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Submission to the NSW Law Reform Commission on the Review of the Guardianship Act 1987 Question Paper 5

This submission outlines the response of the NSW Mental Health Review Tribunal (MHRT) to the call for submissions by the Law Reform Commission in relation to Question 6.1. This response will refer to the MHRT's preliminary submission of 21 March 2016, which addressed in some detail the relationship between the Guardianship Act (GA) and the Mental Health Act (MHA).

Question 6.1 Relationship between the GA and the MHA

(1) Is there a clear relationship between the GA and the MHA?
(2) What areas, if any, are unclear or inconsistent?
(3) How could any lack of clarity be resolved?

(1) As noted in the MHRT's earlier submission there is an overlap between the provisions of the GA and the MHA, in that in some instances a person may be subject to guardianship orders and the provisions of the GA as well as the jurisdiction of the MHRT. The earlier submission stated, relevantly:

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

Section 3C of the GA, sets out the relationship between the GA and the MHA and how any inconsistency is to be resolved. Section 34 of the GA sets out how inconsistences in relation to treatment between the GA and the MHA and the *Mental Health (Forensic Provisions) Act 1990* (MHFPA), are to be resolved. However, it is unclear how forensic patients fit within s 3C. (See response to Q 6.2 below).

The overarching intent of both s3C and s34 is to recognise that persons can be subject to both the GA and the MHA/MHFPA, but that in the event of any inconsistency, the MHA/MHFPA prevails. Whilst these provisions set out a clear relationship between the two legislative regimes, it has been our experience that clinicians, consumers and carers have great difficulty, and are sometimes confused, as to whether the GA and/or the MHA applies in each case.

(2) It is our submission that a number of factors contribute to this confusion:

(a) The complex wording of s3C. Section 3C states:

> "(1) A guardianship order may be made in respect of a patient within the meaning of the Mental Health Act 2007.

(2) The fact that a person under guardianship becomes a patient within the meaning of the Mental Health Act 2007 does not operate to suspend or revoke the guardianship.

(3) However:

(a) a guardianship order made, or

(b) an instrument appointing an enduring guardian, in respect of a person who is, or becomes, a patient within the meaning of the Mental Health Act 2007 is effective only to the extent that the terms of the order or instrument are consistent with any determination or order made under the Mental Health Act 2007 in respect of the patient."

Put simply, s3C states that if a person becomes a patient under the MHA, it does not preclude the making of a guardianship order with respect to that person; nor does it suspend or revoke a current guardianship order. Furthermore, in the event of an inconsistency the MHA prevails. However, the wording is opaque.

(b) Lack of clarity as to how any inconsistency is to be resolved. As pointed out in our preliminary submission:

> "..... Section 3C refers to a consideration of the terms of the guardianship order but does not refer to the terms of the mental health determination or order. A reference to the terms of the guardianship order could mean that a textual test should be used to evaluate inconsistency."

(c) Another factor that contributes to confusion is a general ignorance of how the two Acts interact. Unsurprisingly, some clinicians treating patients under the MHA assume that all decisions in relation to the patient can be resolved under that Act, and they may have little understanding of guardianship laws.

(d) Many inquiries made to the Tribunal are from junior clinicians who do not have the time and resources to navigate the legislation. This is especially evident in relation to "treatment" decisions for patients who are detained or voluntary under the MHA. Our preliminary submission referred to an area of overlap between the two Acts in relation to medical treatment:

> "Generally, consent to medical treatment unrelated to a person's mental illness is to be found in the *Mental Health Act* or the *Guardianship Act* depending on the person's status. This can lead to anomalies and confusion for practitioners and consumers.
>
> The *Mental Health Act* has a substituted consent regime for specific non-mental health decisions, i.e. surgery and special medical treatment depending on the patient's status. All other treatments fall to be decided under the *Guardianship Act*, if the subject person lacks capacity to make decisions.
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> As the *Guardianship Act* also has a legislative regime for surgery and special medical treatment many clinicians working in mental health facilities have difficulty determining which regime applies and frequently seek advice from the MHRT."

The following three examples illustrate the difficulties faced by clinicians. The first example is where a psychiatrist at a mental health facility was treating a patient who had been scheduled under the MHA with a diagnosis of mental illness and intellectual disability. The patient had a guardian, (her mother), and the psychiatrist wanted to know if consent to the insertion of Implanon (a long acting contraceptive) was a "special medical treatment" and whether the MHA or the GA provisions applied.

The second example is where a psychiatrist treating an involuntary patient (experiencing an acute psychotic relapse) under the MHA advised that the relapse was in the context of refusing medication, and furthermore that the delusional beliefs were driving the patient to refuse medical investigations and treatment for his diabetes and high cholesterol. The psychiatrist wished to know if he could prescribe medications for these medical illnesses as the patient's refusal to treat these illnesses were psychotically driven.

