THE LAW SOCIETY
OF NEW SOUTH WALES

Our Ref:ELCS:MTks1270053

6 June 2017

Mr Alan Cameron AO
Chairperson
NSW Law Reform Commission
DX 1227 SYDNEY

By email: nsw_lrc@agd.nsw.gov.au

Dear Mr Cameron,

Review of the *Guardianship Act 1987* – Question Paper 5: Medical and dental treatment and restrictive practices

The Law Society of NSW appreciates the opportunity to comment on *Question Paper 5: Medical and dental treatment and restrictive practices*. The Law Society's Elder Law, Capacity and Succession and Human Rights Committees and the Law Society members of the Medico-Legal Liaison Committee contributed to this submission.

The Law Society notes that Part 5 of the *Guardianship Act 1987* ("Act") applies to a patient who is incapable of giving consent to the carrying out of medical and dental treatment.[1] This includes where a person does not have capacity to make medical and dental treatment decisions with the benefit of support.

If supported decision-making is implemented, there is a need to carefully consider how supported decision-making will interact with Part 5 of the Act. We note this is addressed further at Question 4.9 below.

Question 2.1: "incapable of giving consent"

(1) Is the definition of a person "incapable of giving consent to the carrying out of medical or dental treatment" in s33(2) of the Guardianship Act 1987 (NSW) appropriate? If not, what should the definition be?

We note that in our submission in response to Question Paper 1, we submitted the following:

> The Law Society suggests that the general principles set out in the NSW Capacity Toolkit are a good basis on which to develop principles to be included in the Act.

[1] *Guardianship Act 1987* s 34.

These principles are that, broadly speaking, when a person has capacity to make a particular decision, they are able to do all of the following[2]:

(a) Understand the facts involved.

(b) Understand the main choices.

(c) Weigh up the consequences of the choices.

(d) Understand how the consequences affect them.

(e) Communicate their decision.[3]

We suggest that when read consistently with the above principles, the definition of "incapable of giving consent to the carrying out of medical or dental treatment" in s 33(2) of the Act is appropriate.

(2) Should the definition used to determine if someone is capable of consenting to medical or dental treatment align with the definitions of capacity and incapacity found elsewhere in the *Guardianship Act 1987* (NSW)? If so, how could we achieve this?

The definition used to determine if someone is capable of consenting to medical and dental treatment should align with the definitions of capacity and incapacity found elsewhere in the Act.

We suggest that the definition in s 33(2), when read consistently with the principles as suggested in our response to Question 2.1(1) above, is the appropriate definition for the purposes of defining capacity and incapacity throughout the Act.

A consistent definition will promote better understanding of the Act and the roles of the parties involved in guardianship. It may allow persons considering whether to become guardians under the Act to have a better understanding of the definitions and requirements.

Question 3.1: Withholding or stopping life-sustaining treatment

(1) Should Part 5 of the *Guardianship Act 1987* (NSW) state who, if anyone, can consent to withholding or stopping life-sustaining treatment for someone without decision-making capacity?

We note that while this view is not shared by all of our members, we consider that the Act should indicate who can consent to withholding or stopping life-sustaining treatment for someone without decision-making capacity. Dealing with the withdrawing or withholding of life-sustaining treatment in the Act will allow the process in which these decisions are made to operate more effectively and will allow a better alignment with current clinical thinking.

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[2] *Capacity Toolkit*, NSW Department of Justice, Section 2 What is capacity? at http://www.justive.nsw.gov.au/diversityservices/pages/divserv/ds_capacity_tool/ds_capacity_tool.aspx

[3] Law Society of NSW, *Review of the Guardianship Act 1987 – Question Paper 1: Preconditions for alternative decision-making arrangements*, 4

(2) If so, who should be able to consent and in what circumstances?

