Mental Health Commission of New South Wales

Review of the *Guardianship Act 1987 (NSW)*

Submission to the NSW Law Reform Commission on Question Paper Five: Medical and dental treatment and restrictive practices by the Mental Health Commission of New South Wales

May 2017

Mental Health Commission of New South Wales
Locked Bag 5013
Gladesville NSW 1675
T 02 9859 5200
F 02 9859 5251
E mhc@mhc.nsw.gov.au
W www.nswmentalhealthcommission.com.au

Submission to the NSW Law Reform Commission's review of the *Guardianship Act 1987 (NSW) Question Paper Five: Medical and dental treatment and restrictive practices*

http://www.lawreform.justice.nsw.gov.au/Pages/lrc/lrc_current_projects/Guardianship/Question-Paper-5.aspx

The Mental Health Commission of NSW

The Mental Health Commission of New South Wales (NSW) is an independent statutory agency responsible for monitoring, reviewing and improving the mental health system and the mental health and wellbeing of the people of NSW. The Commission works with government and the community to achieve this goal.

In all its work, the Commission is guided by the lived experience of people with mental illness, and their families and carers. The Commission promotes policies and practices that recognise the autonomy of people who experience mental illness and support their recovery, emphasising their personal and social needs and preferences.

The Commission has provided submissions on the background paper and question papers one, two, three and four. The current submission builds on the arguments put forward in those papers.

Throughout this submission the term 'disability' is used broadly to encompass people who experience psychosocial disability.

General principles

Part 5 of the Guardianship Act 1987 (NSW) (the Act) applies in cases where a person is unable to consent to medical or dental treatment. As such, its remit is much broader than the population of people who otherwise fall under the guardianship regime. For example, Part 5 may be required in the case of a person who otherwise has full decision making capacity but is unconscious at the relevant time.

Part 5 serves some purposes that are unique to the rest of the Act. In particular, an important function of Part 5 is to provide certainty to medical professionals about when they can and cannot act without consent. Therefore, the wording of Part 5 is important not only for the people who come under the regime, but it is also critical to provide clarity for the medical profession.

In British Columbia the *Health Care (Consent) and Care Facility (Admission) Act* (the BC Act) separates the provisions for consent to medical and dental treatment from the guardianship regime. The Commission is supportive of this approach. Rather than trying to address the range of issues associated with substitute decision making on an ongoing basis, the focus is squarely on the medical consent required at a point in time. The BC Act provides a hierarchy of decision makers starting with the presumption of capacity and including guardians (who presumably would be bound by supported decision making principles and other relevant considerations under the Guardianship Act), decision supporters, advance care directives and 'person responsible'. As a whole, the Commission submits that the BC Act provides a good model.

Part 5 amounts to substitute decision making. If provisions relating to medical and dental treatment remain in the Act, it is presumed the general principles the Commission has articulated for other sections of the Act apply. This includes the following:

- people should be provided with all possible support to help them understand the decision to be made,
- substitute decision making should be a last resort,
- where substitute decision making is required, a set of principles (as set out in the Commission's submission on question paper three) should guide substitute decision makers.

- when a patient objects to the proposed medical or dental treatment, there should be very clear guidance available if the decision being made seeks to override the person's own views.

Capacity

In the Commission's submission on question paper one it cited with approval the Standing Committee on Social Issues recommendation for a legislative definition of capacity which includes reference to the ability to understand, retain, utilise and communicate information relating to the particular decision that has to be made at the particular time the decision is required to be made and to foresee the consequences of making or not making the decision.[1] The current test for capacity in Part 5, also based on the person's ability to understand the decision, is broadly similar to this:

"*For the purposes of this Part, a person is incapable of giving consent to the carrying out of medical or dental treatment if the person:*

a) is incapable of understanding the general nature and effect of the proposed treatment, or

b) is incapable of indicating whether or not he or she consents or does not consent to the treatment being carried out."[2]

The Commission has submitted that consent to medical and dental treatment should be a separate piece of legislation from the guardianship regime. If this were to be the case, the current definition in Part 5 could be used in the new medical and dental treatment act. However, if consent to medical and dental treatment remains in the Guardianship Act, there should be a consistent definition for capacity throughout. The definition recommended by the Standing Committee on Social Issues appears sufficiently flexible to apply to consent for medical and dental treatment as well as to broader decision making scenarios. This definition also allows for a sliding scale of capacity, for example, it might be possible for someone to understand the need to take antibiotics to treat an infection, but not more complex surgery.