The third example is where the guardian with a medical consent function of a person on a Community Treatment Order (CTO) made under the MHA, disagreed with the medication in the Treatment Plan and wished to make decisions about medication for the subject person's mental health treatment.

Clinicians seeking to navigate the treatment provisions of the GA not only have to grapple with the different categories and definitions of "treatment" (major, minor, special, surgery) but also have to possess an understanding of "treatment" permitted under the MHA. This requires a working knowledge of the provisions of the MHA relating to surgery, special medical treatment and ECT. This task is likely compounded by the ambiguous wording of s84 MHA as follows:

> "An authorised medical officer of a mental health facility may, subject to this Act and the *Mental Health (Forensic Provisions) Act 1990* give, or authorise the giving of, any treatment (including any medication) the officer thinks fit to an involuntary patient or assessable person detained in the facility in accordance with this Act or that Act."

On one reading "any treatment" could be interpreted as meaning that all treatment (including mental health treatment) could be mandated by an authorised medical officer under the MHA, without reference to the GA. Whilst the MHRT interprets s84 as relating to mental health treatment, it considers that the issue is not beyond doubt.

(e) The Tribunal's preliminary submission also noted another area of overlap and inconsistency relating to definitions in the two Acts:

> "For example, in the *Guardianship Act*, a termination of pregnancy is defined (in cl. 9 of the Regs) as special medical treatment, and so requiring the authorisation of the Guardianship Division. However, a termination is considered to be "surgery" under the *Mental Health Act*. This means that, for involuntary patients (which does not include assessable persons or detained persons) consent may be given by the Secretary of the Ministry of Health, if the patient's designated carer agrees with it, the patient is unable to give informed consent and it is "desirable, having regard to the interests of the patient" (*s100(3))."

Indeed, the level of confusion amongst clinicians about the interaction of the two legislative regimes and which jurisdiction applies has been such, that in 2016 the MHRT published on its website a 'ready reckoner' table of the applicable consent regimes (see Attachment). The Attachment readily demonstrates that resolving questions of jurisdiction is complex as it turns on the person's legal status under the MHA and the nature of the treatment.

(f) Another area of overlap between the MHA and the GA relates to the powers of guardians in respect of voluntary patients. The MHRT draws attention to its preliminary submission as follows:

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

The MHRT is aware of at least one matter in which the Public Guardian has submitted at a review of a voluntary patient order that they could override a patient's decision to discharge themselves. Whilst the MHRT did not accept that argument (the reasons are outlined in the *Official Report of Richard Peters* (2015 NSW MHRT 1) it continues to be an area of confusion for patients, guardians, carers and clinicians.

(3) Suggested Changes

(a) It is submitted in relation to s3C of the GA, that it should be amended to clearly provide that in the event of an inconsistency the MHA prevails. As noted in the preliminary submission:

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

(b) While the current review is focused on the Guardianship Act, the Tribunal refers to the following extract from its submission in December 2012 to the Ministry of Health as part of the review of the Mental Health Act 1990:

"At present, the legislative regime governing non-mental health medical decisions for a person detained in a mental health facility is found in both the Act and the Guardianship Act. For ease and consistency, the Tribunal believes that it would be preferable if the whole of the legislative regime governing medical decisions about a person detained in a mental health facility were found in the Act.

The Tribunal considers that for minor or major treatment (as those terms are defined in the Guardianship Act), consent to treatment should continue to be provided by a "person responsible" as defined in the Guardianship Act. However, where the Guardianship Act confers the power on the Guardianship Tribunal to make a decision, then in circumstances where a person is detained in a mental health facility, it should be the MHRT which is the decision maker.

The Tribunal considers that the relevant Guardianship Act provisions should be imported into the Act.

The Tribunal notes that there is some inconsistency between the definitions in the two Acts. For example, in the Guardianship Act, a termination is defined (in cl. 9 of the Regs) as special medical treatment, and so requiring the authorisation of the Tribunal. That is not the case under the Act. The Tribunal considers that the Guardianship Act definitions should be adopted where there is a discrepancy.

At present s84 deals with the provision of treatment to involuntary patients. This provision has been construed to deal only with mental health treatment. This leaves open the issue of what is considered to be mental health treatment for involuntary patients. For example, there is uncertainty about whether the powers in s84 cover treatment-related activity such as diagnostic testing, investigations, assessments, management of side effects and addressing any counter acting effects between mental health and non-mental health treatments."