We suggest that consideration be given to inserting a new s 37A into the Act which provides that the person responsible may consent to the withholding or stopping of life-sustaining treatment in certain circumstances. Withdrawing or withholding life-sustaining treatment should also be incorporated into the definition of medical treatment.[4]

It is problematic that the person responsible is currently empowered to consent to palliative care, but is unable to consent to the withdrawing of life-sustaining treatment on the basis that *withdrawing* treatment is distinguished from *carrying out* treatment.[5] An advance care directive ("ACD") may assist to allow a family member to give effect to a person's wishes with respect to withholding life-sustaining treatment. There is a risk, however, that depending on its drafting, an ACD may not apply in the particular circumstances. Presently, a guardian can only consent to the withdrawing of life-sustaining treatment if the guardianship appointment contains that power and some of our members consider this ought to continue.[6] However on balance, we consider that the Act should allow a person responsible to consent.

We note that a medical practitioner does not need an alternative decision-maker's consent to withhold or stop life-sustaining treatment if the medical practitioner considers the treatment to be futile.[7]

Question 3.2: Removing and using human tissue

(1) Should Part 5 of the *Guardianship Act 1987* (NSW) state who, if anyone, can consent to the removal and use of human tissue for a person who lacks decision-making capacity?

In accordance with s 32(b) of the Act, any decision made by a person responsible must be consistent with the need to ensure that any medical or dental treatment is carried out for the purpose of promoting and maintaining the person's health and well-being. We consider that the current framework ought to be maintained even in the event the Act is amended to prescribe who can consent to the removal and use of human tissue.

(2) If so, who should be able to consent and in what circumstances?

We consider that unless the removal and use of tissue is for the purpose of promoting and maintaining the person's health and well-being, a person responsible should only consent to the removal and use of human tissue where authorised to do so in a valid ACD. For a person responsible to provide consent to removal and use of human tissue otherwise would be inconsistent with the obligations to only make decisions which are for the therapeutic benefit of the person under guardianship.

A review of the *Human Tissue Act 1983* is currently under way with respect to ante mortem interventions for organ donations in NSW. We recommend that

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[4] We note amendment will also be required to the objects of Part 5 of the Act.
[5] *FI v Public Guardian* [2008] NSWADT 263.
[6] Ibid.
[7] Ibid.

any changes made to the respective Acts to accommodate current clinical thinking ought to be aligned.

Question 3.3: Should the definition of medical and dental treatment in Part 5 of the *Guardianship Act 1987* (NSW) include treatment by a registered health practitioner?

We consider that the definition of medical and dental treatment in Part 5 of the Act should include treatment by a registered health practitioner. 'Registered health practitioner' could be defined in the Act using the definition found in the *Health Practitioner Regulation National Law* (NSW). We recommend that consideration be given to the appropriate level of additional resources required by NCAT to accommodate the increase in workload which is likely to follow the expanded definition of medical and dental treatment.

Question 3.4: Types of treatment covered by Part 5

(1) Are there any other types of treatment excluded from Part 5 of the *Guardianship Act 1987* (NSW) (or whose inclusion is uncertain) that should be included?

The Law Society is of the view that the definition of medical and dental treatment ought to include the withdrawal or withholding of life-sustaining treatment. It is appropriate, in our view that these provisions regarding the giving of consent fall within the guardianship framework.

(2) Should any types of treatment included in Part 5 of the *Guardianship Act 1987* (NSW) be excluded?

We do not consider that any types of treatment currently included in Part 5 of the Act should be excluded.

Question 4.1: Special treatment

(1) Is the definition of special treatment appropriate? Should anything be added? Should anything be taken out?

We consider that the current definition of special medical treatment in the *Guardianship Regulation 2016* ("Regulation") with respect to terminating a pregnancy and the requirement for an order from NCAT is appropriate. Some of our members consider it to be disproportionate to require an NCAT order or Court order to enable medication to be prescribed to terminate a pregnancy. For example, the termination of a pregnancy is not classified as special medical treatment in the definition of the *Children and Young Persons (Care and Protection) Act 1998*. It is, however, included in the definition of special medical treatment in the Act.

(2) Who should be able to consent to special treatment and in what circumstances?

We consider that the provisions in s 36 of the Act outlining who can consent to special medical treatment are appropriate.

(3) How should a patient's objection be taken into account?

We consider that the provisions in the Act outlining the circumstances in which the patient's objections are taken into account or disregarded are appropriate.