This does overlook the second part of the definition for incapacity in Part 5, which includes cases where the person is incapable of *indicating* consent. It may be convenient to retain this part of the definition in Part 5, if an otherwise universal definition of capacity is adopted.

Consent

Supported decision making

The Act should enshrine the principles of supported decision making. Supported decision making should apply equally to all decisions to be made by a guardian, whether to do with medical treatment, accommodation or finances. Of course, in relation to medical and dental treatment there will be scenarios where this might not be possible because an urgent decision is needed or because

[1] NSW Legislative Council Standing Committee on Social Issues, *Substitute Decision-Making for People Lacking Capacity*, Report 43 (2010) Rec 1

[2] s 33 (2) *Guardianship Act 1987 (NSW)*

it is not possible for the person to indicate their wishes. This is an example of the confusion that can arise as a result of trying to deal with questions of guardianship in the same piece of legislation as consent to medical and dental treatment.

S 37 of the Act already permits medical or dental treatment to be carried out without consent in certain urgent situations. Apart from emergencies, where time is a factor, it is not clear why a separate process should apply in relation to medical and dental treatment if supported decision making is adopted elsewhere in the Act.

There is good evidence that where people are more involved in decisions about their health care, they are more likely to engage and achieve better outcomes.[3] Given the physical health of many people who come under the Guardianship Act falls far short of the general population anything that can be done to improve health outcomes for this population should be adopted.

The question paper raises concerns about how a formal supported decision making approach in respect of medical and dental treatment will sit alongside the *Mental Health Act*[4]. The question paper notes that the Mental Health Act "requires that every effort is made to involve the patient in the development of treatment and recovery plans and to consider their views and expressed wishes."[5] This seems to be consistent with a supported decision making model and it is difficult to see why this principle should not apply to all medical and dental treatment.

In any case, as the Commission submits below, the provisions in the Act (or a future, separate medical and dental treatment act) should apply to all medical decisions, except those relating to psychiatric care, but the Mental Health Review Tribunal (MHRT) should be the relevant tribunal for those subject to the Mental Health Act or the Mental Health (Forensic Provisions) Act (Forensic Provisions Act)[6]. This should help resolve any inconsistency.

Advance care directives

Legislation should explicitly recognise advance care directives. This could be in the Act, or if a separate act for consent to medical and dental treatment is created, recognition of advance care directives might need to sit elsewhere. Provisions for advance care directives could sit in the new consent act, as happens in the BC Act, or in a separate advance care directives act, as occurs in *Advance Care Directives Act (SA).* The relevant acts should be cross referenced for this purpose.

The Commission raised the question of advance care directives in its preliminary submission. For people who experience fluctuating capacity advance care directives can be useful not only for medical decisions but also for other decisions where individuals need support or substitute decision making from time to time. General acceptance of this approach should be contained throughout the Act. An example of this broader conception of advance care directives is contained in the *Advance Care Directives Act (SA)*, which extends to residential and accommodation matters and personal

[3] Commonwealth Department of Health (2017), "Consumer involvement in their own healthcare – key to a sustainable national health system", media release, 21 March 2017, Commonwealth Department of Health, Canberra available http://www.health.gov.au/internet/main/publishing.nsf/Content/mr-yr17-dept-dept004.htm

[4] 2007 (NSW)

[5] New South Wales Law Reform Commissions (2017) *Review of the Guardianship Act 1987 Question Paper 5 Medical and dental treatment and restrictive practices*, p 22

[6] 1990 (NSW)

affairs. In this respect, the inclusion of a values/ quality of life statement discussed in the question paper could also be promoted to help provide guidance to future substitute decision makers.

People who experience mental illness are often not heard when it comes to end of life decision making, as it is assumed their decisions are a result of their illness. Anecdotally, this can also be a problem where the person responsible experiences mental illness. A statutory presumption of capacity may go some way to resolving this issue. Advance care directives, however, are a powerful way to overcome this stigma. Any statutory grounds for invalidating an advance care directive will need to be carefully worded so that the fact a person experienced mental illness is not in and of itself used as a reason for disregarding the directive.

