'persons responsible' to be the person's guardian, the spouse, a person who has the care of the person, or a close friend or relative of the person.

- Under section 37 of the Act, medical or dental treatment may be carried out on a patient without consent if the medical practitioner carrying out the treatment considers it is necessary, as a matter of urgency:
  A) to save the patient's life; or
  B) to prevent serious damage to the patient's health; or
  C) except in the case of special treatment – to prevent the patient from suffering or continuing to suffer significant pain or distress.

  However, treatment under section 37 may be unlawful if it is given in the context of a clinical trial that has not been approved by the GD.

- Clinical trials involving intensive care, emergency and pre-hospital patients will generally require GD approval and a GD order in relation to a consent mechanism as most patients are critically unwell and unable to consent to their own medical treatment.

Definition of 'clinical trials' - Standard care

- The NSW Ministry of Health and the Office for Health and Medical Research are aware of several recent GD decisions in relation to NHMRC funded and human research ethics committee (**HREC**) approved clinical trials on intensive care patients. In two of these decisions (ADRENAL and TRANSFUSE) the GD determined that the trials did not fall within the definition of 'clinical trials' under the Act because the treatments were not 'new or experimental' and the applications for approval of the trials were dismissed.

- A principal investigator who recently applied to the GD for approval of a clinical trial on intensive care patients received a letter from the GD stating *"To avoid any potential confusion, the Tribunal regards it as a matter for those proposing to carry out the treatment to consider if the drug or technique is a currently accepted treatment for a condition or if it is properly regarded as new or experimental treatment and whether, as a result, an application should be made pursuant to section 45AA of the Guardianship Act seeking approval for the clinical trial as a trial in which patients to whom Part 5 of the Guardianship Act applies may participate."*

- In light of the recent decisions of the GD effectively excluding standard care or widely accepted common treatments from the definition of 'clinical trials', it is submitted that the Review of the Act consider revising the current definition of clinical trials within section 33(1) of the Guardianship Act as in its current form is broadly drafted and clearly open to interpretation.

Consent Mechanisms

- If the GD finds a trial is a clinical trial for the purposes of the Act, it needs to make an order regarding consent mechanisms under section 45AB. Ambulance NSW. A number of intensive care specialists have advised that the current legislative provisions requiring prospective consent before recruiting an individual to a trial from either the person responsible or the GD are also unworkable in an ICU or emergency environment because of the difficulties in obtaining informed consent and the resulting delays to urgently required treatment.

- NSW legislation is currently at odds with the Australian National Statement on Ethical Conduct in Human Research (NHMRC) which allows for HRECs to approve delayed or waived consent if the risk of harm is low and that the participants or their representatives are informed, as soon as reasonably possible, of the inclusion in the research and of the option to withdraw. Additionally other jurisdictions, including Victoria, allow for waived consent if the person responsible cannot be contacted, the project has been approved by a HREC and the procedure is not contrary to the best interests or wishes of the patient.

- NSW Health is of the view that the current NSW legislative framework is out of step with other Australian jurisdictions and while the GD has attempted to address this by applying a narrower interpretation of a definition of a clinical trial, the Act should be reviewed to ensure clarity and certainty for medical researchers.

Practical Issues

There are many instances where NSW public hospital staff make applications to the Guardianship Division of NCAT (GD), seeking guardianship orders for hospital patients. This occurs when consent is required for medical treatment, and also where accommodation or other decisions are required in order to facilitate a patient's discharge from hospital. Public hospitals in NSW are finding cases arising where patients who are clinically well cannot be discharged from hospital in a timely manner due to the length of time required to lodge and process a guardianship application, and then for the guardian appointed to make a decision.

Currently, the system necessitates a waiting period from when an application is made to the GD and when the GD makes a decision appointing a guardian. There is then a second waiting period while the guardian (often the Public Guardian) investigates the patient's circumstances and makes a decision about where the patient will go when discharged. Based on data from one local health district, the average time between the date that an application is lodged and the hearing is 56 days.

Remaining in hospital when hospitalisation is not clinically indicated puts patients at risk of hospital acquired infections and risk of becoming de-socialised. The cost to government is also substantial. The GD has advised that there are approximately 1000 public hospital in-patients in respect of whom guardianship applications are made each year. If the average time period

between lodgement of the application and the hearing date could be reduced to 21 days (still providing sufficient time for the GD to fulfil its procedural fairness obligations) the estimated saving in unnecessary bed days to NSW Health would be approximately $20M pa (based on $876 approx. bed day cost). This capacity could then be used more effectively.

Based on feedback from local health districts, it appears there are several factors behind the delay, including:

1. The increasing workload of the Guardianship Division of NCAT. NCAT estimates that it receives approximately 1000 applications made by clinical staff on behalf of patients in NSW public hospitals per year (with five per cent annual growth anticipated).
2. The need for the GD to observe strict rules of procedural fairness. The Guardianship Act requires the GD to notify all interested parties that an application has been made, and provide all parties with reasonable notice of the proposed hearing date. This means that unless an application is dealt with urgently, a period of time must elapse before the hearing is held, in order to give other parties sufficient notice. There are no timeframes specified in the legislation limiting the length of the process. There should be capacity to vary the notice periods and procedural fairness requirements to meet the needs of specific patients.
3. There is inconsistency in approaches taken by Public Guardians appointed to make discharge related decisions. Some see themselves solely as decision makers, rather than advocates, thereby placing the burden on clinical staff to explore accommodation options, chase referrals, visit possible accommodation placements and advocate with other services external to the health system.
4. The Public Guardian does not always take clinical recommendations into account.
5. There is no clear pathway for resolving disputes with the Public Guardian around discharge accommodation options.

The NSW Ministry of Health has been discussing these issues with the GD and has established a Whole of Health Guardianship Project. The objectives of the Project include minimising unnecessary lengths of stay for patients who are waiting on a guardianship hearing with the aim of having all guardianship applications from NSW Health inpatient facilities decided within 21 days from lodgement. In order to meet these aims:

- data collection on delays and reasons for delays will be improved across the health system;
- a directory of video conferencing facilities in public health facilities will be created and provided to the GD to facilitate hearings for patients in regional and remote areas;
- an education package will be developed to assist staff in making guardianship applications on behalf of patients, including on-line training; and
- a state-wide practice guideline for making a guardianship application for patients who are inpatients of an acute facility will be developed and implemented.

The Ministry is concerned, that even when these initiatives are introduced across the NSW health system, the potential for long waits within the GD may remain. There is potential for these efforts to be supported by legislative amendments such as:

- The introduction of specified timeframes for the GD to determine guardianship applications (such as those in the Anti-Discrimination Act 1977 or the Health Care Complaints Act 1993)
- The addition of sections in Part 7 setting out the functions of the Public Guardian and requiring the Public Guardian to take clinical recommendations into consideration. Timeframes for decisions of the Public Guardian may also be appropriate.