(4) In what circumstances could special treatment be carried out without consent?

We consider that the provisions in the Act outlining the circumstances in which special medical treatment may be carried out without consent are appropriate.

Question 4.2: Major treatment

(1) Is the definition of major treatment appropriate? Should anything be added? Should anything be taken out?

The definitions of special treatment and major treatment are at risk of becoming out of date from the perspective of clinical practice. The Law Society recommends that targeted consultations be conducted with the medical colleges to modernise the language.

We suggest, by way of example, that testing for HIV should no longer be included as a major treatment as there is no longer the same social stigma attached to HIV as there was in the past.

Some members also suggest that the use of long acting contraceptive treatment ought to be removed from the definition of major medical treatment as it is impractical and no longer consistent with clinical practice. In practice, a guardian might consent to a series of contraceptive treatments of medium acting duration. In these circumstances some members suggest that it is disproportionate to require an order from NCAT for the use of long acting contraceptives as a major medical treatment.

(2) Who should be able to consent to major treatment and in what circumstances?

The Law Society is of the view that the current framework in which consent is provided to major treatment is appropriate.

(3) How should a patient's objection be taken into account?

The Law Society is of the view that the current framework with respect to taking the patient's objection into account is appropriate.

(4) In what circumstances could major treatment be carried out without consent?

The current framework in which major treatment can be carried out without consent under s 37(1) of the Act is appropriate.

Question 4.3: Minor treatment

(1) Is the definition of minor treatment appropriate? Should anything be added? Should anything be taken out?

The Law Society is of the view that the current definition of minor treatment is appropriate.

(2) Who should be able to consent to minor treatment and in what circumstances?

The Law Society is of the view that the current framework indicating who can consent to minor treatment and in what circumstances is appropriate.

(3) How should a patient's objection be taken into account?

A patient's objection to minor treatment should continue to be taken into account in the same way as an objection for major treatment is taken into account.

(4) In what circumstances could minor treatment be carried out without consent?

The Law Society considers that the circumstances set out in s 37 of the Act are appropriate. We note that some Committee members are concerned that the s 37(3) requirement that a medical practitioner provide certification that the treatment is necessary, and is the form of medical treatment that will most successfully promote the patient's health and well-being, and that the patient does not object to the carrying out of the treatment, is unnecessarily burdensome.

On balance, however, we do not recommend s 37 be amended in this regard.

Question 4.4: Does the *Guardianship Act 1987* deal with treatments that fall outside of the Part 5 regime adequately and clearly?

We recommend that the Act should deal with medical and dental treatments which fall within the scope of the *Health Practitioner Regulation National Law* (NSW). Otherwise, the Act deals with treatments which fall outside of the Part 5 regime adequately.

Question 4.5: Categories of treatment as a whole

(1) Does the legislation make clear what consent requirements apply in any particular circumstance? If not, how could it be clearer?

We consider that the changes to the definitions of special and major medical treatment referred to above and ensuring a consistency with the *Health Practitioner Regulation National Law* (NSW) would clarify consent requirements applying under the relevant legislation.

(2) Do you have any other comments about the treatment categories and associated consent regimes in Part 5?

We have no further comments about the treatment categories and associated consent regimes.

Question 4.6: Person responsible

(1) Is the "person responsible" hierarchy appropriate and clear? If not, what changes should be made?

We believe that the "person responsible" hierarchy in the Act is appropriate and clear.

(2) Does the hierarchy operate effectively? If not, how could its operation be improved?

The Law Society suggests that disputes are more likely to arise where more than one person is on the same level on the hierarchy. However it is our view that as the hierarchy does currently operate effectively, it is not necessary to make any changes.

Question 4.7: Are the factors a decision-maker must consider before consenting to treatment appropriate? If not, what could be added or removed?

The Law Society is of the view that the factors a decision-maker must consider before consenting to treatment are appropriate.

Question 4.8: Is the requirement that consent requests and consents must be in writing appropriate? If not, what arrangements should be in place?