One issue that may arise is where a person completed an advance care directive in the past and over time their life changed considerably and they made comments that led the people around them to believe the advance care directive is no longer applicable. How this matter is resolved in legislation may require broader consultation.

Mental health legislation

Physical health and mental illness

People living with mental illness experience higher rates of poor long term physical health than the rest of the population. The life expectancy for people experiencing severe mental illness is reduced by 15 to 20 years – largely due to cardiovascular disease and cancer rather than suicide – and the gap is widening.[7] There are many factors that contribute to these poor health outcomes. Relevantly for this review, one significant issue is around continuity of care between primary health and mental health services.

As the question paper identifies, and as raised in the Commission's preliminary submission to this review, guardianship and mental health law often overlap and when this happens, two substitute decision making regimes apply. This can lead to potential conflict, lack of certainty, duplication of effort and inconsistent provision of care as a person transitions from one regime to another.

Mental Health Act

The Commission's preliminary submission touched on the issue of inconsistent definitions between the Guardianship and Mental Health Acts. It is directly relevant to the issues raised in question paper five and is therefore partially reproduced here:

> *…the Mental Health Act has a number of provisions relating to who can approve surgical procedures or special medical treatments on behalf of a patient. However, the definitions of both the procedures and treatments under the Mental Health Act differ from those under the Guardianship Act. Indeed surgical procedures are not defined under the Guardianship Act, although most would fall into the category of major medical treatment as defined by the Guardianship Regulations. Even where the procedures or treatments covered by the respective pieces of legislation overlap, there are different hierarchies of decision makers under both pieces of legislation with the Guardianship Act providing that the person*

[7] Mental Health Commission of NSW (2016) *Physical health and mental wellbeing: evidence guide*, Sydney, Mental Health Commission of NSW, p 6

> *responsible can approve major medical treatments and the Guardianship Tribunal being able to approve any form of treatment. However, under the Mental Health Act, the person's carer alone cannot provide consent but rather an application must then be made to the Secretary of Health[8] or the Mental Health Review Tribunal can consent with or without the carers consent.[9]*
>
> *These inconsistencies cause real confusion for clinicians providing medical treatment to people who are patients under the Mental Health Act, or who transition either under or out of the Mental Health Act during a course of treatment, and ultimately can result in delays to treatment.[10]*

A separate act for consent to medical and dental treatment might help resolve these inconsistencies, with the same provisions for consent applying regardless of whether the person in subject to guardianship or the Mental Health Act. For people who are under the Mental Health Act, the MHRT should be the relevant body for those decisions that need to be referred to a tribunal. If, however, the process for consent to medical and dental treatment remains in the Guardianship Act, the Commission submits, as it did in the preliminary submission, that Part 5 of the Guardianship Act should apply to all cases of consent to medical and dental treatment, but the MHRT should be the relevant body for decisions that are required under Part 5 to be referred to a tribunal. This would greatly assist in ensuring continuity of care for people who transition from one regime to another as the relevant decision maker would remain the same. More than this, it will also facilitate a more holistic review, considering the whole of a person's care and treatment rather than separating out physical and mental health.

A further issue raised in the question paper is the lack of clarity regarding whether guardianship laws or mental health laws determine who can consent to discharge from mental health facilities of voluntary patients who are under guardianship.[11] This issue was considered in the case of *Sarah White v The Local Health Authority*[12], which highlighted the circulatory nature of the definition of voluntary under the Act where the guardian can override the wishes of a person under guardianship orders in respect of voluntary admission or release.