(c) The MHRT recommends that the GA be amended to include a clear statement as to the limits of a guardian's powers in relation to voluntary patients. The statement should prohibit a guardian from making decisions about a patient's discharge that override a patient's right to be discharged. Similarly, a guardian should be prohibited from re-admitting a patient who has discharged themselves. The latter issue was raised in the decision of *Sarah White v The Local Health Authority & Anor* [2015] NSWSC 417.

(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?

(1) The areas of inconsistency in relation to medical treatment outlined above, apply equally to forensic patients as they do to civil mental health patients. Treatment decisions for forensic patients are found in the MHA and not the *Mental Health (Forensic Provisions) Act 1990* (MHFPA). However, as our

preliminary submission noted, there is no clear answer to the question of whether s3C applies to either forensic or correctional patients under the MHFPA. Section 3Cof the GA does not specifically refer to the MHFPA. As noted in our preliminary submission, this is likely due to legislative oversight.

(2) The issue of primacy of jurisdiction has arisen at the MHRT in relation to a forensic patient who was conditionally released to the community under mental health legislation and who was also the subject of a Guardianship Order. The patient had mental illness, dementia and intellectual disability and was bound by the conditions of his release to accept medication prescribed by his psychiatrist. At the same time he had a guardian appointed to make decisions about health care, and medical and dental treatment. There was a concern that decisions were being made by the guardian about the patient's medication regime which had the potential to impact on the patient's mental state such that it could undermine his mental stability and put him or others at risk of serious harm.

The following examples also illustrate the issue. A person with an intellectual disability and a mental illness who is eligible for ADHC services declines to consent to have those services. ADHC will only provide services if the person consents. These services could facilitate the person's compliance with their forensic order: for example, transporting the person to appointments with their case manager/psychiatrist and drug & alcohol counsellor; or transporting the person to day activities to give the person something to do during the day, which limits the chances of them getting into other trouble. The decision in *ERC* [2015] NSWCATGD 14 considered this situation and NCAT decided not to grant a guardianship order. NCAT said in that case:

> "68 Given this, as previously noted, it is questionable whether a guardianship order made for the primary purpose of seeking to ensure compliance by a forensic patient with conditions that form part of an order pursuant to Part 5 of the MHFPA would be consistent with the principles set out in section 4 of the GA.
>
> 69 Whilst an argument might be put that the appointment of a guardian could be in an individual's best interests if it somehow facilitated compliance with the terms of a conditional release order so that there is a greater chance that the individual will remain living successfully in the community, the making of a guardianship order, in the Tribunal's view, is not the appropriate vehicle to achieve this outcome."

The issue has also arisen in the context of extensions of forensic patient status for those previously on limiting terms. Some individuals will not accept services that the court (and the MHRT) considers are necessary to keep themselves and others safe. The question is whether a guardianship order, which accepts those services on the forensic patient's behalf, allows for the patient to have a less restrictive form of care. This issue is likely to arise more often as the National Disability Insurance Scheme (NDIS) rolls out and takes over the Community Justice Program (CJP) placements.

A third common scenario is the appointment of a guardian to consent to an accommodation arrangement. This is common for those moving to aged care premises. It allows accommodation to be consented to by a guardian

and therefore to be put in place, before the MHRT is asked to consider conditional release to that accommodation. To date, NCAT has made orders in those circumstances, which are later allowed to lapse and the person remains at that accommodation under a conditional release from the MHRT.

Similar issues may arise in relation to prisoners with disabilities who are exiting prison who need guided assistance with their services and to comply with their parole conditions, or to steer clear of "police attention". Transition from gaol to community is critical – often exiting persons do not have a definite address (for example, they may have to spend some time in a hostel). Community mental health teams often will not agree to a CTO or provide services without there being a valid address in their area. This means many have exited gaol without services in place to address their issues. This is a huge gap in the continuity of care that might otherwise be fulfilled by the appointment of a guardian with authority to consent to the provision of services.

(3) The Tribunal suggests that the GA could be amended to make it clear that where a person is a forensic patient, in deciding whether to make a guardianship order, a person's best interests may include the fact that making a guardianship order will facilitate their compliance with any MHRT order. It may be necessary to widen more generally the definition of 'best interests' to include those persons who are exiting prison.

The Tribunal also proposes that the MHFPA prevail over the GA, as does the MHA. Whilst there is clearly an obligation to protect and foster the best interests of the individual, protection of the individual and the community must prevail. Given that forensic patients have been brought to the attention of the criminal justice system the need to ensure the primacy of mental health orders over guardianship orders is obvious. For example, there is a clear issue of community safety as many forensic patients have been involved in serious index events such as murder, manslaughter, arson and serious assault.