The Law Society considers that it is appropriate that consent requests and consents must be in writing in accordance with the current requirements in cls 12 and 13 of the Regulation. Requesting and providing consent in writing, where it is practicable to do so, operates to protect the interests of people under guardianship and protects medical practitioners from liability because there is a record of the consent provided prior to particular treatments being undertaken. There is sufficient flexibility within the practicability consideration to ensure that consent is not overly burdensome on medical practitioners.

The Law Society is of the view that it is a sufficient protection for medical practitioners to be able to rely on a defence that requesting consent in writing or obtaining written consent was not practicable in the circumstances.

Question 4.9: Supported decision-making for medical and dental treatment decisions

(1) Should NSW have a formal supported decision-making scheme for medical and dental treatment decisions?

As indicated in our response to Question Paper 2, the Law Society supports a supported decision-making scheme, including in relation to medical and dental treatment. However, we note that Part 5 of the Act applies where people lack capacity to make decisions regarding their dental and medical treatment, while a supported decision-making model involves people who still have capacity to make treatment decisions, with support. Accordingly, a supported decision-making model would operate in addition to the existing provisions in Part 5.

(2) If so, what should the features of such a scheme be?

We consider Victoria's *Medical Treatment Planning and Decisions Act 2016* (Vic) could be used as a guide, as it provides for the appointment of a medical treatment decision-maker for a person who lacks capacity and a support person for a patient who does have some capacity. The patient should have the opportunity to participate and to consent or refuse treatment whenever they have capacity to do so.

Supported decision-making is appropriate for decisions regarding medical and dental treatment for major or minor treatment or treatment which falls outside the scope of Part 5.

We consider it is appropriate to maintain the most stringent consent requirements for special medical treatment in light of its invasive and risky nature to protect vulnerable people. For this reason the Supreme Court exercising *parens patriae* jurisdiction or NCAT should remain the only bodies able to authorise special medical treatment procedures. We submit that this is consistent with the *Convention on the Rights of Persons with Disabilities* recommendation that there be a ban on the involuntary sterilisation of people who have the capacity to consent "with appropriate decision-making support or on people who might develop a capacity to consent in the future."[8]

Question 4.10: Consent for sterilisation

(1) Who, if anyone, should have the power to consent to a sterilisation procedure?

The Law Society considers that the current framework for consent to sterilisation procedures, as a special medical treatment, under s 33 and s 36 of the Act operates appropriately. We consider that NCAT and the Supreme Court ought to remain the only bodies with the power to consent to sterilisation in order to meet the obligations outlined in the international conventions to which Australia is a party.

The Senate Community Affairs References Committee, Parliament of Australia, *Inquiry into Involuntary or Coerced Sterilisations of women and young people with disabilities* in 2013 stated that unauthorised sterilisations appeared to be carried out throughout Australia.[9] If involuntary or coerced sterilisation of women and girls with disabilities is happening, as it appears to be, this is a serious violation of the rights set out in a number of international instruments to which Australia is a party.

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[8] *Convention on the Rights of Persons With Disabilities*, adopted 13 Dec 2006, entered into force 5 May 2008, UNGA Res. 61/106 13 Dec 2006.

[9] Australia, Senate, Community Affairs References Committee, *Involuntary or Coerced Sterilisations of people with disabilities* (2013). http//www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Involuntary_Sterilisation/First_Report

(2) In what ways, if any, could the *Guardianship Act 1987* (NSW) better uphold the right of people without decision-making capacity to participate in a decision about sterilisation?

The Law Society notes that Part 5 of the Act applies only in circumstances where a person lacks capacity to consent to medical or dental treatment. The Law Society recommends that the objects of the Act should require the provisions of the Act be interpreted in a manner consistent with the *Convention on the Rights of Persons with Disabilities.*[10]

The Law Society considers that the way a person without decision-making capacity can participate in decisions regarding sterilisation and other special medical treatment ought to be explored further.

Question 4.11: What matters should the NSW Civil and Administrative Tribunal be satisfied of before making a decision about sterilisation?

The Law Society considers that the matters that NCAT or the Supreme Court must currently consider before making a decision regarding sterilisation are appropriate.