The Commission's preferred position is that the guardian cannot override the individual's decision to discharge themselves. However, the Commission recognises the complexity that can arise and the lack of suitable alternatives, either in terms of step down services or other alternative accommodation. This lack of options means that, for safety reasons, there may be no other short term option. In this context, an improved monitoring mechanism is required in those cases where a person's decision to discharge themselves is overridden by a guardian. When this does occur, this

[8] [8] S 100 Mental Health Act 2007 (NSW)
[9] S 101 Mental Health Act 2007 (NSW)
[10] Mental Health Commission of NSW (2016), *Preliminary Submission to the Review of the Guardianship Act,* p 3, available http://nswmentalhealthcommission.com.au/publications/review-of-the-guardianship-act-1987-nsw
[11] New South Wales Law Reform Commission (2017), *Review of the Guardianship Act 1987 Question Paper 5 Medical and dental treatment and restrictive practices*, p 39, available http://www.lawreform.justice.nsw.gov.au/Pages/lrc/lrc_current_projects/Guardianship/Question-Paper-5.aspx
[12] *Sarah White v The Local Health Authority & Anor [2015] NSWSC 417 (13 April 2015)*

should trigger a review by the MHRT to ensure every effort is being made to find a suitable alternative as quickly as possible.

Mental Health (Forensic Provisions) Act

For patients who are under the Forensic Provisions Act, the relevant provisions regarding consent for medical treatment are those in the Mental Health Act, discussed above. However, for this population there are additional considerations as forensic patients tend to be in the system for longer, with the average length of stay counted in years as opposed to days for civil patients. Therefore, the range of health conditions and the length of treatment required become more critical. Another important consideration is about respecting the person's autonomy and encouraging their decision making capacity, particularly as they get closer to release, consistent with the principles of recovery which underpin mental health service delivery.

The question paper raises a concern of the NSW Civil and Administrative Tribunal (NCAT) regarding guardianship orders being made primarily to ensure a forensic patient complies with conditions under a conditional release order.[13] The Commission agrees with the Tribunal that a guardianship order is not the appropriate mechanism to achieve this outcome. If the MHRT were to be the relevant Tribunal when a person is under the Forensic Provisions Act this could be more easily managed.

Financial management

Under the *NSW Trustee and Guardian Act*[14], the MHRT has the power to assess a person's capacity to manage their financial affairs and to order that their estate be subject to management under the Act if the MHRT determines the person lacks that capacity.[15] NCAT has the same powers under the Guardianship Act. If the types of changes to the Guardianship Act which are proposed by the Commission and others are adopted, then the Trustee and Guardian Act will also need to be reviewed to ensure there is consistency between the MHRT and NCAT when it comes to the assessment of capacity to manage financial affairs, the making of an order for financial management and the revocation or ending of an order.

Restrictive practices

In addition to Australia's obligations under the United Nations Convention on the Rights of Persons with Disabilities, which, as noted in the question paper, has a prohibition against torture and cruel, inhuman or degrading treatment or punishment, Australia is also working towards ratification of the

[13] New South Wales Law Reform Commission (2017), *Review of the Guardianship Act 1987 Question Paper 5 Medical and dental treatment and restrictive practices*, p 41, available http://www.lawreform.justice.nsw.gov.au/Pages/lrc/lrc_current_projects/Guardianship/Question-Paper-5.aspx

[14] 2009 (NSW)

[15] *NSW Trustee and Guardian Act (2009) NSW* ss 44, 45, 46, 47

Optional Protocol to the Convention Against Torture. The use of seclusion and restraint is contrary to both these international commitments.

To the extent that legislation deals with restrictive practices this should be with the aim of reducing the practice. And, it is ideal for any such legislation to be consistent across NSW and the Commonwealth. In considering the extent to which seclusion and restraint should be regulated, it may be helpful to have regard to the recommendations of the National Seclusion and Restraint Project.[16] However, it is not clear that the Guardianship Act is the best place for such legislation as it is largely an issue of management and regulation of services. To the extent that the Act currently deals with the matter, it is a question of consent. It seems unlikely that anyone would willingly consent to such treatment of their own accord and therefore granting this power to another person seems inconsistent with any substitute decision making principles either in the current act or the proposed revisions.

Importantly, seclusion and restraint is used in settings where there is minimal outside involvement and against extremely vulnerable people. There needs to be a robust system of monitoring and complaint anywhere the practice does or could occur.

In any case, in light of recent events in NSW relating to the use of seclusion and restraint in mental health units and the subsequent review the Government has announced, consideration of this issue is best held over to take into account the findings of the review.

[16] http://www.mentalhealthcommission.gov.au/our-work/national-seclusion-and-restraint-project.aspx