Related issues

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

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

Conclusion

The Tribunal thanks the Commission for this opportunity to make a submission. If any clarification or further comment would assist the [redacted]

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Mental Health Review Tribunal

Medical Consent Regimes

Mental Health and Guardianship Legislation[1]

The following table sets out an understanding of the consent regime likely to be applicable by reference to patient category and treatment for persons under the *Mental Health Act 2007* or the *Mental Health (Forensic Provisions) Act 1990*.[2]

Category	Mental health treatments	Electro convulsive therapy (ECT)	Sterilisation	Termination of pregnancy	Surgical treatment	Any other non-surgical treatment
Voluntary patient	Mental Health or Guardianship[3]	Mental Health	Guardianship	Guardianship	Guardianship	Guardianship
Detained patient Involuntarily admitted and awaiting assessment under s 27 of the MHA or admitted on a breach of a CTO	Mental Health	Mental Health	Guardianship	Guardianship	Guardianship	Guardianship
Assessable person Involuntarily admitted and assessment carried out under s 27 of the MHA but before the Mental Health Inquiry	Mental Health	Mental Health	Guardianship	Guardianship	Guardianship	Guardianship
Mentally disordered patient	Mental Health	Mental Health	Guardianship	Guardianship	Guardianship	Guardianship
Involuntary patient Involuntarily detained after the Mental Health Inquiry (MHRT order has been made)	Mental Health	Mental Health	Mental Health	Mental Health (if surgical treatment[4])	Mental Health[5]	Guardianship(including non-surgical termination of pregnancy)
Forensic or correctional patients	Mental Health	Mental Health	Mental Health	Mental Health (if surgical treatment[6])	Mental Health	Guardianship (including non-surgical termination of pregnancy)

[1] See overleaf for Notes.

[2] Note that references in the table to 'Mental Health' and 'Guardianship' are references to the *Mental Health Act 2007* and *Guardianship Act 1987* respectively.

[3] *Mental Health Act 2007* applies if patient has capacity to consent. *Guardianship Act 1987* applies if the treating practitioner believes the patient lacks capacity to consent.

[4] 'Surgical treatment' is defined in the *Mental Health Act 2007* as 'a surgical procedure, a series of related surgical operations or surgical procedures, and the administration of an anaesthetic for the purpose of medical investigation' (s 98).

[5] See footnote 4 above.

[6] See footnote 4 above.

Notes

The *Guardianship Act 1987*, *Mental Health Act 2007* and the *Mental Health (Forensic Provisions) Act 1990* provide medical consent regimes for people to whom those Acts apply.

Under section 34(2) of the *Guardianship Act 1987*, the provisions of the *Mental Health Act 2007* or the *Mental Health (Forensic Provisions) Act 1990* will prevail in the event of an inconsistency between the provisions of Part 5 of the *Guardianship Act* and either of those two Acts.

Patient categories

These are the relevant patient categories under the *Mental Health Act 2007*:

- **Voluntary patient** – a person admitted under Chapter 2 or reclassified as a voluntary patient.
- **Detained patient** – A person admitted (involuntarily) to a mental health facility awaiting assessment under section 27 of the Act or on a breach of CTO under section 63.
- **Mentally disordered person** – A person (whether or not suffering from a mental illness) whose behaviour is so irrational that they have been assessed under section 27 of the Act as requiring involuntary detention for their own protection from serious physical harm or the protection of others from serious physical harm.
- **Assessable person** - A person detained in a declared mental health facility after examinations under section 27 of the Act for whom a mental health inquiry is required to be held.
- **Involuntary patient** - A person ordered to be detained as an involuntary patient after a mental health inquiry (or otherwise by the Mental Health Review Tribunal) and includes a forensic patient and a correctional patient * (section 4 and section 98) and for the purposes of mental health treatments and ECT includes "a detained person" (section 82).
- **Forensic patients -** a person detained in a mental health facility, correctional centre or released subject to an order for conditional release under the *Mental Health (Forensic Provisions) Act 1990.*
- **Correctional patients** – a sentenced or remand inmate transferred from a correctional centre to a mental health facility.

Community Treatment Order (CTO)

Note the following general comments:

- As persons on CTOs are not "patients" under the MHA, the categories set out above under the MHA do not apply. The Guardianship Act applies.
- The MHA authorises medication and treatment as set out in a Treatment Plan that forms part of the CTO.
- Treatment Plans should be carefully scrutinised if an application for consent to medical treatment is being considered by NCAT to ensure that consent is not being sought for mental health and associated treatment already contained in the treatment plan.
- In addition, if consent is sought for any other treatment or intervention, evidence should be sought as to whether what is being proposed fits with the treatment contained in the Treatment Plan or is not contra indicated.