Question 4.12: Matters that should not be taken into account in sterilisation decisions

(1) Is there anything the NSW Civil and Administrative Tribunal should *not* take into account when deciding about sterilisation?
(2) Should these be stated expressly in the *Guardianship Act 1987* (NSW)?

Our understanding of the case law is that matters such as the risk of pregnancy as a result of sexual abuse, assessments of the person's current or hypothetical capacity to care for children or eugenics are not taken into account when considering the authorisation for sterilisation procedures. These matters could be incorporated into the Act.

Question 4.13: Legislative recognition of advance care directives

(1) Should legislation explicitly recognise advance care directives ("ACD")?

There appears to be general confusion among stakeholders with respect to what constitutes an ACD. We note that depending on its drafting, an ACD may not be effective in the particular circumstances. We also note that many pro forma ACD forms are currently in use in NSW, which may contribute to the confusion regarding the use and recognition of ACDs. Explicit legislative recognition, which includes a definition of an ACD and a template, could provide some clarity and facilitate and promote use of ACDs. Some members have reservations about the Act prescribing an ACD form.

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[10] *Convention on the Rights of Persons With Disabilities*, adopted 13 Dec 2006, entered into force 5 May 2008, UNGA Res. 61/106 13 Dec 2006.

(2) If so, is the *Guardianship Act 1987* (NSW) the appropriate place to recognise advance care directives?

We note that while this view is not shared by all of our members, the Law Society takes the view that it would be useful for ACDs to be recognised in legislation.[11]

Question 4.14: Who should be able to make an advance care directive?

The Law Society supports the common law position which is that a capable adult is the appropriate person to make an ACD.[12]

Question 4.15: What form should an advance care directive take?

We refer to our answers to questions 4.13 (1) and (2) above. Any template ACD should be both comprehensive and easy to understand.

We consider that, where possible, the form should be completed in the presence of a doctor, as doctors are the appropriate professionals to explain the types of situations where an ACD may be required, and the effect of the patient's decisions. Medicare currently allows a scheduled fee for consultation with a doctor of up to 30 minutes to complete an ACD and an additional scheduled fee for periods over 30 minutes. A solicitor should not be required to witness the completion of an ACD.

The Law Society is reluctant to see the form of an ACD becoming a barrier to their use. While it may be beneficial for a person to obtain legal and medical advice when completing an ACD, the absence of legal or medical advice, or a lawyer or medical practitioner as a witness, should not have the effect that the person's wishes, as contained in an otherwise valid ACD, are not given effect.

Question 4.16: What matters should an advance care directive be able to cover?

The Law Society considers that this is primarily a medical issue but makes some general comments below.

In general terms, the Law Society suggests an ACD could include the following matters:

- Circumstances in which the person wishes to receive life-sustaining treatment;
- Circumstances in which the person wishes life-sustaining treatment to be stopped or withheld;
- The person's wishes regarding where they want to live and other personal affairs;
- A values statement indicating the person's views, wishes and beliefs; and
- An appointment of a substitute decision-maker to make health care decisions.

The Law Society would appreciate being part of a stakeholder consultation regarding any pro forma ACD proposed to be incorporated into the Act.

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[11] Including possibly in the Regulation.

[12] *Hunter and New England Area Health Service v A* [2009] NSWSC 761, 74 NSWLR 88. We note that a guardian with a health care function may also make an ACD.

Question 4.17: In what circumstances should an advance care directive be invalid?

We consider that the use of, or compliance with any ACD form should not be a criterion for the validity of an ACD. The Law Society's position is that an ACD should be valid if it is made in accordance with an approved template, whether such a template is incorporated into the Act, the Regulation or other legislation, or if otherwise valid under the common law. As indicated in answer to question 4.15 above, we are of the view that deficiencies as to form should not have the effect that the person's wishes, in an otherwise valid ACD, are not given effect.

An ACD should be held invalid in limited circumstances, including where a person did not have capacity or was under duress at the time the directive was executed. Otherwise, our view is that requirements for an ACD to be valid ought not to be overly prescriptive.

We consider that it is appropriate that the Supreme Court maintains judicial oversight.

Question 4.18: Part 5 Offences

(1) Are the various offences of treating without authorisation and the maximum penalties that apply appropriate and effective?
(2) Is there a need for any other offences relating to medical and dental treatment?

We consider that the various offences of treating without authorisation and the maximum penalties are appropriate and effective. It has been observed anecdotally that some health practitioners, including those working at aged care facilities, are unaware that penalties apply for treating people without consent.

Question 5.1: How should the *Guardianship Act 1987* (NSW) define "clinical trial"?

The Law Society is of the view that consideration ought to be given to adding the terms 'drugs and techniques that have not been approved for the purpose proposed by the Therapeutic Goods Administration' to the definition of 'clinical trial'. The definition of clinical trial currently found in the Act is otherwise appropriate.

Question 5.2: Categories of medical research

(1) Should there be more than one category of medical research?
(2) If so, what should those categories be and what consent regimes should apply to each?

The Law Society considers that there are other stakeholders with more appropriate expertise to answer these questions.

Question 5.3: Who can consent to clinical trial participation

(1) Who should be able to approve a clinical trial?

The Law Society considers that the current approval processes are appropriate.

(2) Who should be able to consent to a patient's participation in a clinical trial if the patient lacks decision-making capacity?

We consider that if a patient lacks decision-making capacity, then the person responsible may provide consent.

(3) How can the law promote the patient's autonomy in the decision-making process?

The law can promote the patient's autonomy in the decision-making process by adopting a supported decision-making model for guardianship together with the 'best interests' model which currently operates.

Question 5.4: Considering the views and objections of patients

(1) If the patient cannot consent, should the decision-maker be required to consider the views of the patient?

The Law Society considers that NCAT and the decision-maker should continue to be required to consider the views of the patient.

(2) What should happen if a patient objects to participating in a clinical trial? Should substitute consent be able to override a patient's objection? If so, in what circumstances?

We believe that the current circumstances in which a patient's objection may be overridden are appropriate.

Question 5.5: What preconditions should be met before a decision-maker can consent to participation?

We believe that the matters that NCAT and the person responsible must take into account before providing consent to participation in a clinical trial, as set out in Divisions 3 and 4 of Part 5 of the Act, are appropriate.

Question 5.6: What should researchers be required to do after consent is obtained?

We believe that the current processes are appropriate.

Question 5.8: Do you have any other comments about the consent requirements for clinical trials?

The Law Society has no other comments to make about the consent requirements for clinical trials.

Question 6.1: Relationship between the *Guardianship Act* and the *Mental Health Act*

(1) Is there a clear relationship between the *Guardianship Act 1987* (NSW) and the *Mental Health Act 2007* (NSW)?

The Law Society considers that, in most respects, the relationship between the Act and *the Mental Health Act* 2007 (NSW) ("MHA") is clear, as the respective Acts serve different functions and purposes.

There is, however, a lack of clarity regarding the operation of s 53 of the MHA with respect to consent for medical and dental treatment under the Act. The Act sets out the relationship with the MHA in s 3C in respect of 'patients' as defined under the MHA. The Act, however, does not make reference to an affected person as defined under the MHA. An 'affected person' under the MHA is a person who involuntarily is prescribed psychiatric treatment under a community treatment order.[13] As an example, a guardian may consent to major medical treatment, such as the administration of sertraline and a community treatment order under the MHA may also compel the person to take another medication, such as sodium valproate. In this example, the consent of the guardian is valid and so is the prescribed treatment under the community treatment order. It is unclear in this instance, which consent would prevail.

(2) What areas, if any, are unclear or inconsistent?

We refer to our comments in response to Question 6.1(1). We also suggest there is an inconsistency between the two Acts regarding the review of patients. A person under guardianship, who is mentally ill, may receive care and treatment as a voluntary patient. A voluntary patient is not reviewed by the Mental Health Review Tribunal until they have been a voluntary patient for 12 months. However, persons who are treated involuntarily under the MHA are reviewed by the Mental Health Review Tribunal between 14 to 21 days after admission. We consider that patients admitted at the request of their guardian should also be reviewed by the Mental Health Review Tribunal between 14 to 21 days after admission as they have not personally requested voluntary admission.

There are several inconsistencies in the consent regimes between the Act and the MHA depending upon the category of patient, including the consent required for sterilisation and for the termination of a pregnancy. For an involuntary patient under a community treatment order, if the termination of a pregnancy is to be a surgical procedure,[14] the consent is determined under the MHA. However any other non-surgical treatment including termination of a pregnancy by non-surgical means is instead consented to under the requirements of the Act.[15]

(3) How could any lack of clarity or inconsistency be resolved?

A uniform approach should be adopted to ensure consistency for the consent requirements for the termination of a pregnancy. We prefer the consent requirements in the Act.[16]

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[13] See s 50 of the *Mental Health Act 2007* (NSW).

[14] Or a series of related surgical operations or surgical procedures, and the administration of an anesthetic for the purposes of medical investigation, see s 98 of the MHA.

[15] Sections 33 and 45(2) of the *Guardianship Act 1987*.

[16] See NSW Legislative Council Standing Committee on Social Issues, *Substitute Decision-making for People Lacking Capacity*, Report 43 (2010) rec 34.

Question 6.2: Relationship between the *Guardianship Act* and the *Forensic Provisions Act*

(1) Is there a clear relationship between the *Guardianship Act* and the *Forensic Provisions Act*?
(2) What areas, if any, are unclear or inconsistent?
(3) How could any lack of clarity or inconsistency be resolved?

The relationship between the Act and the *Mental Health (Forensic Provisions) Act 1990* ("Forensic Provisions Act") is not always easy to navigate. However, we take the view that it is appropriate for NCAT to continue to take a case by case approach in deciding whether to make a guardianship order for a person who is also a patient pursuant to the Forensic Provisions Act.[17]

Question 6.3: Whether mental health laws should always prevail

(1) Is it appropriate that mental health laws prevail over guardianship laws in every situation?
(2) If not, in which areas should this priority be changed?

The Law Society suggests that, in most instances, it will be appropriate that to the extent of any inconsistency, the mental health laws prevail over a guardianship order or instrument.

Difficulties arise with respect to voluntary patients under mental health laws, when a guardian makes a request that the person stay as a voluntary patient in a mental health facility.[18] If the authorised medical officer forms the view that the patient is not or no longer likely to benefit from further care or treatment, then the person, as a voluntary patient, can be discharged and leave at any time. Section 8 of the MHA requires the guardian to be notified of the discharge of the patient. However, the guardian's request that the person reside in the facility is overruled by the discharge of the voluntary patient. This results in a situation where a guardian makes an accommodation decision for the subject person, and if the authorised medical officer of the facility or the subject person decide to discharge from that facility, there is nothing the guardian is able to do other than request another voluntary admission.[19] We recommend consideration be given to changing the interaction of the mental health laws with the guardianship laws in this situation.

Question 7.1: What are the problems with the regulation of restrictive practices in NSW and what problems are likely to arise in future regulation?

The intersection of different Commonwealth and State regulatory frameworks may be problematic. The regulation of restrictive practices could fall within the National Disability Insurance Scheme ("NDIS") Quality and Safeguarding Framework or guardianship laws but the regulation of restrictive practices is also relevant to mental health facilities, aged facilities and other disability sectors as well as private homes.

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[17] ERC [2015] NSWCATGD 14.
[18] Pursuant to s 7 of the *Mental Health Act 2007*.
[19] *White v The Local Health Authority* [2015] NSWSC 417.

Question 7.2: Restrictive practices regulation in NSW

(1) Should NSW pass legislation that explicitly deals with the use of restrictive practices?
(2) If so, should that legislation sit within the *Guardianship Act* or somewhere else?
(3) What other forms of regulation or control could be used to deal with the use of restrictive practices?

The Law Society suggests that it would be more beneficial for information regarding the impact of the Commonwealth regulation of restrictive practices by service providers under the NDIS Quality and Safeguarding Framework to be made available and considered, before a view is provided in answer to this question. Depending upon the results of the Commonwealth regulation of restrictive practices, it may be appropriate to consider enacting complementary legislation in NSW.

At the appropriate time, we suggest that consideration should be given to reforming policy and procedures in the disability sector as well as carrying out an education campaign aimed at changing the culture and mindset throughout the community for service providers, family, educators and carers.

We suggest that this education campaign should include discussions of the alternative strategies that can be used to avoid the need to engage in restrictive practices, such as addressing environmental factors including noise, lighting, and temperature which might trigger problematic behaviours.

Question 7.5: In what circumstances, if any, should restrictive practices be permitted?

We consider that restrictive practices should only be permitted where it is necessary to prevent serious damage to the person's health and safety. Restrictive practices should also only be permitted on a short term basis and in the context of positive approaches to address the person's behaviour and needs.

Question 7.6: Consent and authorisation mechanisms

(1) Who should be able to consent to the use of restrictive practices?

We consider that the Supreme Court, NCAT or a guardian appointed by NCAT ought to be able to consent to the use of restrictive practices for adults.

(2) What factors should a decision-maker have to consider before authorising a restrictive practice?

We suggest that some of the factors a decision-maker ought to consider before authorising a restrictive practice include:

- the gravity of the consequences of using restrictive practices
- whether the restrictive practice is the least restrictive response available
- whether the restrictive practice is the last resort
- whether an order is needed or whether a person responsible can appropriately provide consent to the practice, if it is medication being used to address challenging behaviour

- the risks associated with the restrictive practice
- whether the risk of harm posed by the restrictive practice is proportionate to the risk of harm posed by the challenging behaviour
- the risk of the practice being abused and how any risk of abuse can be reduced
- if medication is being used as a chemical restraint, what positive approaches are being made to address the behaviour
- whether the behaviour of concern causes serious harm to the person or others
- whether the restrictive practice is part of a positive behaviour support plan
- whether the person is to be provided with comforts if seclusion is the restrictive practice involved
- whether the person is protected from abuse, neglect and exploitation
- any available information about how regularly the practice is used and the impact on the challenging behaviour
- whether consenting to the restrictive practice in the particular instance forms part of a principled, transparent and systematic plan to eliminate the need for restrictive practices
- whether consenting to the restrictive practice is in the person's best interests.

(3) What should be the mechanism for authorising restrictive practices in urgent situations?

We consider that the current mechanism for urgent orders to be made by the Supreme Court or NCAT are appropriate.

(4) What changes, if any, should be made to NSW's consent and authorisation mechanisms for the use of restrictive practices?

The Law Society recommends that any authorisation mechanism for the use of restrictive practices ought to be consistent with the NDIS Quality and Safeguarding Framework including mandatory reporting, monitoring and review of the data by an independent body.

Question 7.7: What safeguards should be in place to ensure the appropriate use of restrictive practices in NSW?

As indicated above, safeguards should include mandatory reporting, monitoring and reviews of data and positive behaviour support plans by an independent body.

Question 7.8: Requirements about the use of behaviour support plans

(1) Should the law include specific requirements about the use of behaviour support plans?

We suggest that NCAT already appears to regard it as necessary for a behaviour plan, including both positive elements and restrictive practices, to be presented in an application for a restrictive practices function. For example, it is our committee members' experience that NCAT usually includes a condition that the guardian may only consent to a restrictive practice if positive approaches are also being used to address the person's behaviour or needs.

We submit that inclusion of specific requirements regarding behaviour support plans might highlight the importance of behaviour support plans and lead to a reduction in the use of restrictive practices.

(2) If so, what should those requirements be?

We recommend that consideration could be given to the wording used in other States and Territories. Alternatively the Act could provide that the guardian may only consent to a restrictive practice in the context of the implementation of a positive behaviour support plan. This would bring it in line with the condition used by NCAT when conferring a restrictive practices function.

Thank you for the opportunity to provide comments to this inquiry. If you have any queries about this submission, please do not hesitate to contact Katrina Stouppos, Policy Lawyer, on (02) 9926 0212 or by email at katrina.stouppos@lawsociety.com.au.

Yours sincerely,

[redacted]

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